House Health Committee
Public Hearing Agenda

Wednesday, October 4, 2023
9:00 a.m. to 11:00 a.m.
G-50 Irvis Office Building

Health Subcommittee on Health Facilities: Hearing on Hospital Consolidation and Closure

Panel One

Dr. Rachel Werner
Executive Director, Leonard Davis Institute of Health Economics, University of Pennsylvania

Patrick Keenan
Director of Consumer Protections and Policy, Pennsylvania Health Access Network (PHAN)

Panel Two

Maureen Hensley-Quinn
Senior Program Director, National Academy for State Health Policy (NASHP)

Tracy Wertz
Chief Deputy Attorney General, Antitrust Section, Pennsylvania Office of Attorney General

Eugene Herne
Senior Deputy Attorney General-in-Charge, Pennsylvania Office of Attorney General

Panel Three

Dr. Paula Chatterjee
Director, Health Equity Research at Leonard Davis Institute of Health Economics, University of Pennsylvania

PA House Health Committee Hearing
October 5, 2023
Testimony submitted by:

Rachel M. Werner, MD, PhD
Executive Director, Leonard Davis Institute of Health Economics
Robert D. Eilers Professor of Health Care Management and Economics
Professor of Medicine
University of Pennsylvania

WRITTEN TESTIMONY

Chairpersons Frankel and Rapp, distinguished Committee members, staff, and fellow panelists, thank you for the opportunity to submit written testimony today on this important topic of hospital consolidation and closure. My name is Rachel Werner. I am a general internist and a health economist and have been studying the health care sector, and specifically the effects of health care payment and financing on quality and access, for over 20 years. I am a Professor of Medicine and of Health Care Management and Economics at the University of Pennsylvania. I am also the Executive Director of Penn's Leonard Davis Institute of Health Economics.

A substantial number of United States (U.S.) hospitals have closed in recent years, averaging 21 hospitals annually between 2010 and 2015,[1] with 47 closures in 2019 alone. Closures have been particularly pronounced in rural areas. Between 2010 and 2022, 143 rural hospitals closed — 19 of which occurred in 2020 alone.[2,3] This trend in closures has accelerated with the financial stressors that hospitals experienced during the COVID-19 pandemic. And now, hospitals are facing an additional challenge — rising costs for labor, supplies, and drugs, pronounced workforce shortages, sicker patients and longer hospital stays, increasing the financial pressures on U.S. hospitals.

My goal is to provide an overview of trends in markets for and investment in hospitals, including consolidation, private equity investment, and privatization and, for each, how we understand the impact of these changes on financial outcomes, quality, and access to care.

CONSOLIDATION

There are two main types of consolidation – horizontal and vertical. I will limit my comments today to horizontal consolidation, or when a hospital (or hospital system) merges with another hospital (or hospital system), typically in the same market.

There were 1887 hospital mergers announced between 1998 and 2021, according to the American Hospital Association. Those mergers reduced the number of hospitals from about 8000 down to around just over 6000. As a result of these mergers, the number of independent hospitals declined. By 2017, two thirds of all hospitals were part of a larger system, as compared to 53% in 2005.[4]

Merging hospitals claim potential benefits from horizontal consolidations, including increased care coordination, reduced duplication of clinical services, improved clinical integration and management, reduced operating and administrative costs, and increased local access to acute care services.

At the same time, opponents of consolidation cite several concerns about the effects from consolidation stemming from the increased market power that results from consolidation. These include increased prices and limited benefit to patients or health care quality.

Effect of consolidation on prices, quality, and access

Effect on prices

The effects of horizontal mergers on prices are pretty clear. Research suggests that hospital consolidation leads to higher prices for commercially insured patients. Hospital market power is one factor that affects prices.[5] For example, one study found that hospitals that do not have any competitors within a 15-mile radius have prices that are 12.5% higher than hospitals in markets with three or more competitors.[6] The study also found that when two hospitals within five miles of one another merged, it resulted in an average price increase of 6% or more.[6] A similar study found that mergers of two hospitals in the same state led to price increases of 7% to 9%, even when hospitals were not in the same market (see more on cross-market consolidation below).[7] These price increases are generally thought to be due to increased market power after merging.

Effect on quality

The evidence on the effect of consolidation on quality of care is mixed, but a fair amount of evidence suggests that quality of care may be worse in highly consolidated markets compared to markets with more competition. One study found that risk-adjusted mortality for one year after a heart attack was 4.4% higher in more consolidated hospital markets compared to less consolidated markets.[8] Another study found that patients in areas with a more concentrated cardiology market had worse health outcomes for hypertension and heart attacks.[9] A 2020 study found that in the three years after a hospital was acquired, there was no improvement in patient outcomes, including 30-day readmission and mortality rates. This study also found that patient experience of care worsened slightly after a merger, with patients reporting they were less likely to recommend the hospital and doctors' and nurses' communication was worse.[10]

Effect on access

There is less evidence of the effect of hospital consolidation on access to care. A recent study examined this question, finding that as hospital markets became more consolidated, fewer

Medicaid enrollees were admitted to the hospital compared to overall number of patient admissions. This effect was particularly pronounced for labor and delivery admissions, the most common reason for Medicaid admissions.[11]

Approaches to addressing consolidation

There are a number of potential state actions that could limit hospital consolidation and, once mergers occur, the ill-effects of consolidation.

States can serve as another potential check on anti-competitive mergers and can sue under federal anti-trust law and enforce their own laws. A recent review of state anti-trust enforcement in health care identified several practices that support robust enforcement,[12] including adequate notice requirements for potential mergers and waiting periods for state reviews and establishing criteria for merger review and the ability to conduct a full analysis of economic and health care implications.

Once a merger has taken place, State attorneys general can prohibit anti-competitive practices. This can include pursuing anti-competitive actions that prevent insurers from providing information to enrollees about more or less expensive providers, or from providing incentives to enrollees to go to less expensive providers (e.g., anti-tiering, anti-steering, and gag clauses).

States can also promote competition and consumer choice through benefit design and by improving the transparency of hospital price and quality. Additionally, states can limit the effects of consolidation on commercial prices by establishing caps on provider prices or using all-payer rate setting.

Finally, policymakers and regulators should consider potential impacts of consolidation on care and access for Medicaid patients, in particular, when reviewing mergers or developing policy responses to hospital concentration. Additionally, as Medicaid patients are more likely to receive care at public hospitals, investing in the public hospital systems and the safety net may be warranted in response to increasing market concentration.

CROSS-MARKET CONSOLIDATION

While the prior review has focused on the effects of within-market hospital consolidation, there has been a growth in cross-market consolidation that is noteworthy. There have been a large number of mergers and acquisitions between hospitals and health systems that operate in different regions. A noteworthy recent example in Pennsylvania is the announced plans for Kaiser Permanente (operating in five states in the Western U.S., Georgia, Maryland, Virginia, and DC) and Geisinger (operating in Pennsylvania) to merge.[13]

Cross-market mergers are becoming increasingly common. In one recent study, about 1,500 hospitals were targeted for merger or acquisition between 2010 and 2019 and most of these deals (55%) involved hospitals or health systems in a different market.[14] In another study, one

in eight rural hospitals merged with an out-of-market hospital or health system between 2010 and 2018.[15]

Even when a hospital merges with a hospital in a different geographic area, some studies suggest that the merger can impact competition and prices. Research has estimated that cross-market mergers have led to price increases ranging from 6 to 17 percent.[7,16,17] One reason that prices rise when hospitals merge across markets is that these mergers increase the acquired hospital's bargaining positions with insurers, which seek to have strong provider networks across multiple areas in order to attract employers with employees in multiple locations. Additionally, through network negotiations with insurers, large hospital systems can shift volume to higher cost facilities. For example, hospital systems may require that insurers include *all* hospitals in their system in a provider network if the insurer wants *any* hospitals included. This can lead to higher cost hospitals being in a provider network even when there are lower cost hospitals nearby.

Cross-market mergers could also reduce access to care. This is particularly a concern for cross-market mergers involving rural hospitals. Some research suggests that when a large health system acquires a small rural hospital, the rural hospital may become less responsive to community needs and more willing to eliminate some service lines, such as obstetric care.[18,19] Hospitals may also reduce spending on community benefits after being acquired by a health system.[20]

Historically, cross-market mergers have not received much scrutiny. However, more recently, the Federal Trade Commission has identified these types of deals as an area of interest and has begun investigating some cross-market mergers.

Some states, such as California, have used their legal authority to impose conditions on cross-market deals,[21-23] including restricting price increases and requiring merged hospitals to maintain certain services, including obstetrics. Others, such as Minnesota, have investigated whether to challenge proposed cross-market mergers. In addition, regulators could prohibit certain types of clauses in contracts between hospitals and insurers that limit their ability to leverage market power to negotiate for higher prices in one market based on their strong position in another.[24]

PRIVATE EQUITY ACQUISITION

Acquisitions of hospitals and health systems by private equity (PE) firms has soared over the past decade, sparking debate about the growing influence of PE in U.S. health care and how it might affect costs, quality, and access. These firms typically invest in businesses by taking a majority stake with the goal of increasing the value of the business and potentially selling it at a profit. Private equity firms often sell their investments within three to seven years, so they may have a short time horizon for evaluating investments in improving acquired firms.[25]

In 2010, there were 325 PE deals in health care in the U.S. By 2021, that number was well over one thousand. PE firms have invested nearly $1 trillion through thousands of deals to acquire hospitals and specialized practices in the past decade.[26] In 2017, 11% of inpatient admissions were to a facility that had experienced PE ownership at some point.[27]

PE investment may have benefits for the acquired firm. These investments create value for companies by providing access to capital to support infrastructure improvements like IT systems and new facilities, leveraging economies of scale, and ensuring that firms have adopted managerial best practices. However, critics worry that PE's focus on maximizing returns results in lower quality, lower staffing, and lower access to care. Critics also question whether the short lifecycle of PE funds (of seven to ten years) decreases the investment made in the communities and patients that hospitals serve. Some have raised concerns that PE firms are skilled at exploiting loopholes in existing regulations to maximize their profits.

Effect of private equity acquisition on financial outcomes, quality, and access

Financial Outcomes

While media headlines have reported bankruptcy filings among PE-acquired hospitals, including Hahnemann Hospital in Philadelphia, research has not found evidence to support that PE acquisition causes widespread financial instability after a hospital is acquired by a PE firm. In one study, hospitals on average actually improved their financial performance after being acquired by a PE firm. When compared with similar hospitals in the same market, PE-acquired hospitals increased their operating margins by nearly two percentage points, an improvement that came from both cutting operating costs and increasing revenues. On the cost side, hospitals acquired by PE firms decreased staffing (both overall and specifically for nurses) but also found other ways to become more efficient, amplifying the gains they achieved from staffing changes alone.[28] Another study found that PE buyouts led to an 11% increase in healthcare spending, driven by higher prices at PE-owned hospitals and price spillovers to other hospitals in the same market.[29] Other work found that PE-acquired hospitals had larger increases in net income, charges, and charge to cost ratios.[30]

Quality

Acquisition of hospitals by private equity was associated with improvement in some quality measures relative to nonacquired controls.[30] The aggregate quality score for acute myocardial infarction and pneumonia both increased (by 3.3% and 2.9% respectively) though the aggregate score for heart failure did not differentially change. Another study found that PE acquisition was associated with lower inpatient and lower 30-day mortality (by 1.1 to 1.4 percentage points) among patients admitted with acute myocardial infarction and no differences in other dimensions of quality or in other medical conditions.

Access

At a patient level, there is no evidence at present that shows that PE-acquired hospitals engaged in cherry-picking of healthier patients. The impact of PE acquisition of hospitals on

access to care for low-income and Medicaid-enrolled patients is not known, though there is some evidence that PE-acquired hospitals are more likely to engage in surprise medical billing.[31]

Likewise, there is no strong evidence that PE acquisition is associated with a reduction in unprofitable service lines. In one study, compared to non-acquired hospitals, PE acquisition was associated with a higher probability of adding some profitable hospital-based services (interventional cardiac catheterization and hemodialysis), profitable technologies (robotic surgery and digital mammography), and freestanding or satellite emergency departments. It was also associated with an increased probability of providing services that were previously categorized as unprofitable (for example, mental health services).[32] Some evidence does suggest that PE-acquired hospitals appear to shift their focus from outpatient care to more-lucrative inpatient care services, possibly reducing access to outpatient care.[33]

Effect of private equity acquisition on consolidation

Ongoing monitoring of the direct effects of PE on hospital finances, quality, and access is vitally important. Equally important are the indirect effects of PE through its impact on consolidation. While evidence of consolidation due to PE acquisition in the hospital sector is scant, in the setting physician practices, there is evidence that PE acquisition is increasing consolidation. The pace at which PE firms are acquiring small practices is increasing.[34] These acquisitions represent a small share of practices overall, when considering all medical practices in the United States. However, PE acquisition of small firms can lead to more consolidation over time, as PE firms often continue to acquire additional nearby practices,[35] and this series of small acquisitions results in market consolidation. However, because each individual acquisition is small, it is often not scrutinized. As noted above, the increasing consolidation can lead to commercial higher prices with no positive effects on quality and potentially deleterious effects on access.

Approaches to addressing private equity acquisition

While evidence to date of the negative effects of PE acquisition on hospitals is limited to date, ongoing monitoring of these effects is important given that the profit-focused motivation of PE firms may not align with improvements in patient health and outcomes or with investment in communities.

States have a number of potential levers to limit the effects of PE acquisition of hospitals. These include scrutinizing and closing loopholes that create opportunities for PE firms to profit at the expense of patient welfare. Example of such loopholes include surprise billing or perverse incentives that may adversely impact the affordability, quality, and access to care.

Regulators should monitor small acquisition deals under the $101 M limit – deals that often avoid scrutiny but, when added together, lead to consolidation.

States can require better transparency and reporting of PE deals and the terms of those deals, which would allow closer monitoring and accountability of the impacts of PE acquisition on hospitals and the patients and communities they serve.

PRIVATIZATION

Finally, it is worth noting that privatization of public hospitals may have deleterious effects on quality and access of care, even while helping maintain a hospital's financial stability. Privatization is when private companies (either for-profit or not-for-profit) acquire a previously government-run hospital, converting a publicly financed hospital to a privately financed one. Public hospitals are often important providers of safety-net care for individuals who are uninsured or insured by Medicaid. Although public hospital beds only account for 4% of all hospital beds in Pennsylvania, the trend toward privatization of public beds represents a larger trend focused on profitability of health care over quality and access.

Many hospitals have moved from public financing to private hands over the past decades. The share of hospitals owned and operated by a government body declined by 42% from 1983 to 2019.[36] On one hand, this trend might improve the profitability (and thus stability) of hospitals as revenue per patient increases. At the same time, it could have deleterious effects on patients' access to hospital care, particularly for patients who are uninsured or insured by Medicaid.

One recent study examined this issue, examining the consequences of 258 hospital privatizations from 2000 to 2018 across the U.S.[37] They found that after a private company took over a hospital that was previously public, the hospital became more profitable, increasing patient revenues sufficiently so that the hospitals shift from losing money to generating a modest surplus.

But they also found that access to care declined, observing a decline in overall patient volume by 8.4%, which was largely driven by a decline in Medicaid admissions. While there was a decline in admission for Medicare patients, it was smaller and hospitalizations for Medicare patients appeared to be absorbed by neighboring hospitals. On the other hand, there was an overall decline in hospitalizations for Medicaid patients across the market, which likely reflects a decline in access to care.

The mechanism of these declines in Medicaid access is unknown, but could be due to hospitals declining to renew Medicaid contracts; insurers taking a hospital out of the Medicaid network; or privatized hospitals cutting service lines used by Medicaid-insured patients, such as mental health.

References

1. Kaufman BG, Thomas SR, Randolph RK, et al. The Rising Rate of Rural Hospital Closures. *J Rural Health*. 2016;32:35-43. doi:10.1111/jrh.12128
2. American Hospital Association. *Rural Hospital Closures Threaten Access - Solutions to Preserve Care in Local Communities*. 2022:10. September 2022. https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf
3. Rural Hospital Closures. 2023. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/. Chapel Hill, NC.
4. Cutler DM, Scott Morton F. Hospitals, market share, and consolidation. *JAMA*. 2013;310:1964-1970. doi:10.1001/jama.2013.281675
5. MedPAC. *Report to the Congress: Medicare Payment Policy*. Medicare Payment Advisory Commission; 2020.
6. Cooper Z, Craig SV, Gaynor M, Van Reenen J. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *Q J Econ*. 2019;134:51-107. doi:10.1093/qje/qjy020
7. Dafny L, Ho K, Lee RS. The price effects of cross-market mergers: theory and evidence from the hospital industry. *Rand J Econ*. 2019;50:286-325. doi:10.1111/1756-2171.12270
8. Kessler DP, McClellan MB. Is Hospital Competition Socially Wasteful? *The Quarterly Journal of Economics*. 2000;115:577-615.
9. Koch T, Wendling B, Wilson NE. Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries. *Health Serv Res*. 2018;53:3549-3568. doi:10.1111/1475-6773.12825
10. Beaulieu ND, Dafny LS, McWilliams JM. Changes in Quality of Care after Hospital Mergers and Acquisitions. Reply. *N Engl J Med*. 2020;382:1868. doi:10.1056/NEJMc2001367
11. Desai SM, Padmanabhan P, Chen AZ, Lewis A, Glied SA. Hospital concentration and low-income populations: Evidence from New York State Medicaid. *J Health Econ*. 2023;90:102770. doi:10.1016/j.jhealeco.2023.102770
12. King JSaC, Samuel and Montague, Alexandra and Gudiksen, Katherine and Gu, Amy and Arnold, Daniel and Greaney, Thomas L. *Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States*. Hastings U; 2020. December 8, 2020. https://sourceonhealthcare.org/wp-content/uploads/2020/06/PreventingAnticompetitiveHealthcareConsolidation.pdf
13. Kaiser Permanente and Geisinger come together to launch Risant Health and expand access to value-based care. Geisinger; April 26, 2023. https://www.geisinger.org/about-geisinger/news-and-media/news-releases/2023/04/26/15/46/kaiser-permanente-and-geisinger-come-together-to-launch-risant-health

14. Fulton BD, Arnold DR, King JS, Montague AD, Greaney TL, Scheffler RM. The Rise Of Cross-Market Hospital Systems And Their Market Power In The US. *Health Aff (Millwood)*. 2022;41:1652-1660. doi:10.1377/hlthaff.2022.00337

15. Carroll C, Euhus R, Beaulieu N, Chernew ME. Hospital Survival In Rural Markets: Closures, Mergers, And Profitability. *Health Aff (Millwood)*. 2023;42:498-507. doi:10.1377/hlthaff.2022.01191

16. Schmitt M. Multimarket Contact in the Hospital Industry. *Am Econ J-Econ Polic*. 2018;10:361-387. doi:10.1257/pol.20170001

17. Lewis MS, Pflum KE. Hospital systems and bargaining power: evidence from out-of-market acquisitions. *Rand J Econ*. 2017;48:579-610. doi:10.1111/1756-2171.12186

18. O'Hanlon CE, Kranz AM, DeYoreo M, Mahmud A, Damberg CL, Timbie J. Access, Quality, And Financial Performance Of Rural Hospitals Following Health System Affiliation. *Health Aff (Millwood)*. 2019;38:2095-2104. doi:10.1377/hlthaff.2019.00918

19. Henke RM, Fingar KR, Jiang HJ, Liang L, Gibson TB. Access To Obstetric, Behavioral Health, And Surgical Inpatient Services After Hospital Mergers In Rural Areas. *Health Aff (Millwood)*. 2021;40:1627-1636. doi:10.1377/hlthaff.2021.00160

20. Owsley KM, Lindrooth RC. Understanding the relationship between nonprofit hospital community benefit spending and system membership: An analysis of independent hospital acquisitions. *J Health Econ*. 2022;86:102696. doi:10.1016/j.jhealeco.2022.102696

21. Attorney General Becerra Conditionally Approves Affiliation Agreement Between Cedars-Sinai and Huntington Memorial Hospital. State of California Department of Justice; December 10, 2020, 2020. https://oag.ca.gov/news/press-releases/attorney-general-becerra-conditionally-approves-affiliation-agreement-between

22. Attorney General Bonta Conditionally Approves Affiliation Agreement Between Methodist Hospital and USC Health System. State of California Department of Justice; June 3, 2022, 2022. https://oag.ca.gov/news/press-releases/attorney-general-bonta-conditionally-approves-affiliation-agreement-between

23. Attorney General Bonta Conditionally Approves Sale of Adventist Health Vallejo. State of California Department of Justice; October 5, 2021, 2021. https://oag.ca.gov/news/press-releases/attorney-general-bonta-conditionally-approves-sale-adventist-health-vallejo

24. Guidiksen KL, Montague, Alexandra D., King, James S. *Mitigating the Price Impacts of Health Care Provider Consolidation*. 2021. September 23, 2021. https://www.milbank.org/publications/mitigating-the-price-impacts-of-health-care-provider-consolidation/

25. Resneck JS, Jr. Dermatology Practice Consolidation Fueled by Private Equity Investment: Potential Consequences for the Specialty and Patients. *JAMA Dermatol*. 2018;154:13-14. doi:10.1001/jamadermatol.2017.5558

26. Schulte F. Sick Profit: Investigating Private Equity’s Stealthy Takeover of Health Care Across Cities and Specialties. KFF Health News. 2023.

https://kffhealthnews.org/news/article/private-equity-takeover-health-care-cities-specialties/

27. Offodile AC, 2nd, Cerullo M, Bindal M, Rauh-Hain JA, Ho V. Private Equity Investments In Health Care: An Overview Of Hospital And Health System Leveraged Buyouts, 2003-17. *Health Aff (Millwood)*. 2021;40:719-726. doi:10.1377/hlthaff.2020.01535
28. Cerullo M, Lin YL, Rauh-Hain JA, Ho V, Offodile AC, 2nd. Financial Impacts And Operational Implications Of Private Equity Acquisition Of US Hospitals. *Health Aff (Millwood)*. 2022;41:523-530. doi:10.1377/hlthaff.2021.01284
29. Liu T. Bargaining with Private Equity: Implications for Hospital Prices and Patient Welfare. *SSRN*. 2022:3896410.
30. Bruch JD, Gondi S, Song Z. Changes in Hospital Income, Use, and Quality Associated With Private Equity Acquisition. *JAMA Intern Med*. 2020;180:1428-1435. doi:10.1001/jamainternmed.2020.3552
31. Gustafsson L, Seervai, Shanoor, Blumenthal, David. *The Role of Private Equity in Driving Up Health Care Prices*. 2019. *Competitive Strategy*. October 29, 2019. https://hbr.org/2019/10/the-role-of-private-equity-in-driving-up-health-care-prices
32. Cerullo M, Yang KK, Roberts J, McDevitt RC, Offodile AC, 2nd. Private Equity Acquisition And Responsiveness To Service-Line Profitability At Short-Term Acute Care Hospitals. *Health Aff (Millwood)*. 2021;40:1697-1705. doi:10.1377/hlthaff.2021.00541
33. Cerullo M, Kaila Yang, Kelly, McDevitt, Ryan C., Joynt Maddox, Karen, Roberts, James W., Offodile II, Anaeze C. Research: What Happens When Private Equity Firms Buy Hospitals? Harvard Business Review. Updated March 20, 2023. 2023. https://hbr.org/2023/03/research-what-happens-when-private-equity-firms-buy-hospitals
34. Zhu JM, Hua LM, Polsky D. Private Equity Acquisitions of Physician Medical Groups Across Specialties, 2013-2016. *JAMA*. 2020;323:663-665. doi:10.1001/jama.2019.21844
35. Gondi S, Song Z. Potential Implications of Private Equity Investments in Health Care Delivery. *JAMA*. 2019;321:1047-1048. doi:10.1001/jama.2019.1077
36. Scott D. A worrisome trend in American hospitals is hurting poor patients. Vox. Updated January 13, 2023. 2023. https://www.vox.com/policy-and-politics/2023/1/13/23550067/us-hospitals-medicaid-patients-health-care-access
37. Duggan M, Gupta A, Jackson E, Templeton ZS. The Impact of Privitization: Evidence from the Hospital Sector. *NBER Working Paper Series*. 2023:30824.

Patient Perspectives on Hospital Closures and Consolidation

Testimony for Informational Hearing of the PA House Health Subcommittee on Facilities
October 4, 2023

The Pennsylvania Health Access Network (PHAN) is a statewide organization providing assistance annually to thousands of Pennsylvanians in nearly all of Pennsylvania's 67 counties. We help people navigate problems they encounter enrolling in health coverage, getting care, or resolving issues from care they already received, including medical bills. Through our Helpline and our in-person connections with individuals in local communities, we hear hundreds of stories each year of how healthcare is not working for Pennsylvania families, small business, seniors, and hardworking individuals and young adults. To that end, PHAN also advocates for policies that improve the quality, affordability, and equity of healthcare for all Pennsylvanians.

When hospitals close, local communities struggle. Why are hospitals closing in our state?

Over the past several years, more communities have experienced a hospital closure. Whether a full hospital closure or partial hospital closure with key services eliminated, communities struggle with this impact. Patients not only lose access to hospital-based care, but they often also lose access to diagnostic imaging and tests, and to their trusted doctors, who have to move their practices to new locations. Healthcare jobs, often filled by our neighbors and friends, are lost and our local communities struggle with the economic impacts a closure has.

Closures mean that patients end up traveling longer distances to get care. This additional travel is often complicated by the fact that local providers may be in-network with their current health plan before the closure, but out of network post closure due to needing to get care across county - or even state - lines. Because of all these new challenges related to the closures, patients frequently wait or put off critical, sometimes life-saving care.

While there are many factors and unique situations that lead to a full or partial closure, there is a consistent unifying factor: hospitals that have a full or partial closure almost always have a preceding merger, acquisition, or change in ownership prior to that closure.

- More than 90% of closures are preceded by a merger, acquisition, or change in ownerships. Thirty of the 33 hospital closures we looked at in the past 20 years, and 14 of 15 closures in the past 5 years have been preceded by a merger, acquisition, or change in ownership.
- The pace of hospital closures is increasing with nearly half of the closures in the past 20 years happening in just the last 5 years.
- The time between a merger, acquisition, or change in ownership and a closure has decreased by nearly half: from 7.6 years when you look at the past 2 decades, to just 4.1 years over the past 5 years.

A merger, acquisition, or change in ownership is one of the best predictors that a community will experience a full or partial closure. Many promises are made during these mergers, acquisitions, or changes in ownership and sadly communities often realize too late that those promises are broken as soon as the cameras are off and the attention fades. Our local communities and patients deserve better accountability and transparency whenever their community faces a merger, acquisition, or change in ownership.

Not all mergers, acquisitions, or changes in ownership are bad. We have seen examples in Pennsylvania particularly in the North Central part of the state - Potter, Tioga, and Lycoming Counties - where access to care has been preserved and even enhanced. We have, though, also seen a nearby closure in Lock Haven, Clinton County. While there is no clear, comprehensive data set to examine all of the consolidation-related activity, for the data we have been able to assemble through multiple state and federal data sets, university-based research, and new clippings, it appears that right now in Pennsylvania, roughly one in three mergers, acquisitions or changes in ownership result in a full or partial closure. Communities deserve to know how hospital mergers, acquisitions, or changes of ownership might affect them.

What do hospital mergers, acquisitions, or changes in ownership mean for Pennsylvanians? Closures are a huge part of the problem, but it goes much further than that.

We have heard from other testifiers that in recent years, large health systems have bought up our local hospitals and small regional health systems. The promise has always been that greater efficiency will improve quality and lower costs. In reality, the lack of competition has resulted in few if any gains in patient quality while often leaving communities with higher prices for care.

According to a 2023 statewide survey with a representative sample of Pennsylvania conducted by Altarum's Healthcare Value Hub, **58% of Pennsylvanians** said they are **worried about the impacts of hospital mergers** on their communities.

One in 8 of Pennsylvanians reported that they or a family member were unable to access their preferred health care because of a merger. Of those, **half (52%) skipped follow-up visits**, and **nearly half (45%) delayed or avoided a doctor's visit**. Of those who reported a merger caused some other kind of burden for themselves or their families, **1 in 3** reported **added wait times** in finding or getting care while **1 in 4** reported **added financial burdens**.

Pennsylvanians want solutions that protect patients from anti-competitive practices and the rise of medical monopolies.

The same 2023 Altarum survey showed that across party lines, 9 in 10 Pennsylvanians want the state government to act.

- 89% say the government should stop hospitals from engaging in anti-competitive practices (87% Republicans, 93% Democrats, 87% Independents)
- 86% say the government should strengthen policies to drive more competition in health care markets to improve choices and access (87% Republicans, 88% Democrats, 83% Independents)
- 84% say the government should empower the Attorney General to stop the sale or purchase of hospitals or doctor practices, or monitor those sales for harmful effects such

as reduced access or increased prices (80% Republicans, 89% Democrats, 82% Independents)
- 82% say the government should set limits on healthcare spending growth and penalize payers or providers that fail to curb excessive spending growth (80% Republicans, 85% Democrats, 80% Independents)

Not only are your constituents harmed by a lack of action, but they support you in taking action to improve our healthcare markets, restore competition, and check uncurbed, high and rapidly rising prices.

Thank you for your time and consideration in this matter.

Patrick Keenan, Director of Policy and Partnerships
Pennsylvania Health Access Network
(717) 322-5332
patrick@pahealthaccess.org

Full or Partial Hospital Closures and Hospital Mergers, Acquisitions, or Changes in Ownership 2003 to 2023

Hospital	Closure Type	City	County	Urban or Rural	Year of Merger, Acquisition, or Change in Ownership	Year of Partial or Full Closure	Years between Events
Medical College of Pennsylvania		Philadelphia	Philadelphia	Urban	1998	2003	5
Parkview Hospital		Philadelphia	Philadelphia	Urban	1998	2003	5
Mercy Providence		Pittsburgh	Allegheny	Urban	1993	2004	11
Monsour Medical Center		Jeannette	Westmoreland	Urban	-	2006	
Philipsburg Area Hospital		Phiipsburgh	Centre	Rural	-	2006	
Graduate Hospital		Philadelphia	Philadelphia	Urban	1998	2007	9
Temple University Childrens Medical Center		Philadelphia	Philadelphia	Urban	1997	2007	10
Commonwealth Medical Center		Aliquippa	Beaver	Urban	2004	2008	4
Northeastern Hospital		Philadelphia	Philadelphia	Urban	1995	2009	14
UPMC Braddock		Braddock	Allegheny	Urban	1996	2010	14
Suburban General Hospital		Bellevue	Allegheny	Urban	2004	2010	6
Jeannette Memorial		Jeannette	Westmoreland	Urban	2002	2011	9
Montgomery Hospital		Norristown	Montgomery	Urban	2005	2012	7
St. Catherine's Medical Center at Fountain Springs		Ashland	Schuylkill	Rural	2006	2012	6
Mid Valley Hospital		Peckville	Lackawanna	Urban*	2012	2014	2
St. Joseph's Hospital		Philadelphia	Philadelphia	Urban	1990	2016	26
UMPC Bedford	L&D	Bedford	Bedford	Rural	1997	2017	20
UPMC Southside		Pittsburgh	Allegheny	Urban	1996	2018	22
LVH Schuylkill - Jackson Street	ED	Pottsville	Schuylkill	Rural	2016	2019	3
UPMC Pinnacle Lancaster Hospital		Lancaster	Lancaster	Urban	2017	2019	2
Hahnemann University Hospital		Philadelphia	Philadelphia	Urban	2018	2019	1
Elwood City Medical Center		Elwood City	Lawrence	Rural	2017	2019	2
Bradford Regional Medical Center	L&D, ICU	Bradford	McKean	Rural	2009	2019	10
UPMC Susquehanna Sunbury		Sunbury	Northumberland	Rural	2017	2020	3
Mercy Philadelphia	Inpatient GAC	Philadelphia	Philadelphia	Urban	2018	2020	2
Jennersville Hospital - Tower Health		West Grove	Chester	Urban	2017	2021	4
Springfield Hospital - Crozer Health	ED	Springfield	Delaware	Urban	2016	2022	6
First Hospital - Commonwealth Health		Kingston	Luzerne	Urban	2017	2022	5
Delaware County Memorial Hospital - Crozer Health		Drexel Hill	Delaware	Urban	2016	2022	6
Brandywine Hospital - Tower Health		Coatesville	Chester	Urban	2017	2022	5
Berwick Hospital Center	Inpatient GAC, ED	Berwick	Columbia	Rural	2020	2022	2
Doylestown Hospital	Inpatient Pediatric	Doylestown	Bucks	Urban	-	2022	
UPMC Lock Haven	Inpatient GAC	Lock Haven	Clinton	Rural	2017	2023	6

In the past 20 years, PA had 33 full or partial closures; 30 were preceded by a merger or acquisition.

In the past 5 years, PA had 15 full or partial closures; 14 were preceded by a merger or acquistion.

Total Average Years between Events: **7.6**

Past Five Years Average Years between Events: **4.1**

More closures are happening than ever before, and the amount of time between a merger, acquistion, or change in ownership and a closure has been cut nearly in half.

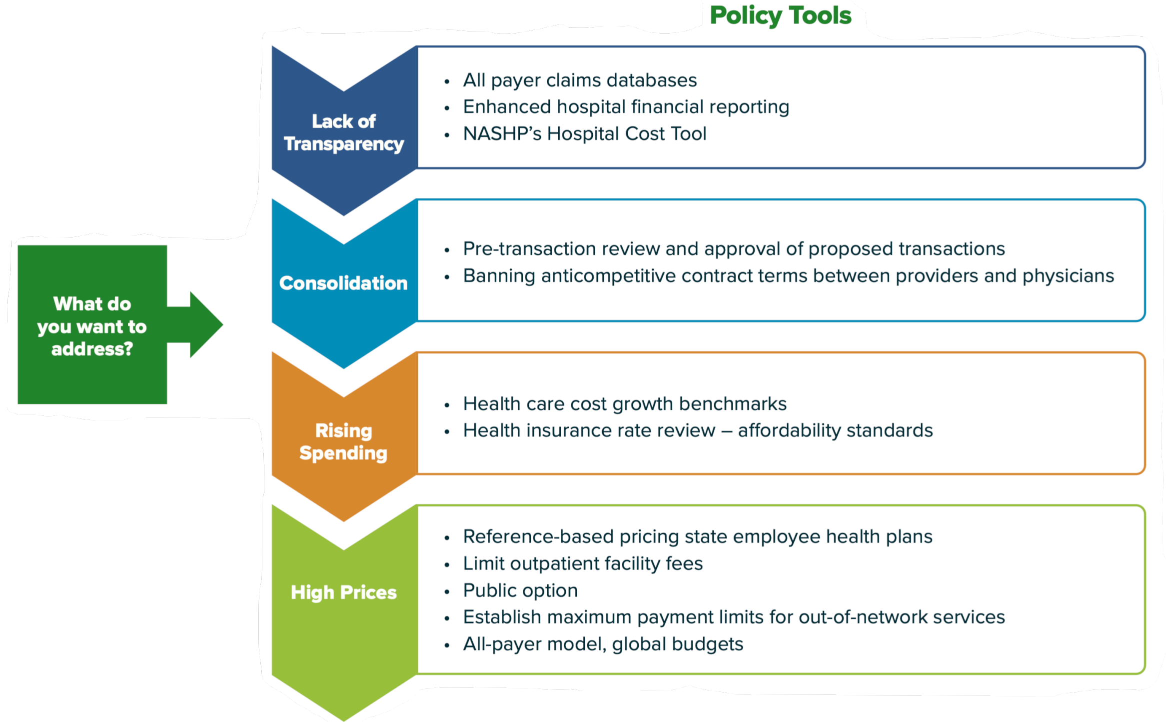
Pennsylvania Health Access Network
Prepared by Patrick Keenan, patrick@pahealthaccess.org, (717) 322-5332

Testimony Relating to Health Market Consolidation

From: Maureen Hensley-Quinn, Senior Director, Coverage, Cost and Value at the National Academy for State Health Policy (NASHP)
To: Health Subcommittee on Health Facilities
Date: October 4, 2023
RE: Informal Meeting on Hospital Consolidation and Closure

NASHP is a national, non-partisan forum of policymakers that works to develop and promote innovative health policy solutions. Our work is guided by state health officials across multiple agencies and offices – including executive and legislative branches of government – to solve problems, conduct policy analysis and research, and provide technical assistance.

At state officials' request, NASHP established a Center on Health System Costs to better understand hospital and health systems financials and understand their role as drivers of health care costs. Based upon further state guidance and requests for policy solutions and assistance, consolidation and the changing health market is a primary focus of NASHP's hospital and health system costs work. While work is always evolving, the following graphic provides a snapshot of states' focus areas and available policy tools that NASHP can assist with or for which NASHP has model policy/legislative language.



Washington, DC
1233 20th Street NW, Suite 303
Washington, DC 20036
202-903-0101

Portland, Maine
Two Monument Sq., Suite 910
Portland, ME 04101
207-874-6524

Potential Policy Solutions States are Using to Address Consolidation

Evidence suggests that vertical integration and growing consolidation in health care leads to higher hospital and provider prices and higher total spending — all while having little to no impact on improving quality of care for patients, reducing utilization, or improving efficiency. A 2021 study also found that mergers that significantly increase hospital concentration result in slowed wage growth for hospital workers. There is growing interest across states to lower health care costs by addressing this consolidation and vertical integration as a root cause for rising health insurance premiums and greater out-of-pocket consumer costs. Additionally, state officials have shared concerns that consolidation can have important access and quality implications that state officials want to monitor more closely.

To date, NASHP supports state policymakers to approach the rapidly changing health market by developing policies to:

- Better navigate an already consolidated market by seeking to mitigate practices that research has demonstrated drive up prices by prohibiting anti-competitive terms in contracts between health purchasers/plans and health systems/hospitals.
- Establish state market oversight authority that includes capacity to review potential transactions and to approve, deny or condition them. Such authority requires entities seeking transactions to alert the state and provide data on the impact to consumers' care and to the overall market.
- Prohibit unwarranted facility fees, defined as added charges to services that are provided either off of a hospital campus in a provider's office or to those that are pre-scheduled on an out-patient basis, such as a routine preventive visit or a screening test, including an MRI or colonscopy. Banning certain facility fees may deincentivize purchase of providers.

These policies can be pursued individually or as a consolidated package that aims to address consolidation by increasing health market competition and by increasing overall market activity transparency. Seeking to address the rapidly changing health market that is increasing costs for the state, employers and consumers is a bi-partisan issue. As noted in NASHP's state legislative tracking on hospital costs Oregon, Texas, Connecticut, Indiana and others have enacted similar policies.

Why Prohibit Anti-Competitive Contracting Terms?

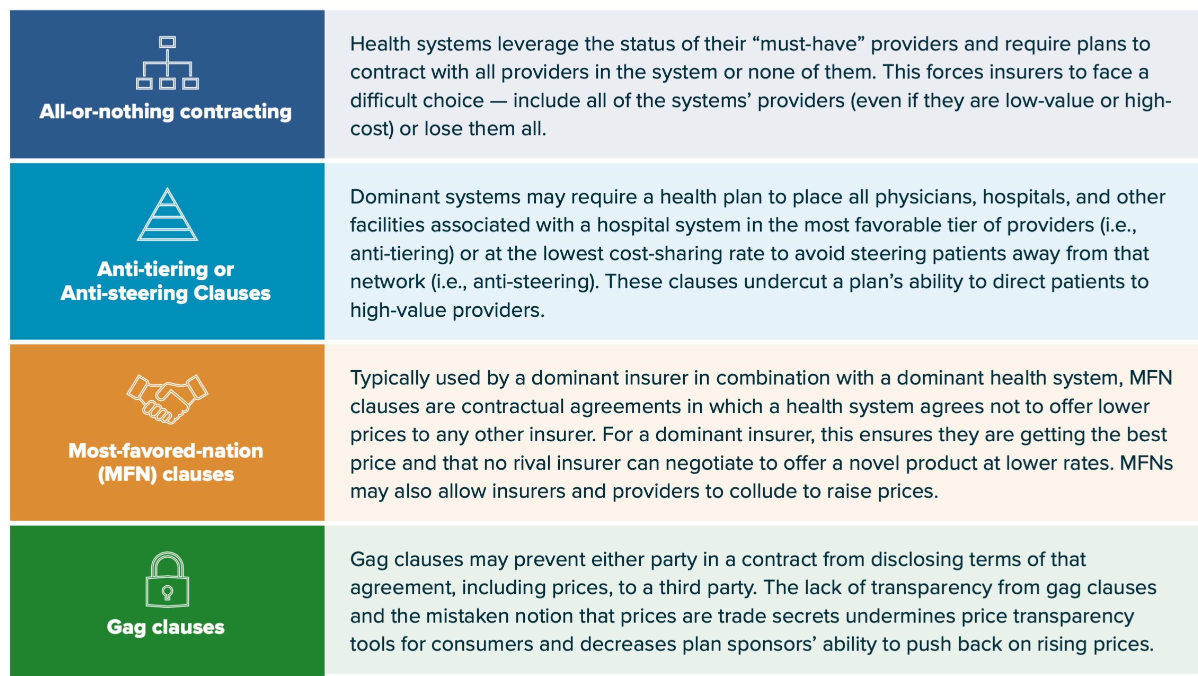
Consolidation of hospitals and providers has created dominant health systems that can use their market power to include anticompetitive clauses in contracts with health plans, which help to drive up health care prices and reduce provider choice for consumers. Insurers may lack the leverage necessary to negotiate more flexible contract terms that could expand in-network providers, increasing competition and consumer choice that could lead to lower reimbursement rates. Prohibiting anticompetitive contract clauses allows insurers a better opportunity to navigate an already consolidated health market.

At states request, NASHP developed a model law to prohibit often used anti-competitive contracting clauses. This white paper offers more background information, additional context and some resources. To date, In addition to state guidance, national and legal experts leveraged available literature, but also information from recent lawsuits (including suits filed against Sutter Health in California) to help identify the contract clauses that have been documented as creating the biggest challenges both to containing prices, but also provider choice. The graphic below highlights each of the contract clauses that

NASHP's model legislation prohibits and why. To date, Nevada, New York, Texas, Indiana, Massachusetts and others have enacted prohibitions on one more of these clauses, with many other states introducing legislation to do the same.

Prohibiting anti-competitive contracting terms

NASHP's model act is designed to help address high-cost drivers **within a consolidated health market** by prohibiting common anti-competitive contracting practices.



Clause	Description
All-or-nothing contracting	Health systems leverage the status of their "must-have" providers and require plans to contract with all providers in the system or none of them. This forces insurers to face a difficult choice — include all of the systems' providers (even if they are low-value or high-cost) or lose them all.
Anti-tiering or Anti-steering Clauses	Dominant systems may require a health plan to place all physicians, hospitals, and other facilities associated with a hospital system in the most favorable tier of providers (i.e., anti-tiering) or at the lowest cost-sharing rate to avoid steering patients away from that network (i.e., anti-steering). These clauses undercut a plan's ability to direct patients to high-value providers.
Most-favored-nation (MFN) clauses	Typically used by a dominant insurer in combination with a dominant health system, MFN clauses are contractual agreements in which a health system agrees not to offer lower prices to any other insurer. For a dominant insurer, this ensures they are getting the best price and that no rival insurer can negotiate to offer a novel product at lower rates. MFNs may also allow insurers and providers to collude to raise prices.
Gag clauses	Gag clauses may prevent either party in a contract from disclosing terms of that agreement, including prices, to a third party. The lack of transparency from gag clauses and the mistaken notion that prices are trade secrets undermines price transparency tools for consumers and decreases plan sponsors' ability to push back on rising prices.

Why Establish Greater Market Oversight?

While the federal government, through the Federal Trade Commission and the Justice Department, and the state Attorney General can review and potentially intervene in hospital and health system mergers that trigger anti-trust concerns, competition in state health markets is decreasing from smaller, more frequent transactions that fall below such thresholds. Many state policymakers don't know that hospital acquisitions of or affiliations with independent or provider groups are happening until they are final. Increasingly, state policymakers report they aren't given advance notice of health system decisions to close clinics, hospitals, or eliminate key services (i.e. birthing services). Creating state market oversight authority can increase transparency of such transactions and allow for evidence-driven reviews with the capacity to allow, deny or condition market changes that wouldn't trigger anti-trust violations.

Health market oversight authority can be established within states in different ways. NASHP explores state options and trade-offs in this paper that leverages existing state experiences and insights. One option is adopt and/or leverage a certificate of need (CON) program. Many states have shared with NASHP that their CON falls short of providing the oversight needed to ensure competition and constrain consolidation. Recognizing Pennsylvania does not currently have CON, a program would need to be developed. However, there is another option – a state market oversight program designed

explicitly to ensure access to services with considerations of other state goals, like affordability and more, as Oregon has implemented.

Leveraging experience from Oregon, as well as that of Massachusetts Health Policy Commission that has transaction review authority, NASHP developed model legislation that establishes increased oversight authority. The NASHP model creates an administrative notice, review, and approval process over a broad range of significant health care transactions, including mergers, acquisitions, or contractual affiliations that result in a change of control. It authorizes a state attorney general to block or place conditions on problematic transactions without going to court. Establishing an administrative process is important because it allows state officials to be more effective at overseeing cumulative, smaller transactions that may amass market power over time.

In addition, state officials can more easily impose conditions on a transaction through an administrative review rather than through an antitrust settlement, which requires the attorney general and merging parties to negotiate an agreement and for the court to approve the settlement in a consent decree. Thus, an administrative transaction review process can be more efficient than antitrust enforcement, and the cost of the review can be paid for through fees charged to the parties of the transaction.

NASHP supports an active workgroup of state officials to discuss policy options for improving market oversight and Minnesota recently enacted legislation to gain more authority for transactions reviews. There are a number of considerations to weigh in pursuing this authority, including data access and analytic capacity, as well as coordination across state entities, including the Attorney General's office. We anticipate there will be more legislative activity in this space in the coming years as states consider their goals, how to leverage existing infrastructure and what else is needed.

Why Prohibit Unwarranted Facility Fees?

Facility fees were originally designed to compensate hospitals for "stand-by" capacity required for trauma centers, emergency departments and inpatient services that are unpredictable. However, as large hospital and health systems acquire more providers and take over their billing, facility fees are added for diagnostic testing and other routine services provided by physicians even if their office is located miles away from a hospital. Through this consolidation, facility fees for non-hospital services are becoming more common and contributing to higher patient out-of-pocket and system costs. Legislation restricting or prohibiting facility fees can help states de-incentivize vertical integration, protect consumers from high costs, and increase transparency of health care costs. As a result, a state advisory group requested and worked with NASHP and legal experts, to develop model legislation to prohibit facility fees soon after the launch of our Center on Health System Costs.

Reduce Incentives for Vertical Integration

A wealth of evidence suggests a link between high costs and vertical integration of health care, when a health system acquires a physician or physician group. Despite potential efficiencies, evidence suggests that vertical integration leads to higher hospital prices, higher physician prices, and higher total expenditures per patient.[1] One way that costs can rise is through the addition of facility fees for outpatient services provided by an acquired physician.

When hospitals acquire a physician practice, a hospital can tack on an additional outpatient facility fee to the professional service fee that physician practice previously charged. Fees for services at physicians' offices usually include both the professional and overhead costs of the service in a single

charge. By contrast, hospital outpatient departments are traditionally paid more than physicians' offices for performing the same type of service. This is because hospital outpatient settings receive a facility fee to compensate them for the expenses of maintaining standby capacity.

However, physician offices do not require the same standby capacity. After being acquired, physicians generally continue to set appointments and see patients as they did prior to becoming affiliated with a hospital. There is often no change in services provided, but the billing has changed. This indicates no change or increase in value but still higher prices than when the physician's practice was characterized as a freestanding community setting. Limiting facility fees charged by off-campus providers reduces incentives for hospitals to acquire physicians because a hospital can't immediately tack on a facility fee and increase revenue.

Protect Consumers

Limiting facility fees can also better protect consumers from high costs. Consumers are increasingly enrolled in insurance plans with high-cost sharing. In the ten years from 2007 to 2017, national average enrollee out-of-pocket spending grew by 58%, more than double the increase in workers' wages during the same period. Consumers are enrolled in plans with higher deductibles and coinsurance rather than copays leaving them more sensitive to the actual cost of health care services. Rising hospital prices and added costs like facility fees can impact consumer's out-of-pocket spending.

News stories have highlighted the variety and severity of facility fees billed for services. One incident in Connecticut for a telehealth visit with a pediatric specialist was found to bring a facility fee of anywhere between $50 and $350 because the doctor would be on hospital property. While a facility fee may seem small when examining overall health care spending, it can be a substantial burden for consumers. Prohibiting unwarranted facility fees and requiring greater consumer notice can offer patients some protection from new or existing costs brought on by vertical integration.

Increase Transparency

One of the key challenges in understanding and addressing facility fees is the lack of transparency and data on these costs. These fees vary greatly across services and providers. As such, it can be challenging for states to understand their impact on overall health care costs. Additionally, a patient might not know if his/her doctor appointment will yield an additional fee. Several states have enacted laws to require better consumer notice of facility fees in a variety of formats – during appointment scheduling, in physical offices, and on itemized bills.

Connecticut has the most experience to date in addressing facility fees. Over time, the state has increased transparency at the consumer level by requiring notice that these fees may be charged, but also for through reporting to the state's Office of Health Strategy. Additional state laws now prohibit facility fees from being charged by providers for evaluation, management and assessment service codes. Colorado, Maine, and Indiana have also taken steps to understand and limit these fees.

Conclusion

Consolidation, both vertical and horizontal, have decreased competition, impacting costs and increasingly access to services, making this a primary issue for states. As a result, there are a growing

number of policy options designed to increase competition. States need to consider their access to data, analytic capacity, and infrastructure to build upon or develop in determining the best policy options for their needs.

Through NASHP's Health System Costs Center, our team is available to answer any questions or help make connections with other states that can share experiences. Please contact me with any follow-up as needed; my email is mhq@nashp.org. Thank you for the opportunity to share this information.

Respectfully,

Maureen Hensley-Quinn
Senior Director | Coverage, Cost, and Value Team
National Academy for State Health Policy
October 4, 2023

[1] Laurence C. Baker, M. Kate Bundorf & Daniel P. Kessler, Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending, 33 Health Aff. 756, 760 (2014); Cory Capps, David Dranove, Christopher Ody, The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending, 59 J. Health Econ. 139 (2018); James C. Robinson & Kelly Miller, Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California, 312 JAMA 1663 (2014); Hannah T. Neprash et al., Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices, 175 JAMA Internal Med. 1932, 1937 (2015).

Testimony of the
Office of Attorney General

Tracy W. Wertz
Chief Deputy Attorney General
Antitrust Section

Eugene Herne
Chief Deputy Attorney General
Charitable Trusts and Organizations Section

Public Hearing Before the
Health Committee

October 4, 2023
G050 Irvis Office Building
Harrisburg, PA

Thank you for the opportunity to [submit testimony / appear today] on what powers the Office of Attorney General has in reviewing hospital transactions and what tools would help strengthen its oversight authority.

The Office of Attorney General reviews hospital transactions and investigates certain conduct in healthcare markets in the Commonwealth. The access to affordable, quality healthcare is of paramount importance in Pennsylvania.

As this Committee and others explore the regulatory and oversight role of the Attorney General in these matters, please allow us to explain the jurisdiction and authority of the Office of Attorney General.

The Attorney General's jurisdiction in these matters is grounded upon the Commonwealth's *parens patriae*[1] responsibility to protect the public's health, safety and welfare, primarily through three areas of law set forth in the Commonwealth Attorneys Act:

> a) The Attorney General shall represent the Commonwealth and its citizens in any action brought for violation of the antitrust laws of the United States and the Commonwealth;
>
> b) The Attorney General shall represent the Commonwealth and … may intervene in any other action, including those involving charitable bequests and trusts …; and
>
> c) The Attorney General shall administer the provisions relating to consumer protection ….
>
> Commonwealth Attorneys Act, 71 P.S. §§ 732-204(c) and (d).

---

[1] *Parens patriae* refers to the traditional role of the state in protecting quasi-sovereign interests such as the health, safety and welfare of the people.

Under federal antitrust laws, the Attorney General has the ability to bring an action as *parens patriae* to protect the general economy. *Georgia v. Pennsylvania Railroad*, 324 U.S. 439 (1945); *Hawaii v. Standard Oil*, 405 U.S. 251 (1972); *California v. American Stores*, 495 U.S. 271 (1990); and *Pennsylvania v. Mid-Atl. Toyota Distributors, Inc.*, 704 F.2d 125 (4th Cir. 1983). Using this authority, the Office of Attorney General has investigated dozens of hospital mergers over the years. In some cases, we have concluded that the transaction posed no competitive risk or that one of the institutions was in such poor financial shape it had no choice other than to merge. In other cases, we have advised hospitals we would sue to block their transactions and have sued to block. In other instances, we have entered into consent decrees.

In analyzing hospital transactions, we look to see whether the proposed transaction will substantially lessen competition or tend to create a monopoly. When investigating conduct in healthcare markets, we look at whether any of the players in the market are trying to acquire market power through their actions; and, if they have acquired market power, we look at whether they are taking unlawful steps to maintain it.

The Office's charitable trust *parens patriae* focus is different from antitrust — it is intended to ensure that our charitable institutions lawfully pursue their charitable missions for the benefit of the public, their ultimate beneficiary. Any nonprofit corporation formed for charitable purposes under state law, is subject to the charitable oversight of the Office of Attorney General. "[A]ll property held by a nonprofit corporation is held in trust to carry out its charitable purposes. All property

held by a charitable nonprofit including the operating revenues, grants, donations, bequests, etc. generated therefrom, constitute property committed to charitable purposes." *In Re Roxborough Memorial Hospital*, 17 Fiduc.Rep.2d 412 (O.C. Phila. 1997). The "Attorney General . . . by virtue of the powers of [the] office, is authorized to inquire into the status, activities and functioning of public charities." *Commonwealth v. Barnes Foundation*, 398 Pa. 458, 467, 159 A.2d 500, 505 (1960). It has been held "[t]hat such powers, *parens patriae*, are broad and sweeping powers there can be no dispute. For it is of the essence of a public charity that it be subject to the visitorial powers of the sovereign." *Commonwealth v Barnes Foundation (No. 2)*, 11 Fiduc. Rep. 29, 31 (O.C. Montg. 1961).

As such, our Office regularly investigates allegations of misconduct by officers and directors of nonprofit corporations and other fiduciaries administering charitable assets through whatever form. The Attorney General's office is not empowered to substitute our judgment for a board's lawful exercise of its discretion. So, unless we uncover a violation of law, we are obliged to acquiesce in the board's decision.

The Office's *Review Protocol for Fundamental Change Transactions Affecting Health Care Nonprofits*, attached, was created as a guide for reviewing mergers, divisions, conversions, sales, and affiliations, among health care nonprofits. As mentioned above, this Office has reviewed dozens of such transactions over the past two decades. The scope of review varies with the specifics of each transaction, but generally seeks to ensure that the transaction is the product of due diligence after consideration of all other available alternatives;

that it is free of private inurement; that full and fair value is being paid when any sale of charitable assets is implicated; that any restricted assets will remain segregated and committed to the intended charitable purposes; and that the transaction will not unduly impact the community's access and availability to health care.

Past reviews have strengthened the enforceability of a buyer's pledge to make post-closing capital improvements, increased the purchase price ultimately obtained from a sale, and avoided the closing of a community hospital. It is important to note that the review protocol has never been signed into law and lacks the statutory authority requiring compliance with its notification and other provisions. Absent the transaction parties' voluntary compliance, the office needs to initiate a legal action to compel their compliance.

Finally, the Office of Attorney General has the authority to investigate unfair or deceptive practices in the advertising, sale, and provision of goods and services – including healthcare and insurance services – to consumers under the Administrative Code and the Commonwealth Attorneys Act. Our Office provides assistance to constituents through our Bureau of Consumer Protection and the Office's Health Care Section. The Office has jurisdiction to enjoin unfair methods of competition and unfair or deceptive acts or practices by persons engaged in trade or commerce within the Commonwealth of Pennsylvania. That authority is contained in Pennsylvania's Unfair Trade Practices and Consumer Protection Law which can be found at 73 P.S. §§ 201-1, *et seq.*(UTPCPL). The healthcare systems in question are persons engaged in trade and commerce with respect to consumer healthcare transactions. *See*, *Chalfin v. Beverly Enterprises, Inc.*, 741 F. Supp.

1162 (E.D. Pa 1989), *reconsideration denied* 745 F. Supp. 1117. Consequently, those healthcare systems come within the ambit of the UTPCPL.

The general purpose of the UTPCPL is "designed to 'benefit the public at large by eradicating unfair or deceptive business practices [and] to ensure fairness of market transactions.'" *Danganan v. Guardian Prot. Servs.*, 645 Pa. 181, 187, 179 A.3d 9, 12 (2018) (citing *Commonwealth v. Monumental Props.*, 459 Pa. 450 (1974)). The remedies available under the UTPCPL for violations include injunctive relief, disgorgement and restitution. In addition, the UTPCPL provides for up $1,000.00 in penalties per violation and up to $3,000.00 per violation perpetrated against victims 60 years of age or older. Moreover, the violation of an injunctive order or an assurance of voluntary compliance (a court filed settlement agreement) under the UTPCPL can result in the disenfranchisement of a business from further activities in Pennsylvania and additional civil penalties.

While the Office of Attorney General has been very active in reviewing hospitals transactions and other healthcare matters, there are additional tools and authority the legislature could provide which would strengthen our ability to protect the public and its access to high quality affordable healthcare services.

First, as previously mentioned the Office of Attorney General has authority under the Commonwealth Attorneys Act to represent the Commonwealth and its citizens in any action brought for violation of the antitrust laws of the United States and the Commonwealth. The Commonwealth, however, does not have an antitrust statute, so our Office must rely on state common law, some of which dates back to the 1800's, to pursue state causes of action in addition to our federal causes of

action. It is worth noting that Pennsylvania is the only state that does not have an antitrust law.

A state antitrust statute could provide for pre-merger notification to our Office of mergers and transactions, including healthcare transactions. It could also provide our Office with better tools to conduct investigations and to recover damages and monetary equitable relief for Commonwealth Agencies and consumers. It could provide for the repayment of fees and costs. Finally, it would make clear that unfair methods of competition[2] such as monopolization, price fixing and market allocation are illegal in Pennsylvania.

Currently without a state antitrust statute, we rely on parties to notify us of their plans to merge or we learn about a transaction through press reports or complaints filed with our Office. A state antitrust statute with a pre-merger notification provision for transactions would ensure that our Office is notified in advance before parties enter into a transaction. While we have reviewed a steady stream of hospital mergers and affiliations as well as physician acquisitions and mergers over the last twenty plus years, there are also many that have occurred without our knowledge. Given that healthcare consolidation continues and the importance of maintaining competitive healthcare markets, the Office of Attorney General and the public would benefit from pre-merger notification of healthcare

[2] The UTPCPL makes unfair methods of competition unlawful in Section 3. However, its definition in Section 2 (4) does not include anticompetitive practices with which the term is traditionally associated.

transactions involving hospitals, physicians, and other ancillary healthcare providers.[3]

A state antitrust statute with pre-complaint subpoena power would enable us to get the necessary information from parties and third parties in a timely and efficient manner and to preserve the confidentiality of the information. Currently, the Attorney General's subpoena power under the Administrative Code is very limited and the Commonwealth Court has now ruled twice that information obtained through an Administrative Code subpoena may not be used for enforcement purposes, even in court. So, without an antitrust statute, we have limited pre-complaint subpoena power and have to rely on targets of investigations to voluntarily provide information regarding their proposed transactions or evidence of their wrong-doing. A state antitrust statue would also better enable us to recover damages and monetary equitable relief for Commonwealth Agencies and consumers, provide for civil penalties and enable us to recover our fees and costs.

Second, the legislature could enact legislation targeting anticompetitive provider-payer contract provisions. Other states have already enacted statutes directed at anticompetitive healthcare contract provisions and there currently is pending federal legislation.[4] There are six contract clauses that have raised the most concern and have been addressed by other states: 1) Most Favored Nation

[3] The Commonwealth would not be the first state to impose pre-merger notification for healthcare transactions. Rather, several states including Connecticut, Massachusetts, Oregon, Minnesota and Washington already require pre-notification of certain healthcare transactions.
[4] S 2840 – Bipartisan Primary Care and Health Workforce Act and H 3120 – Health Competition for Better Care Act.

Clauses[5] in which another party cannot be offered better terms than that given to the contracting parties; 2) All or Nothing Provisions[6] in which a party is required to contract with all of a system's facilities and providers in order to contract with any part of the system; 3) Anti-Tiering/Anti-Steering Provisions[7] which either require an insurer to place all of a system's facilities and providers in the most favorable tier or prohibit an insurer from directing patients to other lower cost facilities and providers; 4) Gag Clauses[8] which prevent patients or employers from knowing the negotiated rates and other costs of healthcare services; 5) System-Wide Contracting which require insurers to pay the same prices for all parts of a system and its providers; and 6) Exclusive Contracting Clauses[9] which prevent an insurer from contracting with other competitive healthcare providers.

Legislation targeting anticompetitive contract provisions in provider-payer contracts is necessary given the consolidation that has already occurred in healthcare markets across the Commonwealth. This consolidation has resulted in the creation of large vertically integrated health systems with multiple hospitals, their

[5] Other states which restrict the use of MFN's include Arkansas, Connecticut, Georgia, Hawaii, Idaho, Indiana, Kentucky, Massachusetts, Maryland, Maine, Michigan, Minnesota, North Carolina, North Dakota, New Hampshire, New Jersey, New York, Ohio, Texas and Vermont. California and Washington have legislation pending. *See* https://sourceonhealthcare.org/provider-contracts/#:~:text=All%2Dor%2Dnothing%20Clause%3A,of%20their%20must%2Dhave%20facilities.

[6] Connecticut, Massachusetts, Nevada and Texas restrict the use of All or Nothing Provisions and legislation is pending in California, Maine, New Jersey, New York and Washington. *Id.*

[7] Connecticut, Massachusetts, Nevada and Texas restrict the use of Anti-Tiering/Anti-Steering provisions and California, Maine, New Jersey, New York and Washington have legislation pending. *Id.*

[8] California, Connecticut, Indiana, Massachusetts, Minnesota, New York, Ohio and Texas restrict the use of Gag Clauses. *Id.*

[9] Minnesota, New Hampshire, New York, Nevada and Wisconsin restrict the use of Exclusive Contracting Clauses. *Id.*

own health plans, employed physicians, and ancillary services that service large regions of the Commonwealth. We have experienced firsthand what this means for consumers who do not carry the right insurance card. They are told to switch insurance plans in order to access their trusted physicians, local hospitals and life-saving medical care, something which is not possible for many consumers to do. We have also seen healthcare costs increase without corresponding improvements in quality.

Finally, in addition to enacting a statute targeted at anticompetitive contract provisions, the legislature could impose a duty to negotiate in good faith for healthcare providers and insurers similar to the relief[10] the Attorney General's Office requested in its 2019 UPMC Litigation, *Commonwealth of Pennsylvania, et al., v. UPMC, et al.*, No. 334 M.D. 2014 (Pa.Comwlth. Feb. 7, 2019). This would require that healthcare providers and insurers negotiate in good faith with one another for contracts and submit to last best offer arbitration after 90 days to determine all unresolved material terms.

While the Office of Attorney General has been very active in reviewing hospital transactions and other healthcare matters for quite some time, providing the Office with additional tools would strengthen our authority and oversight of healthcare markets. These tools include a state antitrust statute with a pre-merger notification requirement, pre-complaint subpoena power, the ability to recover

[10] See attached Modified Consent Decree which was attached as Exhibit G to the Commonwealth's 2019 Petition to Modify Consent Decrees. The Proposed Modified Consent Decree imposed a duty to negotiate or UPMC and Highmark healthcare providers and health plan subsidiaries. It also prohibited certain contract terms including the six common concerning contract provisions referenced previously.

damages and monetary equitable relief for Commonwealth Agencies and consumers, civil penalties and the ability to recover fees and costs. They also include legislation targeted at common anticompetitive provider-payer contract provisions and imposing a duty to negotiate in good faith for healthcare providers and insurers. These tools would enable us to better investigate and challenge anticompetitive hospital transactions and other healthcare provider mergers as well as address anticompetitive conduct in the marketplace to protect consumers and market participants.

Thank you again for the opportunity to [testify / comment] on these important issues. We would be happy to meet with you to discuss our existing authority over healthcare mergers and acquisitions and our need for additional tools to better protect consumers and ensure access to high quality affordable healthcare services and provide a level playing field for market participants.

Review Protocol for Fundamental change transactions affecting health care nonprofits

Underlying Principle

Whenever a nonprofit, charitable health care entity enters into a transaction effecting a fundamental corporate change which involves a transfer of ownership or control of charitable assets, regardless of the form of the transaction contemplated (i.e., sale, merger, consolidation, lease, option, conveyance, exchange, transfer, joint venture, affiliation, management agreement or collaboration arrangement, or other method of disposition); unless the transaction is in the usual and regular course of the nonprofit's activities; and regardless of whether the other party or parties to the transaction are a nonprofit, mutual benefit or for-profit organization; the Office of Attorney General, as parens patriae, must review each transaction to ensure that the public interest in the charitable assets of the nonprofit organization is fully protected. Consequently, to review each transaction, the OAG must be provided relevant financial, corporate, and transactional information, in order to reach a decision on whether or not to object to or withhold objection to the proposed transaction. This decision will determine the Attorney General's position relative to Orphans' Court proceedings required in fundamental change transactions under the Nonprofit Corporations Law.

Review Protocol

This Protocol was developed to be used as a guide by attorneys and reviewers in the Charitable Trusts & Organizations Section, and its outside experts, in reviewing fundamental transactions affecting nonprofit, charitable health care entities. It provides broad, general guidelines with respect to issues that routinely appear in such transactions and is not intended to be an exhaustive or exclusive list of items to be reviewed and investigated, as these will vary on a case-to-case basis.

1. Notice to the Attorney General

The parties to the transaction shall provide written notice of same to the Attorney General at least 90 days prior to the contemplated date of its consummation. The Attorney General shall be given sufficient time from the receipt of the written notice within which to review and evaluate adequately and fully the proposed transaction. This notice shall include any and/or all of the following documents as the Attorney General may determine to be necessary:Continue Reading

a. all information, including organic documents such as Articles of Incorporation, bylaws, endowment fund documentation, trust restrictions, expenditure history, and other information necessary to define the trust upon which the charitable assets are held;

b. all complete transaction documents with attachments, including collateral or ancillary agreements involving officers, directors or employees (i.e., employment contracts, stock option agreements in the acquiring entity, etc.);
c. all documents signed by the principals or their agents which are necessary to determine the proposed transaction's effect, if any, on related or subsidiary business entities, whether nonprofit or for-profit;
d. all asset contribution agreements, operating agreements, and management contracts, if any, which comprise part or all of the transaction;
e. all financial information and organic documents regarding the post-transaction successor or resulting charitable entity (foundation), including the information detailed in Item (a), supra; and including relevant information with respect to officers, directors, and employees (current and post-transaction), in order to determine independence, board composition, charitable purpose, and to review any financial arrangements with officers, directors, or employees which may be affected by the transaction, particularly those which have the potential of affecting an individual's objectivity in supporting or approving the transaction;
f. all information necessary to evaluate the effects of the transaction on each component of an integrated delivery system, where transactions involve hospitals, including any changes in contracts between the integrated delivery system entities and related physician groups;
g. all financial documents of the transaction parties and related entities, where applicable, including audited financial statements, any fiduciary accounts whether or not filed with the various Orphans' Courts of the Commonwealth, ownership records, business projection data, current capital asset valuation data (assessed at market value), and any records upon which future earnings, existing asset values and fair market value analysis can be based;
h. all fairness opinions and independent valuation reports of the assets and liabilities of the parties, prepared on their behalf;
i. all relevant contracts (assets and liabilities) which may affect value, including, but not limited to, business contracts, employee contracts such as buy-out provisions, profit-sharing agreements, severance packages, etc.;
j. all information and/or representations disclosing related party transactions, which are necessary to assess whether or not the transaction is at arms length or involves self-dealing;
k. all documents relating to non-cash elements of the transaction, including pertinent valuations of security for loans, stock restrictions, etc.;
l. all tax-related information, including the existence of tax-free debt subject to redemption, disqualified person transactions yielding tax liability, etc.;
m. a listing of ongoing litigation, including full court captions, involving the transaction parties or their related entities, which may affect the interests of the parties and the valuation of charitable assets;
n. all information in the possession of the transaction parties relative to the perspective of the nonprofit's beneficiary class or representatives thereof (e.g., the community);

o. all information, including internal and external reports and studies, bearing on the effect of the proposed transaction on the availability or accessibility of health care in the affected community;
p. organizational charts of the parties to the transaction, as they exist both pre- and post- consummation of the transaction involved, detailing the relationship between the principal parties and any and all subsidiaries thereof; and
q. any and all additional documents that the Office of Attorney General deems necessary for its review purposes.

Any and all confidential information provided in the course of the review will be held in confidence by the Office of Attorney General as a part of its investigative files and, as such, will not be returned to the transaction parties. Only information that is a public record will be privately or publicly disseminated concerning any transaction that is not objected to by the Attorney General, unless such a dissemination is ordered by a court of competent jurisdiction. The Attorney General will notify all transaction parties of any formal or informal request seeking access to the information provided.

2. The Review Process

The Attorney General is entitled to retain outside experts and consultants for the purpose of evaluating information detailed in Item 1, supra. This is more likely to occur in a nonprofit to for-profit transaction. These consultants may be either from state agencies, the private sector, or both. They shall be retained pursuant to written contracts, and the costs for retaining such consultants shall be paid by the parties requesting transaction approval.

The review of the transaction shall include, among other components:

a. information gathering;
b. review of fiduciary responsibilities of directors, particularly relative to the exercise of due diligence, the assessment of self-dealing and whether or not the transaction is at arms length;
c. fair market valuation analysis;
d. inurement inquiry, including stock options, pension plans and perquisites, performance bonuses, consulting contracts or other post-transaction employment agreements, corporate loans, golden parachute provisions and severance packages, salaries, and related party transactions;
e. public interest review to evaluate the transaction’s effect upon the availability and accessibility of health care in the affected community, to include community involvement and antitrust review; and
f. appropriate cy pres determination, to ensure that all restricted funds remain segregated and used for their restricted purposes; and that the remaining or successor charitable organization competently and efficiently utilizes the assets for a like charitable purpose benefitting the same class of beneficiaries. The analysis is particularly important when the transaction results in the reallocation of charitable funds from operational use to grant-making use, to ensure that a

constancy of charitable purpose is maintained. It is critical to evaluate whether the acquiring entity will maintain control of the charitable assets, post-transaction, through the creation of a newly controlled foundation or through appointments to the existing charity's board.

3. Notice to the Public

The role of the Office of Attorney General in its review of the proposed transaction is to ensure that the actions of nonprofit directors satisfied their fiduciary duties to the public beneficiaries of the health care entity, and to ensure that the charitable assets thereof are preserved and used for their proper charitable purpose. Further, the Attorney General will consider the broad public policy issue of whether the transaction is in the public interest, specifically whether the proposed transaction will adversely affect the availability or accessibility of health care in the affected community or region.

Implicit in this review is that reasonable public notice of a proposed transaction shall be provided by the parties to the affected community or region, along with reasonable and timely opportunity for such community to contribute to the deliberations of the parties and the Attorney General relative to the health care and charitable trust issues.

In this way, a thorough and complete review of the transaction can be accomplished in a manner that is open to public scrutiny, and the interest of public beneficiaries of nonprofit health care entities may best be protected.

4. Response of Attorney General

Upon completion of its review of the transaction, the Office of Attorney General may: issue a letter indicating that it has no objection to the transaction; bring judicial proceedings to enjoin consummation of any disputed transaction; seek to void any transaction consummated as being in derogation of the law or contrary to public policy; or take any other action it deems appropriate. If, in the opinion of the Office of Attorney General the public interest will be best served thereby, the Office of Attorney General may request that the parties to the transaction seek approval of the Orphans' Court in the county of the nonprofit charitable corporation's registered office. This is more likely to occur in a nonprofit to for-profit transaction.

The procedures set forth in this protocol are in addition to all other powers conferred on the Office of Attorney General by statute or common law.

5. Post-transaction Oversight

The Office of Attorney General will maintain oversight of the transaction after its consummation to ensure that no subsequently executed contracts or arrangements between the parties or their agents effect a denigration of its terms. This oversight may mandate that the resulting entity or surviving charity report on some basis to the OAG to ensure that the terms of the transaction are fulfilled.

Received 2/7/2019 2:33:43 PM Commonwealth Court of Pennsylvania

EXHIBIT G

PROPOSED
MODIFIED CONSENT DECREE

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, By JOSH SHAPIRO, Attorney General; PENNSYLVANIA DEPARTMENT OF INSURANCE, By JESSICA ALTMAN, Insurance Commissioner; And PENNSYLVANIA DEPARTMENT OF HEALTH, By DR. RACHEL LEVINE, Secretary of Health, Petitioners, v. UPMC, A Nonprofit Corp.; UPE, a/k/a, HIGHMARK HEALTH, A Nonprofit Corp. And HIGHMARK INC., A Nonprofit Corp.; Respondents.	No. 334 M.D. 2014

MODIFIED CONSENT DECREE

AND NOW, this ____________ day of __________________________, 20___, upon the ***Petition for Supplemental Relief to Modify Consent Decrees*** filed by the Commonwealth of Pennsylvania through its Attorney General, Josh Shapiro, and the record in this case, the Consent Decrees approved by this Court on July 1, 2014 are hereby combined into this single decree and modified as follows:

INTERPRETIVE PRINCIPLES

1. The terms of this Modified Consent Decree are based upon the status of the respondents as charitable institutions committed to public benefit and are intended to promote the public's interest by: enabling open and affordable access to the respondents' health care services and products through negotiated contracts; requiring last best offer arbitration when contract negotiations fail; and, ensuring against the respondents' unjust enrichment by prohibiting excessive and unreasonable charges and billing practices in the rendering of medically necessary health care services.

DEFINITIONS

2.1 "Acquire" means to purchase the whole or the majority of the assets, stock, equity, capital or other interest of a corporation or other business entity or to receive the right or ability to designate or otherwise control the corporation or other business entity.

2.2 "All-or-Nothing" means any written or unwritten practice or agreement between a Health Care Provider and a Health Plan that requires either party to contract for all of the other party's providers, services or products in order to contract with any of the other party's providers, services or products.

2.3 "Anti-Tiering or Anti-Steering" means any written or unwritten agreement between a Health Care Provider and a Health Plan that prohibits the Health Plan from placing the Health Care Provider in a tiered Health Plan product for the purpose of steering members to Health Care Providers based on objective price, access, and/or quality criteria determined by the Health Plan, or which requires that the Health Plan place the Health Care Provider in a particular tier in a tiered Health Plan product.

2.4 "Average In-Network Rate" means the average of all of a Health Care Provider's In-Network reimbursement rates for each of its specific health care services provided, including, but not limited to, reimbursement rates for government, commercial and integrated Health Plans.

2.5 "Balance Billing" means when a Health Care Provider bills or otherwise attempts to recover the difference between the provider's charge and the amount paid by a patient's insurer and through member Cost-Shares.

2.6 "Cost-Share" or "Cost-Sharing" means any amounts that an individual member of a Health Plan is responsible to pay under the terms of the Health Plan.

2.7 "Credential" or "Credentialing" means the detailed process that reviews physician qualifications and career history, including, but not limited to, their education, training, residency, licenses and any specialty certificates. Credentialing is commonly used in the health care industry to evaluate physicians for privileges and health plan enrollment.

2.8 "Emergency Services/ER Services" means medical services provided in a hospital emergency or trauma department in response to the sudden onset of a medical condition requiring intervention to sustain the life of a person or to prevent damage to a person's health and which the recipient secures immediately after the onset or as soon thereafter as the care can be made available, but in no case later than 72 hours after the onset.

2.9 "Exclusive Contract" means any written or unwritten agreement between a Health Care Provider and a Health Plan that prohibits either party from contracting with any other Health Care Provider or Health Plan.

2.10 "Gag Clause" means any written or unwritten agreement between a Health Care Provider and a Health Plan that restricts the ability of a Health Plan to furnish cost and quality information to its enrollees or insureds.

2.11 "Health Care Provider" means hospitals, skilled nursing facilities, ambulatory surgery centers, laboratories, physicians, physician networks and other health care professionals and health care facilities but excludes services from for-profit ambulance and air transport providers.

2.12 "Health Care Provider Subsidiary" means a Health Care Provider that is owned or controlled by either of the respondents, and also includes any joint ventures with community hospitals for the provision of cancer care that are controlled by either of the respondents.

2.13 "Health Plan" means all types of organized health-service purchasing programs, including, but not limited to, health insurance, self-insured, third party administrator or managed-care plans, whether offered by government, for-profit or non-profit third-party payors, Health Care Providers or any other entity.

2.14 "Health Plan Subsidiary" means a Health Plan that is owned or controlled by either of the respondents.

2.15 "Highmark" means Highmark Inc., the domestic nonprofit corporation incorporated on December 6, 1996, with a registered office at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222. Unless otherwise specified, all references to Highmark include Highmark Health and all of its controlled nonprofit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities, including entities for which it manages provider contracting, however styled.

2.16 "Hospital" means a health care facility, licensed as a hospital, having a duly organized governing body with overall administrative and professional responsibility and an organized professional staff that provides 24-hour inpatient care, that may also provide outpatient services, and that has, as a primary function, the provision of inpatient services for medical diagnosis, treatment and care of physically injured or sick persons with short-term or episodic health problems or infirmities.

2.17 "Inflation Index" means the Medicare Hospital Inpatient PPS market basket index published annually by the Centers for Medicaid and Medicare Services.

2.18 "In-Network" means where a Health Care Provider has contracted with a Health Plan to provide specified services for reimbursement at a negotiated rate to treat the Health Plan's members. The member shall be charged no more than the Cost-Share required

pursuant to his or her Health Plan, the member shall not be refused treatment for the specified services in the contract based on his or her Health Plan and the negotiated rate paid under the contract by the Health Plan and the member shall be payment in full for the specified services.

2.19 "Material Contract Terms" means rates, term, termination provisions, the included providers, assignment, claims processes, addition or deletion of services, outlier terms, dispute resolution, auditing rights, and retrospective review.

2.20 "Most Favored Nations Clause" means any written or unwritten agreement between a Health Care Provider and a Health Plan that allows the Health Plan to receive the benefit of a better payment rate, term or condition that the provider gives to another Health Plan.

2.21 "Must Have" means any written or unwritten practice or agreement between a Health Care Provider and a Health Plan that requires either party to contract for one or more of the other party's providers, services or products in order to contract with any of the other party's providers, services or products.

2.22 "Narrow Network Health Plan" means where a Health Plan provides access to a limited and specifically identified set of Health Care Providers who have been selected based upon criteria determined by the Health Plan which shall include cost and quality considerations.

2.23 "Out-of-Network" means where a Health Care Provider has not contracted with a Health Plan for reimbursement for treatment of the Health Plan's members.

2.24 "Payor Contract" means a contract between a Health Care Provider and a Health Plan for reimbursement for the Health Care Provider's treatment of the Health Plan's members.

2.25 "Provider Based Billing," also known as "Facility Based Billing" and "Hospital Based Billing," means charging a fee for the use of the Health Care Provider's building or facility at which a patient is seen in addition to the fee for physician or professional services.

2.26 "Tiered Insurance Plan" or "Tiered Network" means where a Health Plan provides a network of Health Care Providers in tiers ranked on criteria determined by the Health Plan which shall include cost and quality considerations, and provides members with differing Cost-Share amounts based on the Health Care Provider's tier.

2.27 "Top Tier" or "Preferred Tier" means the lowest Cost-Share Healthcare Providers within a Tiered Insurance Plan or Tiered Network.

2.28 "Unreasonably Terminate" means to terminate an existing contract prior to its expiration date for any reason other than cause.

2.29 "Highmark Health," means the entity incorporated on October 20, 2011, on a non-stock, non-membership basis, with its registered office located at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222. Highmark Health serves as the controlling member of Highmark.

2.30 "UPMC" and the "UPMC Health System," also known as the "University of Pittsburgh Medical Center," means the non-profit, tax-exempt corporation organized under the laws of the Commonwealth of Pennsylvania having its principal address at 600 Grant Street, Pittsburgh, Pennsylvania 15219. Unless otherwise specified, all references to UPMC include all of its controlled nonprofit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities, including entities for which it manages provider contracting, however styled.

2.31 "UPMC Health Plan" means the Health Plans owned by UPMC which are licensed by the Pennsylvania Department of Insurance or otherwise operating in Pennsylvania.

2.32 "UPMC Hospitals" means the Hospitals operated by the following UPMC subsidiaries: UPMC Presbyterian-Shadyside, Children's Hospital of Pittsburgh of UPMC, Magee Women's Hospital of UPMC, UPMC McKeesport, UPMC Passavant, UPMC St. Margaret, UPMC Bedford Memorial, UPMC Horizon, UPMC Northwest, UPMC Mercy, UPMC East, UPMC Hamot, UPMC Hamot, affiliate - Kane Community Hospital, UPMC Altoona, UPMC Jameson, UPMC Susquehanna, UPMC Pinnacle, UPMC Cole, Western Psychiatric Institute and Clinic of UPMC and any other Hospital Acquired by UPMC following the entry of the Court's July 1, 2014 Consent Decree or this Modified Consent Decree.

TERMS

3.1 Internal Firewalls – Highmark and UPMC shall implement internal firewalls as described in Appendix 2 by the Pennsylvania Insurance Department in its April 29, 2013 Order as part of Highmark's acquisition of West Penn Allegheny Health System.

3.2 Health Care Provider Subsidiaries' Duty to Negotiate – Highmark's and UPMC's respective Health Care Provider Subsidiaries shall negotiate with any Health Plan seeking a services contract and submit to single, last best offer arbitration after 90 days to determine all unresolved Material Contract Terms, as provided in Section 4 below.

3.3 Health Plan Subsidiaries' Duty to Negotiate – Highmark's and UPMC's respective Health Plan Subsidiaries shall negotiate with any credentialed Health Care Provider seeking a services contract and submit to single, last best offer arbitration after 90 days to determine all unresolved Material Contract Terms, as provided in Section 4 below. Nothing herein shall be construed to require a Health Plan Subsidiary to include a Health

Care Provider in a particular Narrow Network Health Plan, including in any particular tier in a Tiered Insurance Plan or Tiered Network.

3.4 Prohibited Contract Terms – Highmark and UPMC are prohibited from utilizing in any of their Health Care Provider or Health Plan contracts:

3.4.1 Any Anti-Tiering or Anti-Steering practice, term or condition;

3.4.2 Any Gag Clause, practice, term or condition;

3.4.3 Any Most Favored Nation practice, term or condition;

3.4.4 Any Must Have practice, term or condition;

3.4.5 Any Provider-Based Billing practice, term or condition;

3.4.6 Any All-or-Nothing practice, term or condition;

3.4.7 Any Exclusive Contracts practice, term or condition;

3.5 Limitations on Charges for Emergency Services – Highmark's and UPMC 's Health Care Provider Subsidiaries shall limit their charges for all emergency services to their Average In-Network Rates for any patient receiving emergency services on an Out-of-Network basis.

3.6 Limitations on Terminations – Highmark and UPMC shall not Unreasonably Terminate any existing Payor Contract.

3.7 Direct Payments Required – Highmark's and UPMC's Health Plan Subsidiaries shall pay all Health Care Providers directly in lieu of paying through their subscribers for services.

3.8 Non-Discrimination – Highmark and UPMC shall not discriminate in the provision of health care services, the release of medical records, or information about patients based upon the identity or affiliation of a patient's primary care or specialty physician, the patient's Health Plan or the patient's utilization of unrelated third-party Health Care

Providers – provided, however, that this provision shall not be understood to require Highmark and UPMC to provide privileges or credentials to any Health Care Provider who otherwise does not qualify for privileges and credentials.

3.9 Duty to Communicate – Highmark and UPMC shall maintain direct communications concerning any members of their respective health plans that are being treated by the other's provider to ensure that their respective agents, representatives, servants and employees provide consistently accurate information regarding the extent of their participation in a patient's Health Plan, including, but not limited to, the payment terms of the patient's expected out-of-pocket costs.

3.10 Advertising – Highmark and UPMC shall not engage in any public advertising that is unclear or misleading in fact or by implication.

3.11 Changes to Corporate Governance – Highmark Health and UPMC Health System shall replace a majority of their respective board members who were on their respective boards as of April 1, 2013 by January 1, 2020, with individuals lacking any prior relationship to Highmark Inc. or UPMC, respectively, for the preceding five (5) years.

CONTRACT RESOLUTION
(LAST BEST OFFER ARBITRATION)

4.1 Highmark and UPMC shall provide a copy of this Modified Consent Decree to any Health Plan licensed by the Pennsylvania Department of Insurance seeking a services contract or, to any Health Care Provider licensed by the Pennsylvania Department of Health seeking a services contract. Any such Health Plan or Health Care Provider may, at its option, require Highmark or UPMC to participate in the two-step contract resolution provisions of this Modified Consent Decree contained in paragraphs 4.2 through 4.8 by opting in, as set forth in paragraph 4.2, provided that: in the case of Health Care

Providers, the Health Care Provider has identified the specific Health Plan product of either Highmark or UPMC with which the Health Care Provider desires to contract.

4.1.1 First Step - period of good faith negotiations. If no contract is reached during the period;

4.1.2 Second Step - the Health Plan or Health Care Provider may request binding arbitration as outlined in paragraphs 4.3 through 4.8.

4.2 A Health Plan or Health Care Provider must give written notice to Highmark or UPMC of its desire to opt in and utilize the contract resolution provisions of this Modified Consent Decree at least ninety (90) days prior to the expiration of its existing contract with Highmark or UPMC. If a Health Plan or Health Care Provider does not have an existing contract with Highmark or UPMC, the Health Plan or Health Care Provider must give such notice within thirty (30) days after it has notified Highmark or UPMC, in writing, of its interest in a contract. A failure to opt-in to this contract resolution provision is deemed an opt- out for a period of one year.

4.3 As the First Step, a Health Plan or Health Care Provider shall negotiate in good faith toward a contract for Highmark's or UPMC's health care services and/or health plan for at least ninety (90) days. At the conclusion of the ninety (90) day negotiation period, if the negotiations have been unsuccessful, the Health Plan or Health Care Provider may trigger binding arbitration with Highmark or UPMC (hereinafter collectively referred to as the "Arbitration Parties") before an independent body, but must do so, in writing, within thirty (30) days after the conclusion of good faith negotiations:

4.3.1 The arbitration panel will be an independent body made up of five representatives. A representative or his or her employer shall not have been an

officer, director, employee, medical staff member, consultant or advisor, currently or within the past five (5) years with either of the Arbitration Parties:

4.3.1.1 The local or regional Chamber of Commerce shall appoint one (1) member from an employer with less than 100 employees;

4.3.1.2 The local or regional Chamber of Commerce shall appoint one (1) member from an employer with more than 100 employees;

4.3.1.3 The Pennsylvania Health Access Network shall appoint one (1) member;

4.3.1.4 The Health Plan or Health Care Provider shall appoint one (1) member; and

4.3.1.5 Highmark or UPMC, where they are an Arbitration Party, shall appoint one (1) member.

4.3.2 The Arbitration Parties shall each submit to the independent body its last contract offer and a statement of agreed upon contract terms and those Material Contract Terms which remain unresolved. The independent body may reject a request for arbitration if the number of unresolved Material Contract Terms exceeds the number of agreed upon Material Contract Terms and order the Arbitration Parties to engage in another sixty (60) days of negotiation.

4.3.3 The independent body may retain such experts or consultants with expertise in health plan and health care provider contracting issues to aid it in its deliberations, provided that any such experts or consultants shall not have been an officer,

director, employee, medical staff member, consultant or advisor, currently or within the past five (5) years with either of the Arbitration Parties. The cost of such experts or consultants shall be divided equally between the Arbitration Parties.

4.3.4 If, during the course of the negotiation process outlined above, either of the Arbitration Parties fails to propose Material Contract Terms prior to arbitration, the arbitration panel shall impose the proposed terms of the party which did make a proposal with respect to such Material Contract Terms. If both Arbitration Parties submit proposed contracts, the independent body shall inform the Arbitration Parties of any information the independent body believes would be helpful in making a decision. The independent body shall not prohibit the presentation of information by either of the Arbitration Parties for consideration, but must consider the following:

4.3.4.1 The existing contract or contracts, if any, between the Arbitration Parties.

4.3.4.2 The prices paid for comparable services by other Health Plans and/or accepted by other Health Care Providers of similar size and clinical complexity within the community.

4.3.4.3 The criteria required by either Highmark or UPMC concerning the credentialing of Health Care Providers seeking an agreement with either Highmark or UPMC.

4.3.4.4 Whether the Health Care Provider is seeking an agreement in a tiered Health Plan of either Highmark or UPMC; in no event shall either respondent be required to permit a Health Care Provider to participate in a Narrow Network Health Plan, including in a particular tier in either of the respondents' Tiered Insurance Plans or Tiered Networks.

4.3.4.5 Whether a contract between the Arbitration Parties would prevent other Health Care Providers in such Health Plan from meeting quality standards or receiving contracted for compensation.

4.3.4.6 The weighted average rates of other area hospitals of similar size and clinical complexity for all payors, separately for each product line (commercial, Medicare managed care and/or Medicaid managed care) for which the Health Plan or Health Care Provider is seeking an agreement with either Highmark or UPMC.

4.3.4.7 The costs incurred in providing the subject services within the community and the rate of increase or decrease in the median family income for the relevant county(ies) as measured by the United States Department of Labor, Bureau of Labor Statistics.

4.3.4.8 The rate of inflation as measured by the Inflation Index, and (i) the extent to which any price increases under the existing contract between the Health Plan or Health Care Provider and Highmark or UPMC (as applicable) were commensurate with the rate of inflation and (ii) the extent to which the Health Plan's premium increases, if any, were commensurate with the rate of inflation.

4.3.4.9 The rate of increase, if any, in appropriations for Managed Care Organizations participating in Pennsylvania's Medical Assistance program for the Department of Public Welfare, in the case of a Medicaid Managed Care Organization participant in this arbitration process.

4.3.4.10 The actuarial impact of a proposed contract or rates paid by the Health Plan and a comparison of these rates in Pennsylvania with Health Plan or Health Care Provider rates in other parts of the country.

4.3.4.11 The expected patient volume which likely will result from the contract.

4.3.4.12 The independent body shall not consider the extent to which a party is or is not purchasing health plan or health care services from the other party.

4.4 Once the arbitration process has been invoked, the independent body shall set rules for confidentiality, exchange and verification of information and procedures to ensure the fairness for all involved and the confidentiality of the process and outcome. In general, the Arbitration Parties may submit confidential, competitively-sensitive information. Therefore, the independent body should ensure that it and any consultants it retains do not disclose this information to anyone outside the arbitration process.

4.5 The independent body must select the Material Contract Terms proposed by one of the Arbitration Parties. The parties are bound by the decision of the independent body. Any disputed non-Material Contract Terms shall be resolved in favor of the Respondents to this Modified Consent Decree unless the arbitration is between the Respondents in which case the non-Material Contract Terms of the Respondent whose Material Contract Terms are selected shall apply.

4.6 Because of the important interests affected, the independent body shall commence the arbitration process within twenty (20) days after it is triggered by a written request from a Health Plan or Health Care Provider. It shall hold an arbitration hearing, not to exceed three (3) days, within sixty (60) days of the commencement of the arbitration process. The independent body shall render its determination within seven (7) days after the conclusion of the hearing. The Arbitration Parties, by agreement, or the independent body, because of the complexity of the issues involved, may extend any of the time periods in this section, but the arbitration process shall take no more than ninety (90) days from its commencement.

4.7 The Arbitration Parties shall each bear the cost of their respective presentations to the independent body and shall each bear one-half of any other costs associated with the independent review.

4.8 During the above arbitration process:

4.8.1 If the Arbitration Parties have an existing contract, the reimbursement rates set forth in that contract will remain in effect and the reimbursement rates will be adjusted retroactively to reflect the actual pricing determined by the independent body.

4.8.2 If the Arbitration Parties have no contract, the Health Plan shall pay for all services by Highmark or UPMC (as applicable) for which payment has not been made, in an amount equal to the rates in its proposed contract. This amount will be adjusted retroactively to reflect the actual pricing determined by the independent body.

4.8.3 If the amounts paid pursuant to paragraphs 4.8.1 and 4.8.2 are less than the amounts owed under the contract awarded as the result of arbitration, the Health Plan shall pay interest on the difference. If the amounts paid pursuant to paragraphs 4.8.1 and 4.8.2 are greater than the amounts owed under the contract awarded as the result of arbitration, the Health Care Provider shall reimburse the excess and pay interest on the difference. For purposes of calculating interest due under this paragraph, the interest rate shall be the U.S. prime lending rate offered by PNC Bank or its successor as of the date of the independent body's decision on arbitration.

MISCELLANEOUS TERMS

5. Binding on Successors and Assigns – The terms of this Consent Decree are binding on Highmark and UPMC, their directors, officers, managers, employees (in their respective capacities as such) and to their successors and assigns, including, but not limited to, any person or entity to whom Highmark or UPMC may be sold, leased or otherwise transferred, during the term of this Modified Consent Decree. Highmark and UPMC shall not permit any of their substantial parts to be acquired by any other entity unless that entity agrees in writing to be bound by the provisions of this Modified Consent Decree.

6. Enforcement – The OAG, PID and DOH shall have exclusive jurisdiction to enforce this Modified Consent Decree. If the OAG, PID or DOH believe that a violation of this Modified Consent Decree has taken place, they shall so advise Highmark and UPMC and give the offending respondent twenty (20) days to cure the violation. If after that time the violation has not been cured, the OAG, PID or DOH may seek enforcement of the Modified Consent Decree in the Commonwealth Court. Any person who believes they have been aggrieved by a violation of this Modified Consent Decree may file a complaint with the OAG, PID or DOH for review. If after that review, the OAG, PID or DOH believes either a violation of the Modified Consent Decree has occurred or they need additional information to evaluate the complaint, the complaint shall be forwarded to Highmark or UPMC for a response within thirty (30) days. If after receiving the response, the OAG, PID or DOH, believe a violation of the Consent Decree has occurred, they shall so advise Highmark or UPMC and give the offending party twenty (20) days to cure the violation. If after that time the violation is not cured, the OAG, PID or DOH may seek enforcement of the Modified Consent Decree in this Court. If the complaint

involves a patient in an ongoing course of treatment who must have the complaint resolved in a shorter period, the OAG, PID or DOH may require responses within periods consistent with appropriate patient care.

7. Release – This Modified Consent Decree releases any and all claims the OAG, PID or DOH brought or could have brought against Highmark or UPMC for violations of any laws or regulations within their respective jurisdictions, including claims under laws governing nonprofit corporations and charitable trusts, consumer protection laws, insurance laws and health laws relating to the facts alleged in the Petition for Review or encompassed within this Modified Consent Decree for the period of July 1, 2012 to the date of filing. Any other claims, including but not limited to violations of the crimes code, Medicaid fraud laws or tax laws are not released.

8. Compliance with Other Laws – The parties agree that the terms and agreements encompassed within this Consent Decree do not conflict with the obligations of Highmark and UPMC under the laws governing nonprofit corporations and charitable trusts, consumer protection laws, antitrust laws, insurance laws and health laws.

9. Notices – All notices required by this Modified Consent Decree shall be sent by certified or registered mail, return receipt requested, postage prepaid or by hand deliver to:

If to the Attorney General:

Executive Deputy Attorney General
Public Protection Division
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

Chief Deputy Attorney General
Charitable Trusts and Organizations Section
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

Chief Deputy Attorney General
Health Care Section
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

Chief Deputy Attorney General
Antitrust Section
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

If to Highmark

Chief Executive Officer
120 Fifth Avenue, Suite 3112
Pittsburgh, PA 15222

Copies to:

Executive Vice President and Chief Legal Officer
120 Fifth Avenue, Suite 3112
Pittsburgh, PA 15222

If to UPMC:

Chief Executive Officer
University of Pittsburgh Medical Center
U.S. Steel Tower 62nd Floor
600 Grant Street
Pittsburgh, PA 15219

Copies to:

General Counsel
University of Pittsburgh Medical Center
U.S. Steel Tower 62nd Floor
600 Grant Street
Pittsburgh, PA 15219

10. Averment of Truth – Highmark and UPMC aver that, to the best of their knowledge, the information they have provided to the OAG, PID and DOH in connection with this Modified Consent Decree is true.

11. Termination – This Consent Decree shall remain in full force and effect until further order of the Court.

12. Modification – If either the OAG, PID, DOH, Highmark or UPMC believes that further modification of this Modified Consent Decree would be in the public interest, that party shall give notice to the other parties and the parties shall attempt to agree on a modification. If the parties agree on a modification, they shall jointly petition the Court to modify the Consent Decree. If the parties cannot agree on a modification, the party seeking modification may petition the Court for further modification and shall bear the burden of persuasion that the requested modification is in the public interest.

13. Retention of Jurisdiction – Unless this Modified Consent Decree is terminated, jurisdiction is retained by this Court to enable any party to apply to this Court for such further orders and directions as may be necessary and appropriate for the interpretation, modification and enforcement of this Modified Consent Decree.

BY THE COURT:

____

, J.

TESTIMONY OF PAULA CHATTERJEE, MD, MPH

Assistant Professor of Medicine
Perelman School of Medicine, University of Pennsylvania

Senior Fellow & Director of Health Equity Research
Leonard Davis Institute of Health Economics, University of Pennsylvania

Before the

Pennsylvania House of Representatives,
Health Committee

On
"Informational meeting on Hospital Consolidation and Closure."

October 4, 2023

I am testifying in my own capacity. The views expressed here today do not necessarily represent those of the University of Pennsylvania Health System or the Perelman School of Medicine.

***

I. **Hospital market forces have contributed to growing wealth for some hospitals and deepening poverty for others**
II. **These forces have had similar and disparate impacts among rural and urban hospitals**
III. **Payment policy has been proposed as a tool to address concerns about access and quality of care that have arisen as a result of these market forces**
IV. **Policy solutions may also need to exist outside of the traditional boundaries of payment policy**

***

I. Hospital market forces have contributed to growing wealth for some hospitals and deepening poverty for other hospitals

Hospitals in the United States have experienced unprecedented market-level changes over the past decade. My colleague, Dr. Rachel Werner MD, PhD, has provided information about the rates of consolidation, the role of private equity acquisition and the rates of closures in U.S. hospitals. My testimony will build on this foundation and focus on (1) the way in which these forces might impact hospital finances, and (2) payment models that have been proposed with either the implicit or explicit goal of reducing financial instability in hospitals.

Over the same period that market-level consolidation and acquisition trends have accelerated, hospitals, *on average*, have fared financially well (Figure 1 below[1]). However, there is heterogeneity across hospital types (Figure 2 below[2]): some hospitals have experienced unprecedented profits and wealth (particularly non-profit hospitals and academic medical centers) while others have come under growing financial precarity (such as rural hospitals and safety-net hospitals).

Understanding the effects of consolidation, which most commonly manifests through hospital mergers and acquisitions, on finances is challenging due to limitations in data and reporting of hospital profits. Specifically, after a hospital becomes acquired by an entity, it becomes difficult to distinguish their financial circumstances from that of the parent entity. However, it is well-established that hospital consolidation has led to higher prices with little improvement in quality of care or patient outcomes.[3]

---

[1] March 2023, MedPAC Report to Congress. Accessed October 2, 2023, https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_v2_SEC.pdf.
[2] March 2023, MedPAC Report to Congress. essed October 2, 2023, https://www.medpac.gov/wp-content/uploads/2023/03/“Mar23_MedPAC_Report_To_Congress_v2_SEC.Pdf.”
[3] Leemore Dafny, “Estimation and Identification of Merger Effects: An Application to Hospital Mergers,” *The Journal of Law & Economics* 52, no. 3 (2009): 523–50, https://doi.org/10.1086/600079; Zack Cooper et al., “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured*,” *The Quarterly Journal of*

Private equity acquisition can be considered a subset of the broader trend of consolidation. Hospitals acquired by private equity firms typically have improvements in financial circumstances after being acquired, though at baseline, the hospitals being acquired tend to be more financially well-off relative to their local counterparts.[4] The effects of private equity acquisition on quality of care have been mixed, suggesting improvements in certain domains (such as care for acute myocardial infarction) but not in others (such as care for heart failure).[5]

***

II. These forces have had similar and disparate impacts among rural and urban hospitals

Rates of consolidation and private equity investment have increased across all types of hospital markets, both urban and rural. Much of the existing research has focused on urban markets that are more often represented in the data used for these studies. However, the consequences of these market forces have been shown to vary across geography.

Among rural hospitals, there is some evidence that hospital mergers have been associated with improvements in quality of care.[6] Other work suggests that hospital mergers in rural areas are associated with reductions in important clinical care service lines, such as obstetric care, surgical care, and substance use disorder care.[7] These consequences are particularly salient for rural areas that already suffer from access challenges and experience disproportionate burdens of disease related to maternal health and substance use.

The role of private equity acquisition in rural areas is growing: more rural areas in the United States are more likely to have hospitals that are private equity-owned.[8] Unfortunately, given

---

Economics 134, no. 1 (February 1, 2019): 51–107, https://doi.org/10.1093/qje/qjy020; Nancy D. Beaulieu 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.

[4] Joseph D. Bruch, Suhas Gondi, and Zirui Song, “Changes in Hospital Income, Use, and Quality Associated With Private Equity Acquisition,” *JAMA Internal Medicine* 180, no. 11 (November 1, 2020): 1428–35, https://doi.org/10.1001/jamainternmed.2020.3552; Anaeze C. Offodile II et al., “Private Equity Investments In Health Care: An Overview Of Hospital And Health System Leveraged Buyouts, 2003–17,” *Health Affairs* 40, no. 5 (May 2021): 719–26, https://doi.org/10.1377/hlthaff.2020.01535; Marcelo Cerullo et al., “Financial Impacts And Operational Implications Of Private Equity Acquisition Of US Hospitals,” *Health Affairs* 41, no. 4 (April 2022): 523–30, https://doi.org/10.1377/hlthaff.2021.01284.

[5] Bruch, Gondi, and Song, “Changes in Hospital Income, Use, and Quality Associated With Private Equity Acquisition”; Marcelo Cerullo et al., “Association Between Hospital Private Equity Acquisition and Outcomes of Acute Medical Conditions Among Medicare Beneficiaries,” *JAMA Network Open* 5, no. 4 (April 29, 2022): e229581, https://doi.org/10.1001/jamanetworkopen.2022.9581.

[6] H. Joanna Jiang et al., “Quality of Care Before and After Mergers and Acquisitions of Rural Hospitals,” *JAMA Network Open* 4, no. 9 (September 20, 2021): e2124662, https://doi.org/10.1001/jamanetworkopen.2021.24662.

[7] Rachel Mosher Henke et al., “Access To Obstetric, Behavioral Health, And Surgical Inpatient Services After Hospital Mergers In Rural Areas,” *Health Affairs* 40, no. 10 (October 2021): 1627–36, https://doi.org/10.1377/hlthaff.2021.00160.

[8] “Characteristics of Private Equity–Owned Hospitals in 2018 | Annals of Internal Medicine,” accessed October 2, 2023, https://www.acpjournals.org/doi/full/10.7326/M20-

small sample sizes overall and the relatively new nature of the phenomenon, little is known about the specific effects of private equity acquisitions in these markets.

Importantly, the evidence on consolidation and private equity investment in rural markets is limited to-date and rarely causal in nature, meaning that it often does not allow for conclusions that directly connect the act of consolidation to an outcome of interest (such as changes in finances or quality).

Much attention has been brought to trends in rural hospital closures over the past several decades, which may or may not be exacerbated by trends in consolidation and private equity acquisition. A large body of qualitative evidence has suggested that rural hospital closures reduce access to care for patients in the local market.[9] Quantitative evidence has shown that travel times for emergency and surgical care can increase after rural hospital closure.[10]

However, whether rural hospital closures are associated with changes in patient outcomes, such as mortality, is not clear. In urban areas, hospital closures may be less likely to be associated with changes in mortality from acute conditions because there is sufficient supply of services in the local area independent of the closed facility.[11] In rural areas, this relationship is less clear,[12] especially given growing evidence that rural patients frequently bypass their local hospital to obtain hospital care.[13]

***

III. Payment policy has been proposed as a tool to address concerns about access and quality of care that have arisen as a result of these market forces

Policymakers have wrestled with challenges in adequately funding hospitals while promoting efficiency, quality, and access for decades and the recent consolidation and acquisition trends have escalated the urgency.

1361?casa_token=NUiqxcXnMZUAAAAA%3AejnuQGoCJUHmFazexf82EkEQ5KsNPFbVRJbab2k80IRHvAMER8KwrEskH-M7gMNGRMjI1H9jek11Ew.

[9] Jane Wishner et al., "A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies - Issue Brief," *KFF* (blog), July 7, 2016, https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/.

[10] Katherine E. M. Miller et al., "The Effect of Rural Hospital Closures on Emergency Medical Service Response and Transport Times," *Health Services Research* 55, no. 2 (2020): 288–300, https://doi.org/10.1111/1475-6773.13254; Sean McCarthy et al., "Impact of Rural Hospital Closures on Health-Care Access," *Journal of Surgical Research* 258 (February 1, 2021): 170–78, https://doi.org/10.1016/j.jss.2020.08.055.

[11] Karen E. Joynt et al., "Hospital Closures Had No Measurable Impact On Local Hospitalization Rates Or Mortality Rates, 2003–11," *Health Affairs* 34, no. 5 (May 1, 2015): 765–72, https://doi.org/10.1377/hlthaff.2014.1352.

[12] Kritee Gujral and Anirban Basu, "Impact of Rural and Urban Hospital Closures on Inpatient Mortality" (Cambridge, MA: National Bureau of Economic Research, August 2019), https://doi.org/10.3386/w26182; Paula Chatterjee, Yuqing Lin, and Atheendar S. Venkataramani, "Changes in Economic Outcomes before and after Rural Hospital Closures in the United States: A Difference-in-Differences Study," *Health Services Research* 57, no. 5 (2022): 1020–28, https://doi.org/10.1111/1475-6773.13988.

[13] "Understanding Rural Hospital Bypass Among Medicare Fee-for-Service (FFS) Beneficiaries in 2018," 2020, 23.

I will discuss 4 recent payment approaches that are relevant to the challenge of ensuring hospital financial viability. Some of these approaches are specific to rural hospitals (such as Pennsylvania's Rural Health Model and the Rural Emergency Hospital Program) while others are not.

Pennsylvania Rural Health Model & Global Budgets

Since 2019, Pennsylvania has been a site of national innovation in the space of rural health and hospital viability. The Pennsylvania Rural Health Model (PARHM) offered by the CMS Center for Medicare and Medicaid Innovation (CMMI) established global budget payments to rural hospitals to create predictable and stable cash flow, so that the hospitals would not be subject to year-to-year volume fluctuations.[14] The goal of the demonstration was to align incentives for investments in population health while ensuring the viability of rural hospitals in Pennsylvania.

The evidence with respect to whether PAHRM has achieved its stated goals is still evolving. To-date, 18 rural hospitals in Pennsylvania have elected to participate in the model. Early reports suggest that while the global budget was financially stabilizing for participating rural hospitals, the sustainability of the approach was unclear, particularly from the standpoint of the six participating payers across the state.[15] Furthermore, distinguishing the patient-level consequences of the global budget (such as changes in access to care, chronic condition management, and population health outcomes) independent of potential effects of Covid-19 pandemic as well as associated supplementary funding for rural hospitals has proven to be a methodologic challenge.

Work on other global budget programs, such as in Maryland, has shown middling effects. After two years of participation, Maryland's global budget program was not associated with changes in hospital or primary care use that were clearly attributable to the program.[16] Other research, however, has reported reductions in hospital admissions and increases in emergency department use without admission.[17]

In 2023, CMMI indicated early termination of the program due to concerns related to savings goals that may have dissuaded broader participation. Other challenges in PARHM include the fact that stabilized cash flow alone may be an insufficient financial incentive to move delivery system transformation forward for financially strapped hospitals already operating with small or negative margins. Additionally, the global budget does not represent the entire net payment revenue for hospitals, which may limit the model's capacity to transform care delivery.

CMS's Rural Emergency Hospital Program

---

[14] "Pennsylvania Rural Health Model | CMS Innovation Center," accessed September 30, 2020, https://innovation.cms.gov/innovation-models/pa-rural-health-model.
[15] Elvedin Bijelic and Alana Knudson, "First Annual Report," n.d.
[16] Eric T. Roberts et al., "Changes in Health Care Use Associated With the Introduction of Hospital Global Budgets in Maryland," *JAMA Internal Medicine* 178, no. 2 (01 2018): 260–68, https://doi.org/10.1001/jamainternmed.2017.7455.
[17] Joshua M. Sharfstein, Elizabeth A. Stuart, and Joseph Antos, "Global Budgets in Maryland: Assessing Results to Date," *JAMA* 319, no. 24 (June 26, 2018): 2475–76, https://doi.org/10.1001/jama.2018.5871.

In 2021, Congress established a novel provider type to offer an opportunity for critical access hospitals and certain rural hospitals to avoid closure and continue serving their communities, known as the Rural Emergency Hospital (REH) designation.[18] Conversion to an REH allows for a hospital to continue providing emergency services, observation care, and limited outpatient services, while downgrading their inpatient care capabilities. In other words, REHs must maintain a 24-hour emergency department but will not provide inpatient care.[19]

The goal of this program was to meet the perennial challenge of high operating costs and low inpatient occupancy rates that rural hospitals have grappled with for decades. By allowing them to downsize their inpatient care capabilities, the goal was to allow rural hospitals to avoid the high costs of operation while still maintaining access to clinical services that require timely care. Hospitals began converting into REHs in 2023, though very few have indicated their proclivity to participate. Hospitals that do participate will receive a 5% add-on to Medicare outpatient prospective payment rates and a new facility payment.

There are several outstanding challenges that remain unaddressed by the REH model, but are relevant to its implementation. Existing research has shown that REH-eligible hospitals had poorer baseline finances and provided fewer emergency, outpatient, and telehealth services than non-eligible hospitals.[20] These findings suggest that hospitals interested in participating in the REH program may have to make substantial investments at the outset to provide the services that the program is most seeking to preserve and promote in rural areas. It is not clear whether the financial resources associated with participation will be sufficient to support these types of operational changes.

Furthermore, whether the resources allocated through the REH program can counter broader rural health challenges, such as those related to workforce shortages, remains unknown. Telemedicine may be a potential avenue to add value to the delivery of emergency care in rural emergency departments, however, the cost of implementation is a commonly reported barrier that may be limiting the extent of adoption.[21]

CMS's AHEAD Model

The Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model was announced in September 2023 by CMMI.[22] The goal of the model is to promote investment in primary care, ensure financial stability for hospitals, and support beneficiary connection to community resources. The model "seeks to drive state and regional health care transformation

[18] "Consolidated Appropriations Act of 2021.," accessed August 2, 2022, https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf.
[19] "Rural Emergency Hospitals Proposed Rulemaking | CMS," accessed August 29, 2022, https://www.cms.gov/newsroom/fact-sheets/rural-emergency-hospitals-proposed-rulemaking.
[20] Paula Chatterjee et al., "Characteristics of Hospitals Eligible for Rural Emergency Hospital Designation," *JAMA Health Forum* 3, no. 12 (December 9, 2022): e224613, https://doi.org/10.1001/jamahealthforum.2022.4613.
[21] Kori S. Zachrison et al., "Understanding Barriers to Telemedicine Implementation in Rural Emergency Departments," *Annals of Emergency Medicine* 75, no. 3 (March 1, 2020): 392–99, https://doi.org/10.1016/j.annemergmed.2019.06.026.
[22] "States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model | CMS," accessed October 2, 2023, https://www.cms.gov/priorities/innovation/innovation-models/ahead.

and multi-payer alignment, with the goal of improving the total health of a state population and lowering costs."

Participating states will assume responsibility for managing costs across all payers in the state, as well as ensuring that providers deliver high-quality care, improve population health, offer greater care coordination, and advance health equity. The AHEAD Model will operate over 11 years and provide participating states with funding (up to $12 million per state) as well as other tools.

Taken together, the AHEAD model seeks to combine elements from other payment programs under a single umbrella. Specifically, hospital payments will be allocated through a global budget with similar goals as those of the PARHM model. Primary care providers will also be an essential component of the model and will be closely linked to state-level efforts related to innovation in the Medicaid program.

As states can begin applying for the program in Fall 2023, it is too early to assess its consequences for hospital financial viability or patient outcomes. Important questions to consider in the coming months and years will include (1) whether the AHEAD model accounts for prior implementation challenges related to the global budget for hospitals that were revealed in both Pennsylvania and Maryland; (2) whether states have sufficient jurisdiction to motivate quality improvement to meet the targets they establish; and (3) whether incentives can be aligned between hospitals and primary care practices to ensure success of the model.

State Discretionary Funding Pools to Improve the Financial Viability of Hospitals

In recognition of the growing financial strain of certain hospitals, some states have begun to establish new pools of supplemental funding to bolster these hospitals and ensure their viability.

In June 2023, the New York State Department of Health established the Hospital Vital Access Provider Assurance Program (Hospital VAPAP).[23] The program provides "temporary (up to three years) operating assistance to financially distressed providers for the purpose of redesigning their healthcare delivery systems to promote financial sustainability. Funding is provided for operational costs associated with transformation initiatives that address financial viability, community service needs, quality of care, and health equity." The program is open to a wide variety of hospitals, including public hospitals, critical access hospitals, and sole community hospitals, among others and is meant to target facilities with negative operating margins for the past 2 years or hospitals without assets or resources to maintain their operations.

In May 2023, California's State Legislature passed a bill to establish the Distressed Hospital Loan Program.[24] The goals of the program are similar to New York's Hospital VAPAP but its

[23] "Hospital Vital Access Provider Assurance Program (Hospital VAPAP)," accessed September 26, 2023, https://www.health.ny.gov/facilities/hospital/vapap/.
[24] "California AB112 | 2023-2024 | Regular Session," LegiScan, accessed October 2, 2023, https://legiscan.com/CA/text/AB112/id/2809108.

scope is narrower in that it targets non-profit and publicly operated hospitals in financial distress, and is based on an interest-free loan that is payable over 72 months.[25]

In some ways, these state-based efforts are similar to existing supplementary funding pools, such as the Disproportionate Share Hospital Payment program or the Upper Payment Limit Program. These types of supplementary funding pools come with tradeoffs. While they allow states an immense amount of flexibility in allocating funds to hospitals that they think are in need, there is significant opportunity for mistargeting of such funds. For example, recent work has shown that up to 30% of Medicaid Disproportionate Share Hospital payments may be mistargeted to hospitals that don't actually need them to ensure financial viability.[26]

***

IV. Policy solutions may also need to exist outside of the strict boundaries of payment policies.

While policy solutions designed to ensure hospital financial viability have typically centered on the role of payment, there are several aspects of this approach that may be worth reconsidering as well as other policy solutions outside the realm of payment that may be worthy of attention.

1) Perhaps surprisingly, hospital finances do not perfectly predict hospital closure, especially in rural markets. Recent research has found that rural markets are experiencing meaningful rates of hospital closures and mergers, yet many hospitals have survived despite persistently poor financial performance (Figure 3 below).[27]

   Instead, the closure of a rural hospital may be due to factors that are outside the realm of hospital finances and payment. It may be that bolstering rural health care may require bolstering rural communities more broadly.

   A recent study from 2020 sought to evaluate the economic consequences of rural hospital closures.[28] Specifically, the goal of this study was to evaluate whether a county's economic circumstances (including unemployment rates, labor force participation rates, per capita income, total jobs, health care sector jobs, disability program participation rates, percent of the population with subprime credit scores, and bankruptcies filing) worsened after a rural hospital closure.

   The findings of this study suggest that while rural hospital closures were associated with reductions in health care sector employment, they were not associated with changes in

[25] "Distressed Hospital Loan Program," HCAI, accessed October 2, 2023, https://hcai.ca.gov/construction-finance/distressed-hospital-loan-program/.
[26] Paula Chatterjee et al., "Variation And Changes In The Targeting Of Medicaid Disproportionate Share Hospital Payments," *Health Affairs* 41, no. 12 (December 2022): 1781–89, https://doi.org/10.1377/hlthaff.2022.00153.
[27] Caitlin Carroll et al., "Hospital Survival In Rural Markets: Closures, Mergers, And Profitability," *Health Affairs* 42, no. 4 (April 2023): 498–507, https://doi.org/10.1377/hlthaff.2022.01191.
[28] Chatterjee, Lin, and Venkataramani, "Changes in Economic Outcomes before and after Rural Hospital Closures in the United States."

any other economic measure. Instead, economic conditions were already declining in counties with closures compared to those that did not (Figure 5 below[29]).

The finding that economic decline *precedes* rural hospital closures suggests that previously hypothesized determinants of closures–such as declining occupancy rates and worsening finances–may themselves result from broader "upstream" economic drivers. These factors may include declining economic opportunity, loss of employment in other, larger, sectors of the economy, or the loss of investors and loss of other sources of community capital.

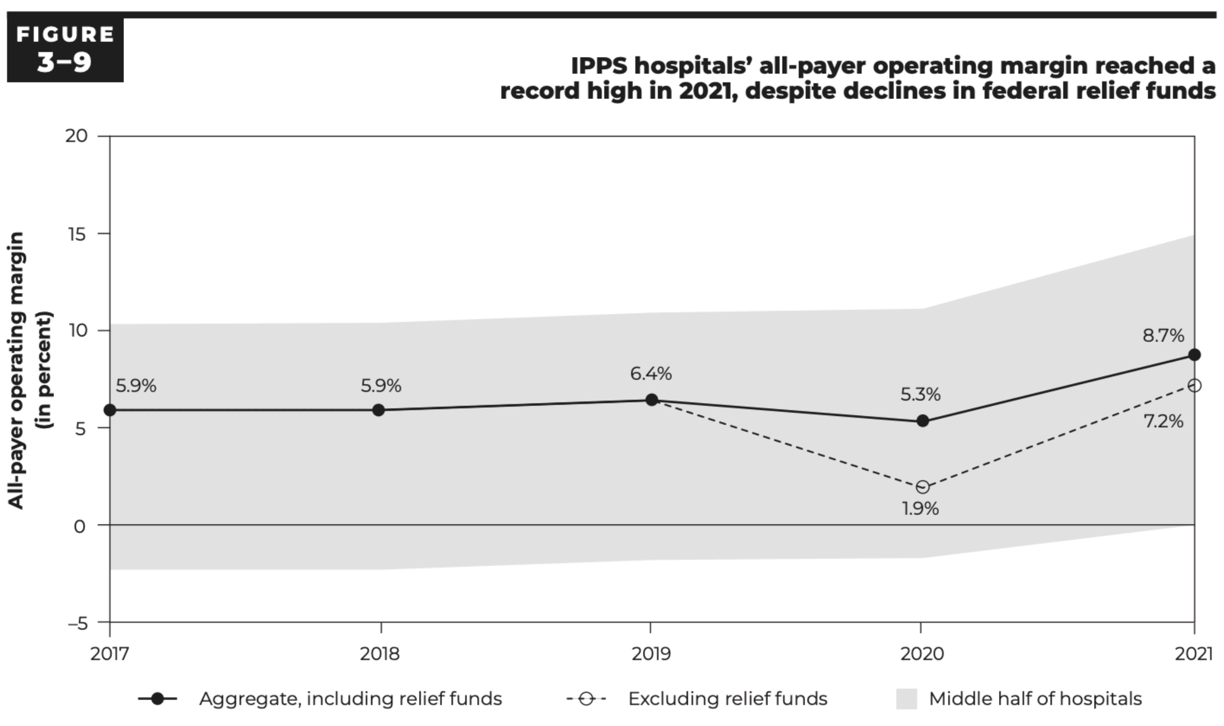
If this is the case, then efforts to reduce rural hospital closures may require a broader focus on local communities and economies in order to be successful. Existing rural economic development efforts, such as tax credits to encourage industries to enter rural markets or place-based federal investments (e.g., "Empowerment Zones"), may play an important and complementary role in reducing the risk of rural hospital closures.

2) Another factor that may be contributing to rural hospitals' financial challenges, but is often not accounted for in policy discussions, is that rural patients are increasingly bypassing local hospitals to seek care at larger hospital systems that are further away (Figure 4 below[30]). This is true even when the needed clinical service is available at a nearby rural hospital. In 2018, CMS reported that while almost 60% of rural Medicare fee-for-service inpatient stays were at the nearest rural hospital, over 33% were at another hospital for services that could have been provided by the nearest rural hospital.

   Understanding the drivers of these "bypass" behaviors will be essential to ensuring that rural patients benefit from the most from their health systems. Are patients bypassing local hospitals because of perceived quality differences? Do they have relationships with more distant providers due to referral patterns introduced by the outpatient market? Only by understanding the answers to these questions will be truly be able to design patient-centered rural health care policies.

[29] Chatterjee, Lin, and Venkataramani.
[30] CMS Data Highlight. "Understanding Rural Hospital Bypass Among Medicare Fee-for-Service (FFS) Beneficiaries in 2018."
https://www.cms.gov/files/document/hospitalbypassamongmedicaredatahighlightsept2020.pdf

Figure 1: Changes in Hospital Operating Margins Over Time



Note: IPPS (inpatient prospective payment systems). Hospitals' margins are calculated as aggregate payments minus aggregate costs, divided by aggregate payments. "All-payer" margin includes payments from all payers. The "operating" margin is limited to patient care and other operating revenue, and in 2020 and 2021 these margins are reported with and without federal relief funds (Provider Relief Fund payments and forgiven loans from the Paycheck Protection Program). Data are for IPPS hospitals that had a cost report with a midpoint in the fiscal year and that was complete as of our analysis.

Source: MedPAC analysis of hospital cost reports.

Source: March 2023, MedPAC Report to Congress. Accessed October 2, 2023, https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_v2_SEC.pdf.

Figure 2: Variation in Changes in Operating Margins Across Hospital Types

TABLE 3–3

In 2021, IPPS hospitals' all-payer operating margins continued to vary across hospital groups, including an all-time high among for-profit hospitals

				2020		2021	
Hospital group	**2017**	**2018**	**2019**	**With relief funds**	**Without relief funds**	**With relief funds**	**Without relief funds**
All IPPS	**5.9%**	**5.9%**	**6.4%**	**5.3%**	**1.9%**	**8.7%**	**7.2%**
Ownership							
For profit	10.5	11.4	12.2	12.6	10.4	15.1	13.9
Nonprofit	5.9	5.5	6.1	4.7	1.2	8.2	6.8
Location							
Metropolitan (urban)	6.0	6.1	6.6	5.3	2.0	8.6	7.3
Rural micropolitan	4.9	3.9	5.2	6.2	1.9	9.2	6.8
Other rural	2.1	0.2	0.7	3.4	–1.5	7.6	3.0
Teaching and DSH							
Both	5.7	5.8	6.2	4.8	1.4	8.4	6.9
DSH only	5.5	5.6	6.3	6.2	2.8	8.9	7.3
Teaching only	8.8	8.7	7.7	6.0	4.1	7.7	6.7
Neither	9.0	9.1	10.1	8.4	6.0	13.5	11.8

Note: IPPS (inpatient prospective payment systems), DSH (disproportionate share hospital). Hospitals' margin is calculated as aggregate payments minus aggregate costs, divided by aggregate payments. "All-payer operating margin" includes patient care and other operating revenue from all payers, and, for 2020 and 2021, is reported with and without reported federal relief funds (Provider Relief Fund payments and Paycheck Protection Program forgiven loans). Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Data are for IPPS hospitals that had a cost report with a midpoint in the specified fiscal year and that were complete as of our analysis.

Source: MedPAC analysis of hospital cost reports and census geographic files.

Source: March 2023, MedPAC Report to Congress. Accessed October 2, 2023, https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_v2_SEC.pdf.

Figure 3: Rates of Hospital Closures and Mergers by Baseline Profitability

EXHIBIT 1

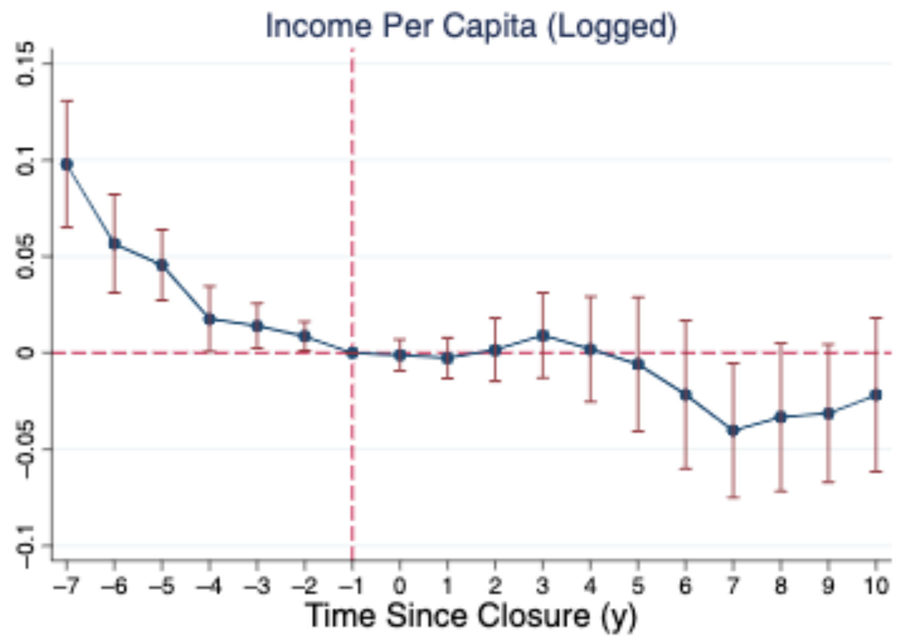
Rates of hospital closures and mergers in rural markets, by baseline profitability, 2010–18

	All hospitals		No hospitals within 15 miles		1 or more hospitals within 15 miles	
	Unprofitable	Profitable	Unprofitable	Profitable	Unprofitable	Profitable
No. of hospitals in 2010	325	533	243	411	82	122
Hospital outcomes by 2018						
No closure or merger	77%	84%	81%	85%	65%	80%
Closure	7	2	5	1	11	5
Within-market merger	4	3	3	1	7	7
Out-of-market merger	13	12	11	13	18	10

SOURCE Authors' analysis of data from the Healthcare Cost Report Information System, Irving Levin Associates, the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, the American Hospital Directory, the Dartmouth Atlas, and the National Bureau of Economic Research's Health Systems and Provider Database. NOTES $N = 858$ hospitals. This table shows average rates of hospital closures and mergers in rural markets, among hospitals that were open in 2010. Profitability was based on each hospital's average total margin at baseline (2008–10). Within-market mergers indicate that merging facilities operated in the same commuting zone before the mergers.

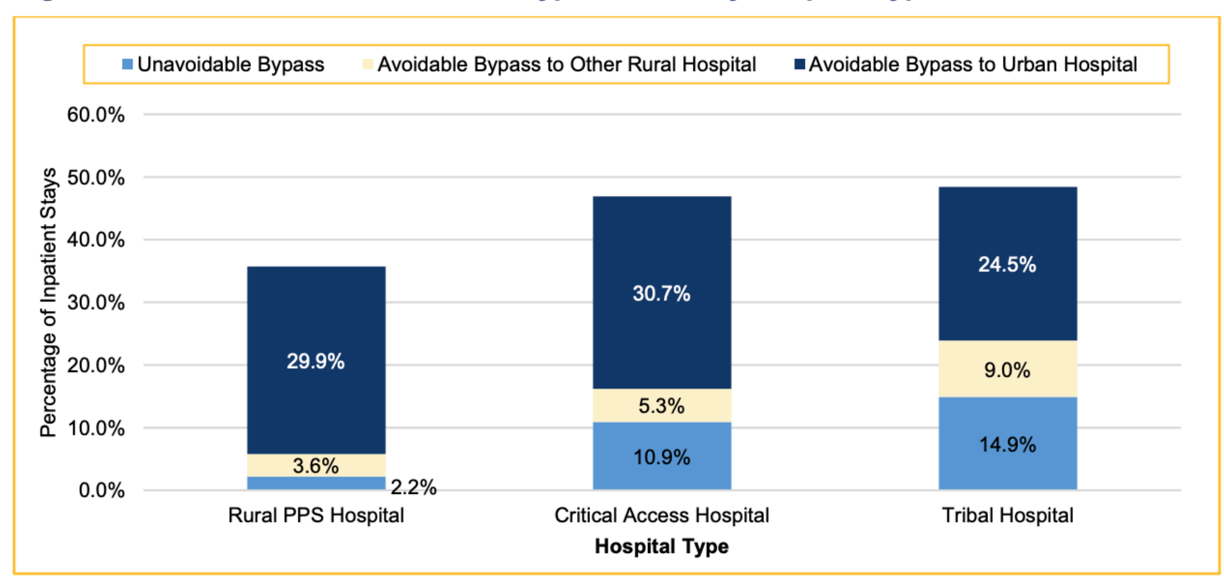
Source: Caitlin Carroll et al., "Hospital Survival In Rural Markets: Closures, Mergers, And Profitability," *Health Affairs* 42, no. 4 (April 2023): 498–507, https://doi.org/10.1377/hlthaff.2022.01191

Figure 4: Changes in Rural County Economic Outcomes Before and After Hospital Closure



Source: Paula Chatterjee, Yuqing Lin, and Atheendar S. Venkataramani, "Changes in Economic Outcomes before and after Rural Hospital Closures in the United States: A Difference-in-Differences Study," *Health Services Research* 57, no. 5 (2022): 1020–28, https://doi.org/10.1111/1475-6773.13988.

Figure 5: Prevalence of Hospital Bypass Across Rural Hospital Types



Notes: Table shows the unavoidable and avoidable bypass rates by hospital type. Unavoidable bypass is the percentage of inpatient stays for which rural Medicare beneficiaries received care in Market 3 or Market 4 because services were not available in Market 1 or Market 2 (their local hospital). Avoidable bypass is the percentage of inpatient stays for which rural Medicare beneficiaries received care in Market 3 (other rural hospital) or Market 4 (urban hospital) even though those services were available in Market 1 or Market 2. The total rural Medicare inpatient stays with non-missing data for the 50 most common DRGs is 1,168,099.
Source: Estimates were produced using Medicare Provider Analysis and Review files (MedPAR) inpatient claims.

Source: CMS Data Highlight. "Understanding Rural Hospital Bypass Among Medicare Fee-for-Service (FFS) Beneficiaries in 2018."
https://www.cms.gov/files/document/hospitalbypassamongmedicaredatahighlightsept2020.pdf.

Hon. Dan Frankel
326 Main Capitol Building
P.O. Box 202023
Harrisburg, PA 17120-2023
(717) 705-1875
Fax: (717) 705-2034

Hon. Kathy L. Rapp
312 Main Capitol Building
P.O. Box 202065
Harrisburg, PA 17120-2065
(717) 787-1367
Fax: (717) 787-5854

Dear Pennsylvania House Health Committee Members,

Service Employees International Union Healthcare Pennsylvania (SEIU Healthcare Pennsylvania) is the largest union of healthcare workers in Pennsylvania, uniting over 20,000 front line healthcare workers in our health systems, nursing homes, homecare, and public sector. We welcome the opportunity to submit testimony to the House Health Subcommittee on Facilities. Our health system is currently facing historic levels of strain with patient outcomes in the balance. Many patients do not have access to adequate care. When people can access sufficient care, many face staggering costs and medical debt. Meanwhile, healthcare workers have been pushed to their breaking point. Many nurse clinicians and technicians have left their work because of substandard conditions.

There is a common catalyst of poor patient outcomes, skyrocketing costs, and a healthcare workforce in crisis: the healthcare industry is highly consolidated and undergoing continued horizontal and vertical integration. A handful of health systems are emerging to dominate various regions of the Pennsylvania market. The result is a system that exploits market power, prioritizing profits (including in the "non-profit" sector) and corporate growth over the stated goal of healthy populations. The largest and clearest example is UPMC, a forty-hospital colossus dominating markets radiating from its headquarters in Pittsburgh.

SEIU Healthcare and the Strategic Organizing Center submitted an antitrust complaint to the U.S. Department of Justice in May 2023. We share that complaint as an appendix to this testimony to the PA House Health Committee as a striking example of how healthcare consolidation, when unchecked, harms healthcare workers. Market power is used by UPMC and other industry giants to suppress staffing levels and wages, with corresponding effects on patient quality and health of labor markets.

In addition to evidence of market power, the complaint demonstrates that UPMC extends its market power through further ant-competitive behaviors. These include non-compete requirements for clinicians, real or perceived "do not rehire" policies, refusals to accept patients holding rival insurance, and unfair labor practice violations for harsh repression of workers attempting to unionize.

The complaint includes its own appendices: (1) UPMC Market Share Analysis; (2) UPMC Impact on Market Concentration and Utilization of Hospital Beds, 2013-2021, and (3) Monopsony Power Over Hospital Workers: Evidence of a UPMC "Wage Penalty".

In addition to our complaint filed with the Department of Justice, we highlight the hospital closures analyzed by the Pennsylvania Health Access Network. It demonstrates the link between hospital acquisitions and closures. They noted that "Thirty of the 33 hospital closures we looked at in the past 20 years, and 14 of 15 closures in the past 5 years have been preceded by a merger, acquisition, or change in ownership of the hospital."[1] They note six UPMC full or partial closures in the study period.

Lastly, we point to a large and growing body of academic literature that demonstrates that consolidation of the healthcare industry is hurting patients and healthcare workers.

> The Medicare Payment Advisory Committee wrote to Congress in 2020 stating that "The preponderance of the research suggests that hospital consolidation leads to higher prices for commercially insured patients. However, hospital market power is just one factor that affects prices. The literature also suggests that insurer market power can lead to lower hospital prices for commercially insured patients (though these savings may not flow through to lower insurance premiums)."[2] Markets dominated by integrated health systems, where providers and insurers are vertically integrated, such as UPMC and Highmark in the Pittsburgh area and Geisinger in the North East, face the risk of higher costs.
>
> Joseph et al (2023) found a positive relationship between a hospital joining a health system and closure of inpatient pediatric services.[3]
>
> Qiu and Sojourner (2023) found that health care labor-market concentration pushed down employee wages[4].
>
> The Kaiser Family Foundation (KFF) explained that "A wide body of research has shown that provider consolidation leads to higher health care prices for private insurance; this is true for both horizontal and vertical consolidation." Healthcare markets are already highly concentrated and getting more concentrated over time. And while prices increase in highly concentrated, anti-competitive markets, "there is no clear evidence that consolidation improves quality of care."[5]
>
> O'Hanlon (2020) used a qualitative study of a broad stakeholder mix to reveal perceptions that "consolidation had potentially reduced patient access to care, accountability, and transparency, systems' willingness to collaborate, and physician autonomy," in the Pittsburgh market.[6]

While Pennsylvania's hospital market is already heavily consolidated, recently announced merger proposals are only exacerbating this reality: UPMC's intended acquisition of Washington Health System and Kaiser Permanente subsidiary

---

[1] Pennsylvania Health Access Network. "Hospital Closures Are On The Rise In Pennsylvania; Harrisburg Must Step In". Published June 16, 2023. Accessed online 10/2/2023. https://pahealthaccess.org/hospital-closures-are-on-the-rise-in-pennsylvania-harrisburg-must-step-in/

[2] March 2020 Report to the Congress: Medicare Payment Policy. Chapter 15: Congressional request on health care provider consolidation. Published March 13, 2020. Accessed 10/2/2023. https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar20_entirereport_sec-pdf/

[3] Joseph AM, Davis BS, Kahn JM. Association Between Hospital Consolidation and Loss of Pediatric Inpatient Services. JAMA Pediatr. 2023;177(8):859–860. doi:10.1001/jamapediatrics.2023.1747

[4] Qiu, Y., & Sojourner, A. (2023). Labor-Market Concentration and Labor Compensation. ILR Review, 76(3), 475-503. https://doi.org/10.1177/00197939221138759

[5] Schwartz, Karyn; Lopez, Eric; Rae, Matthew; Neuman, Tricia. "What We Know About Provider Consolidation". Kaiser Family Foundation. https://www.kff.org/report-section/what-we-know-about-provider-consolidation-issue-brief/ Published 9/2/2020. Accessed 10/2/2023.

[6] O'Hanlon CE. Impacts of Health Care Industry Consolidation in Pittsburgh, Pennsylvania: A Qualitative Study. INQUIRY: The Journal of Health Care Organization, Provision, and Financing. 2020;57. doi:10.1177/0046958020976246

Risant's planned acquisition of Geisinger. These ongoing mergers may appear at the surface to shift the market dynamics of our hospital mix only marginally, but when looked at as the latest in a decades long string of consolidation and dominance by only a few institutions, this committee should act with urgency to expose the very real implications that these and other mergers have for Pennsylvania healthcare workers and their consumers.

While legislation will be necessary to address the many impacts and trends of consolidation, more can be done today by calling on the Attorney General, PA Department of Health, Pennsylvania Insurance Department, and Department of Human Services to work together and to the fullest extent of their existing power to slow, mitigate and reverse harm to healthcare workers and consumers. Additionally, there are several steps currently or recently under consideration by the General Assembly to strengthen that power and ensure that regulations are sufficient for today's healthcare conglomerates:

- A Pennsylvania anti-trust statute that addresses both monopolist and monopsonist practices.
- Updated regulations accompanying the Health Facilities act that require a thorough public input process when entities are attempting to acquire, merge, close, or construct hospitals and health systems.
- "Any willing insurer" legislation to prevent anti-competitive practices by integrated delivery networks.
- Ban non-compete and training repayment agreements, which are used by employers in consolidated markets to artificially suppress the mobility and market power of workers.

Finally, we implore you to remember one important truth when discussing the future of Pennsylvania healthcare: at the center of the care that millions of Pennsylvanians receive everyday are the nurses, aides, techs, and doctors who deliver that care. It is essential that they remain are the table for every part of this conversation and that we continue to ensure that healthcare workers have a strong voice in the care they provide. We thank the Committee for its work towards dignified healthcare and good jobs for all Pennsylvanians.

Sincerely,

Silas Russell
Executive Vice President
SEIU Healthcare Pennsylvania

Leading for Better Health

Statement of

The Hospital and Healthsystem Association of Pennsylvania

for the

Pennsylvanian House of Representatives
Health Committee, Subcommittee on Health Facilities
Informational Meeting on Hospital Consolidation

Harrisburg, Pennsylvania
October 4, 2023

The Hospital and Healthsystem Association of Pennsylvania (HAP) appreciates the opportunity to provide an overview of hospital mergers and acquisitions.

Given the extraordinary challenges placed on the health care delivery system, hospital mergers and acquisitions represent a tool in stressed hospitals' toolboxes to respond to financial pressures and mitigate risk while balancing their commitment to their communities. Well-constructed mergers strive to advance the goals of providing higher quality, farther reaching, more equitable, more innovative, less costly, or more stable patient care for the communities both organizations are proud to serve.

The urgent challenge currently before the commonwealth's policymakers is to systematically strengthen the financial stability of Pennsylvania's hospitals.

At Risk: Hospital Viability

Among the significant factors contributing to consolidation activity is an ongoing and increasing threat to the financial viability of American hospitals.

This spring, the American Hospital Association (AHA) issued a report [1] that details the extraordinary financial pressures that are threatening hospitals, health systems, and patients' access to care. The strain is so significant that the authors frame it as a "new existential challenge."

The Financial Stability of America's Hospitals and Health Systems Is at Risk as the Costs of Caring Continue to Rise reports that expenses across the board increased at double digit rates during 2022 compared to pre-pandemic levels. You are likely already aware of the deep challenges related to rising workforce and pharmaceutical costs. Maybe less well known are details related to the substantial financial pressure from other essential operational requirements including, for example, medical supplies, food/nutrition, sanitation, facilities management, and information technology.

From 2019 to 2022, the national decline in hospitals' median operating margin ranged from -37 percent to -133 percent.[2] More than half of all hospitals operated at a financial loss during 2022, which the report rightly notes is "an unsustainable situation for any organization in any sector."[3]

A recent financial analysis by the Pennsylvania Health Care Cost Containment Council confirms these alarming trends in Pennsylvania. Its June report[4] documents that 39 percent of Pennsylvania hospitals posted negative operating margins in fiscal year 2022, which means that the hospitals lost money providing care. In addition to that 39 percent, another 13 percent had margins of less than 4 percent, which is generally considered the minimum necessary to be sustainable for the long term.

On average, labor accounts for roughly half of a hospital's budget. The health care labor market has experienced a fundamental shift during the past five years. We all know that COVID-19 has been a worldwide economic disruptor. It is not unreasonable to imagine that some of the deepest and most lasting impacts would manifest with the people, facilities, and systems who shouldered the largest share of its burden.

---

[1] American Hospital Association (AHA). The Financial Stability of America's Hospitals and Health Systems Is at Risk as the Costs of Caring Continue to Rise. April 2023. Retrieved from: https://www.aha.org/system/files/media/file/2023/04/Cost-of-Caring-2023-The-Financial-Stability-of-Americas-Hospitals-and-Health-Systems-Is-at-Risk.pdf.

[2] KauffmanHall. The Current State of Hospital Finances: Fall 2022 Update. Retrieved from: https://www.kaufmanhall.com/sites/default/files/2022-09/KH-Hospital_Finances_Report-Fall2022.pdf.

[3] KauffmanHall. National Hospital Flash Report: January 2023. Retrieved from: https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-january-2023.

[4] Pennsylvania Health Care Cost Containment Council (PHC4). Financial Analysis 2022-Volume One. June 22, 2023. Retrieved from: https://www.phc4.org/news-and-press-releases/financial-analysis-2022-volume-one-news-release/.

Experienced, exhausted professionals have exited direct-care settings and there is fierce competition to recruit and retain an increasingly scarce clinical workforce—particularly across certain specialties. Additionally, the personnel needed to support clinical professionals are being hired away by logistics and retail organizations, for example, that do not require 24/7/365 coverage and that offer extremely competitive starting pay. Hospitals are filling gaps by contracting with temporary agencies, many of which are taking advantage of market dynamics and have raised their fees to what some have called "price gouging" levels.

While the trend is not as pronounced in Pennsylvania as it is in other places, private equity firms—not constrained by the Stark law's limits on physician practices—have been acquiring physician groups and specialists at increasing rates.[5] Hospitals and health systems are closely monitoring this activity and making sure they are ready to effectively respond to broader trends in the physician market.

The cost of labor is expected to continue to rise as wages across all industries steadily increase and as recruitment and retention of the health care professionals needed to provide safe, high-quality care remains difficult and costly.

Non-labor expenses are also stressing hospital finances. Widespread inflation is driving up costs associated with pharmaceuticals, medical supplies, equipment maintenance, facilities management, and purchased-service expenses for things like clinical sub-specialties, IT support, and food services. In less than five years, non-labor expenses have increased more than 16 percent on a per patient basis.[6]

Chronic underpayment by government payors is another significant factor that exacerbates hospitals' financial distress. Nationally, during 2019, Medicare and Medicaid paid about $75.8 billion less than the cost of care, according to the AHA.[7] Here in Pennsylvania, about 63 percent of our acute care hospitals rely on government payors for at least half of their care-related revenue.[8]

---

[5] ModernHealthcare.com. "Specialty physician groups attracting private equity investment" by Harris Meyer. August 2019. Retrieved from: https://www.modernhealthcare.com/physicians/specialty-physician-groups-attracting-private-equity-investment.
[6] McKinsey & Company. The gathering storm: The transformative impact of inflation on the healthcare sector. September 19, 2022. Retrieved from: https://www.mckinsey.com/industries/healthcare/our-insights/the-gathering-storm-the-transformative-impact-of-inflation-on-the-healthcare-sector.
[7] AHA. "Fact Sheet: Underpayment by Medicare and Medicaid. February 2022. Retrieved from: https://www.aha.org/system/files/media/file/2020/01/2020-Medicare-Medicaid-Underpayment-Fact-Sheet.pdf#:~:text=This%20fact%20sheet%20provides%20the%20definition%20of%20underpayment,through%20a%20negotiation%20process%2C%20as%20with%20private%20insurers.
[8] HAP analysis of Pennsylvania Health Care Cost Containment Council's Financial Analysis Fiscal Year 2022, General Acute Care Hospitals

In Pennsylvania, even before the pandemic, Medicaid and Medicare paid roughly 84 cents and 81 cents, respectively, on average for every dollar that hospitals spend to provide necessary care for some of our most vulnerable neighbors.[9], [10] Merging with a hospital or health system can help some hospitals ease these financial burdens and improve patient care.

Nationally, commercial market dynamics and payor practices place stress on hospital finances. Insurers wield substantial market power in negotiating commercial rates, and new payment models come with considerable downside risk for hospitals and often do not fully account for the provision complex, high-acuity care. Excessive commercial payor administrative practices coupled with limited discharge options leave patients stranded and add to hospital costs. Risk mitigation can be achieved by serving larger, more diverse patient populations which can be particularly challenging for smaller hospitals or for facilities that are forced to reduce services or close beds due to workforce shortages.

It is not hard to envision how these and other financial stressors can collide and contribute to a downward spiral that threatens any given hospital's ability to keep its doors open and provide high-quality patient care.

The Goal: Access to Quality Care

The ideal situation for consolidation activity occurs between entities that are individually strong. In other instances, mergers and acquisitions are a tool that some health systems use to keep financially struggling hospitals open, averting bankruptcy or even closure. Kaufman Hall conducted an analysis that reveals that almost 40 percent of hospitals were financially distressed prior to merger/acquisition and that, of those, more than 80 percent of bankrupt hospitals analyzed remain in service today.[11]

Mergers can preserve local access to hospitals that serve vulnerable rural and urban communities. In many instances, but for operating under a system umbrella, hospitals could not have remained

---

[9] Dobson & DaVanzo. The Adequacy of Medicaid Program Payments to Hospitals in the Commonwealth of Pennsylvania. April 10, 2019. Retrieved from: https://haponlinecontent.azureedge.net/resourcelibrary/Medicaid-Program-Adequacy-Final-Report-Dobson-DaVanzo-April2019.pdf.
[10] AHA. "Fact Sheet: Underpayment by Medicare and Medicaid. February 2022. Retrieved from: https://www.aha.org/system/files/media/file/2020/01/2020-Medicare-Medicaid-Underpayment-Fact-Sheet.pdf#:~:text=This%20fact%20sheet%20provides%20the%20definition%20of%20underpayment,through%20a%20negotiation%20process%2C%20as%20with%20private%20insurers.
[11] AHA. Partnerships, Mergers, and Acquisitions Can Provide Benefits to Certain Hospitals and Communities. October 2021. Retrieved from: https://www.aha.org/system/files/media/file/2021/10/KH-AHA-Benefits-of-Hospital-Mergers-Acquisitions-2021-10-08.pdf.

in those communities. Since 2010, six rural hospitals and one urban hospital in Pennsylvania have closed, a number which would be much higher had it not been for the ability of health systems to merge.[12] The additional resources provided through affiliation help to temper challenges presented by fluctuating or low patient volumes, heavy reliance on government payors, and increased regulatory burden.

Moreover, when hospitals join systems, patients and communities often benefit from advantages that the facility was unable provide on its own—thus strengthening the continuum of care and improving patient outcomes: a win-win. As an example, leveraging the negotiating power of a system, a hospital is able to generate greater economies of scale in purchasing costly, cutting-edge equipment that it likely would not have been able to invest to purchase otherwise.

A National Council on Compensation Insurance Insights report indicates that clinical processes improve as protocols become more standardized and resources become more robust. Patients benefit from more access to specialty care and better coordination as they move along the continuum.[13], [14] A recent study published in JAMA Network Open found that certain hospital mergers are associated with lower mortality for patients admitted to the hospital for heart attack (9.4% pre-merger to 5.0% post-merger), heart failure (3.5% pre-merger to 2.7% post-merger), stroke (7.5% pre-merger to 5.8% post-merger) and pneumonia (4% pre-merger to 2.8% post-merger).[15]

Mergers are also associated with a 3.3 percent reduction in operating expenses, which helps reduce the gap between increasing expenses and insufficient payments.[16] Some of most broadly circulated reports that seek to correlate hospital consolidation and pricing are based on old claims data and represent only about 13.5 percent of covered lives.[17] More credible analysis would review current claims data and ensure representative samples of beneficiaries.

---

[12] Cecil G. Sheps Center for Health Services Research, University of North Carolina. *Rural Hospital Closures.* Accessed September 29, 2023. Retrieved from: https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
[13] NCCI.com. The Impact of hospital consolidation on medical costs. June 11, 2018. Retrieved from: https://www.ncci.com/Articles/Pages/II_Insights_QEB_Impact-of-Hospital-Consolidation-on-Medical-Costs.aspx.
[14] Deloitte.com. Hospital M&A: When done well, M&A can achieve valuable outcomes." Retrieved from: https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/hospital-mergers-and-acquisitions.html.
[15] JAMA Open Network. *Quality of Care Before and After Mergers and Acquisitions of Rural Hospitals*. September 20, 2021. Retrieved from: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784342
[16] AHA. Hospital Merger Benefits: An Econometric Analysis Revisited. August 2021. Retrieved from: https://www.aha.org/system/files/media/file/2021/08/cra-merger-benefits-revisited-0821.pdf#:~:text=Our%20updated%20results%20indicate%20that%20these%20acquisitions%20were,at%20acquired%20hospitals%20are%20long-term%20rather%20than%20transitory.
[17] AHA. Eight Myths About Hospital Mergers and Acquisitions. February 2020. Retrieved from: https://trustees.aha.org/system/files/media/file/2020/02/fact-vs-fiction-8-myths-about-hospital-mergers-aquisitions-consolidation-0220.pdf.

Action Steps: Enhance Hospital Stability

- Enact policies that support hospitals' current, hard-working health care professionals and enable hospitals to reduce reliance on costly agency staff.
- Work to ensure Pennsylvania's health care career pipeline can supply the future talent we need to take care of the commonwealth's aging population.
- Remove unnecessary bureaucracy associated with professional licensing to get caregivers to the bedside.
- Enable health care professionals to practice to the fullest extent of their training.
- Support pilot programs that explore collaboration and promote innovation in care delivery.
- Solidify and build upon advancements made by the Pennsylvania Rural Health Model.
- Assess and adjust Medicaid and Medicare payment rates to ensure that they cover the actual cost of providing care.

ROBERT P. CASEY, JR., PENNSYLVANIA, CHAIRMAN

KIRSTEN E. GILLIBRAND, NEW YORK
RICHARD BLUMENTHAL, CONNECTICUT
ELIZABETH WARREN, MASSACHUSETTS
MARK KELLY, ARIZONA
RAPHAEL WARNOCK, GEORGIA
JOHN FETTERMAN, PENNSYLVANIA

MIKE BRAUN, INDIANA, RANKING MEMBER

TIM SCOTT, SOUTH CAROLINA
MARCO RUBIO, FLORIDA
RICK SCOTT, FLORIDA
J.D. VANCE, OHIO
PETE RICKETTS, NEBRASKA

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400
(202) 224-5364

April 28, 2023

U.S. Attorney General Merrick Garland
950 Pennsylvania Avenue NW
Department of Justice
Washington, D.C. 20530

Chair Lina Khan
Federal Trade Commission
600 Pennsylvania Avenue NW
Washington, D.C. 20580

Dear Attorney General Garland and Chair Khan:

We write with growing concern regarding hospital consolidations across the country and the resulting impacts on health care quality, costs, and the workforce. As members of the U.S. Senate Special Committee on Aging, we are particularly concerned about the impact of hospital consolidation on older adults and people with disabilities. We urge you to utilize the full range of your oversight and remedial authorities to defend competition and a safe and strong hospital system.

On July 9, 2021, President Biden issued an Executive Order, which included a directive for antitrust agencies to focus on hospital consolidation as part of their response to corporate consolidation. Specifically, the president urged the Department of Justice and the Federal Trade Commission to "review and revise" merger guidelines to ensure patients are not harmed. We request the Administration to provide us updates on the progress of these recommendations and priorities regarding consolidation in domestic health care markets.

While the COVID-19 pandemic contributed to the shift towards consolidation in the health care industry, this trend was occurring well before the pandemic and has contributed to these negative trends. Rapid consolidation of hospitals and health systems has become more common across the country over the past few decades. According to the American Hospital Association, between 1998 and the end of 2021, there were 1,887 hospital mergers announced, reducing the number of hospitals from 8,000 to 6,000 nationwide.[1] The top ten health systems now control nearly a quarter of the market share, and their revenue has grown at twice the rate of the rest of the market.[2] These consolidations and closures are especially stark in rural areas; since 2010, more than 151 rural hospitals have closed, including 37 over the last three years.[3]

[1] https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/#:~:text=%E2%80%9CIt's%20not%20a%20new%20trend,to%20around%20just%20over%206%2C000.%E2%80%9D

[2] https://www2.deloitte.com/us/en/insights/industry/health-care/hospital-mergers-acquisition-trends.html

[3] https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

Furthermore, health system acquisitions of physician practices have also steadily increased, including during the COVID-19 pandemic. Hospitals acquired 4,800 physician practices between January 2019 and January 2022, increasing hospital-owned practices by nine percent. As of January 2022, 74 percent of physicians work for a hospital or corporate entity, growing by 19 percent since January 2019.[4]

While the economy continues to improve under President Biden's leadership, consolidation in the health care industry at-large has driven up prices for consumers and driven down wages for workers. Evidence shows that hospitals with fewer competitors charge significantly higher prices. For example, hospitals without a competitor nearby charge 12 percent higher on average than hospitals with three or more competitors nearby. Prices in hospitals with one nearby competitor are on average 7.3 percent higher.[5] These higher prices are often not accompanied by better quality care, and studies suggest higher rates of consolidation may lead to higher mortality rates.[6] While higher rates of consolidation may promote efficiency and increase care coordination, studies show that merged hospitals and integrated systems are not less costly or higher quality than their independent peers.

Decades of health system consolidation leave communities without access to necessary care. Those most affected by downsizing and closing certain outpatient services, a common byproduct of health system consolidation, are people of color, older adults, and people with disabilities. Independent hospital closures or mergers with larger health systems occur in rural and urban areas and can cause significant strain on their communities.[7]

While higher costs and lower quality care are concerning outcomes from increasing hospital consolidation, we are also worried about the impact to the workforce. There is strong evidence that hospital mergers lead to reduced workers compensation and benefits, as well as the loss of employment options for health care workers.[8] There is a clear link between hospital consolidation and wage stagnation in one of the most critical areas of our workforce.[9] Also, the nation faces a health care workforce shortage that has been severely exacerbated by the COVID-19 pandemic. An aging workforce, burnout, and the lack of nursing faculty are all factors contributing to the overall staffing shortage, and the World Health Organization has predicted a shortfall of 15 million health care workers by 2030.

We appreciate your time and attention in answering the following questions:

---

[4] https://revcycleintelligence.com/news/physician-practice-acquisitions-by-hospitals-corporations-grew

[5] https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf

[6] https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf

[7] https://communitycatalyst.org/posts/addressing-the-impact-of-hospital-consolidation-on-health-equity/

[8] https://www.aeaweb.org/articles?id=10.1257/aer.20190690

[9] https://www.aeaweb.org/articles?id=10.1257/aer.20190690

1. Since President Biden issued the Executive Order on "Promoting Competition in the American Economy" in June 2021, what specific steps has your agency or department taken to address the impact of hospital consolidation on health care costs, patient care, and the health care workforce?
2. Hospital consolidations can have greater negative impacts in certain areas, such as rural communities, and on populations that face challenges in accessing quality, affordable health care, such as people with disabilities, people with low incomes, and communities of color. In its regulatory and enforcement actions, how does your agency or department assess the impact of hospital consolidation on these communities?
3. The COVID-19 pandemic further taxed the already stressed health care workforce, and reduced competition in the health care industry has further limited their employment opportunities. In its regulatory and enforcement actions, how does your agency or department assess the impact of hospital consolidation on health care workers?
4. How do the Department of Justice (DOJ) and the Federal Trade Commission (FTC) coordinate to ensure a consistent approach to regulatory and enforcement action when addressing the effects of mergers and acquisitions in the health care industry?
5. How do the DOJ and FTC work with other federal partners, including the Department of Health and Human Services (HHS) and the Department of Labor (DOL), on issues related to hospital consolidation and its impact on patient care quality, accessibility, and the health care workforce?

Thank you for your consideration. We commend the Biden Administration for being a champion for promoting competition across the economy. We look forward to working with you to craft responsive policies that address the negative impacts of hospital consolidation on health care quality, cost, and the workforce.

Sincerely,

Robert P. Casey, Jr.
United States Senator
Chairman, Special Committee on Aging

John Fetterman
United States Senator

Elizabeth Warren
United States Senator

Raphael Warnock
United States Senator

Richard Blumenthal
United States Senator

CC: DOL, HHS, White House