Commercial Sector Prices

Administrative Policy Options for Addressing Health Care Consolidation and Lowering Health Care Prices

American families, businesses, and taxpayers are increasingly burdened by unreasonably high health care costs, primarily driven by increases in the prices charged for health care services. This problem has become particularly acute as large hospitals and health systems continue to acquire smaller hospitals and physician offices and use their increased market power to limit competition and raise prices without improvements in the quality of care. This restricts patients' choices for care and increases their premiums and out-of-pocket costs, making it harder for patients to access and afford the care they need to be healthy.

The Administration can pursue the policies below to reduce wasteful health care spending, lower health care costs for American families, businesses, and taxpayers, and create a more competitive, functional health care market.

INCREASE TRANSPARENCY OF HEALTH CARE PRICES AND PROVIDER ENTITIES

Despite important work to enhance transparency, the price of care — and where it is delivered — is often opaque and inaccessible. Robust price, billing, and ownership transparency can empower consumers, employers, researchers, and policymakers with essential information regarding the price of care and where it is received. These policies can improve patient decision-making and employer purchasing decisions, strengthen market competition, and provide a better understanding of health care prices for the media, policymakers, and researchers that can inform future policymaking.
The Department of Health and Human Services (HHS) should:

- **Strengthen price transparency** to take action on President Trump's Executive Order, *Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information*, including by:
  - Requiring hospitals to display all price information in dollars and cents, rather than in algorithms or Medicare percentages.
  - Further levying financial penalties on hospitals and health systems who are noncompliant or partially compliant with price transparency regulations.
  - Increasing the financial penalties for noncompliance and eliminating the maximum penalty cap for noncompliance.
- **Enhance site-of-service billing transparency** to improve transparency over where care is delivered and address the challenge of patients being charged excessively high hospital prices for care that is actually being provided in a lower-cost setting (e.g., hospital-owned physician offices or outpatient departments) by:
  - Requiring hospitals to identify the National Provider Identifiers (NPI) of all of their organizational subparts, including any unique NPIs obtained by off-campus hospital outpatient departments (HOPDs), in their Medicare Cost Reports.
  - Updating CMS claims forms by adding additional modifiers — such as "owned by" or "affiliated with" — to the "Place of Service" codes to better understand additional information about the provider when a facility fee or higher payment rate is being billed on provider claims.

- **Strengthen ownership transparency** to provide clarity on ownership and financial relationships across the health care system to inform policies aimed at improving health care market competition and addressing emerging forms of consolidation by:
  - Releasing merger, acquisition, and changes in ownership data collected in Medicare's Provider Enrollment, Chain, and Ownership System (PECOS) for hospitals, certain physician practices (including those owned by hospitals, health plans and other entities), and other health care providers such as ambulatory surgical centers. Analyses of trends in horizontal and vertical consolidation should be published at least annually moving forward.
  - Improving PECOS by creating specific indicators for ownership type (e.g., for profit, nonprofit, private equity, venture capital, etc.) and for "parent" companies to identify common ownership across health care markets.

EXPAND SITE-NEUTRAL PAYMENT REFORMS

Large, consolidated hospitals have been buying up independent physician offices and charging patients higher hospital prices for the same service. Legislative efforts to advance comprehensive site-neutral reforms would protect patients from being charged more for services based on where they receive them. Such efforts would also lower health care costs for patients and taxpayers, saving billions of dollars in health care spending and reducing the incentive for further consolidation in the health care industry. To strengthen site-neutral payments and lower health care costs, HHS should:

- **Apply site-neutral payments to all evaluation and management (e.g., office) visits** provided at on-campus hospital-owned physician offices or outpatient departments.
- **Expand the use of site-neutral payments in Medicare for additional services** beyond evaluation and management (e.g., office) visits (such as for drug administration or imaging).
- **Release data on how many locations are currently exempt from existing site-neutral policies** (e.g., grandfathered locations) and utilization trends for these grandfathered locations to understand the impact and magnitude of eliminating the grandfathering exception.

ENCOURAGE COMPETITION AND PREVENT FURTHER HEALTH CARE MARKET CONSOLIDATION

Over the last several decades, large hospitals and health systems, as well as other powerful providers have engaged in rampant health care consolidation. These entities then leverage their market power to demand higher prices for care, ultimately raising health care costs for consumers, businesses, and taxpayers. To help counteract this consolidation, promote competition, and lower health care costs, the Administration should:

- **Pursue aggressive antitrust enforcement and oversight** through the Federal Trade Commission (FTC) and Department of Justice (DOJ) to prevent the continued growth of monopolies — particularly in less explored areas, such as vertical integration, smaller mergers that typically would not trigger antitrust oversight but ultimately have anticompetitive effects ("roll-ups"), and cross-market mergers.
- **Establish a "Healthy Markets Czar" and Council** to coordinate among relevant Agencies (HHS, DOJ, and FTC) to promote and strengthen health care competition while maximizing efficiency across Agencies. This will lead to stronger policies aimed at improving market competition and allow each agency to leverage its own regulatory authority more effectively. The Council could:
  - Pursue independent or joint investigations into anticompetitive conduct, consolidated markets, and other predatory or monopolistic practices pursued by powerful health care entities.

- Support the regular collaboration and data-sharing of hospital and provider data on ownership and consolidation across the Administration to understand what new or additional data would be helpful to strengthen market competition.

- **Issue guidance or health care policy statements on newer forms of consolidation (vertical integration, cross-market mergers) and anticompetitive conduct (e.g., anticompetitive contracting practices)** to inform private and state antitrust litigation and legislative policymaking efforts aimed at addressing consolidation.

ENHANCE OVERSIGHT OVER NONPROFIT HOSPITALS

More than half of hospitals in the United States are nonprofit institutions exempt from federal, state, and local taxes in exchange for providing "community benefits" to the communities they serve. However, research has consistently shown that nonprofit health systems are failing to meet community benefit standards and are charging egregiously high prices for care. Transparency and oversight are important first steps to ensure nonprofit hospitals are providing appropriate community benefits to justify the tax breaks they receive. To enhance oversight over nonprofit hospitals, HHS and the Internal Revenue Services Administration should:

- **Support efforts to strengthen community benefit standards** to better define community benefit, increase accountability over nonprofit hospital behavior, and ensure the appropriate provision of nonprofit hospital tax benefits.

- **Revise nonprofit hospital reporting tools (Form 990)** to ensure that the information demonstrating the community benefits provided by hospitals is transparent, including by:

  - Requiring nonprofit hospitals to report their estimated tax breaks; and

  - Ensuring that information on community benefit and charity care is publicly available in quantitative, machine-readable files.

- **Pursue stronger auditing efforts** over nonprofit hospitals to ensure community benefit standards are met.

- **Update Medicare Cost Reports to enhance transparency over hospital and health system finances** to include data from and better align with providers' audited financial statements and require this information to be reported on a quarterly basis.

STRENGTHEN IMPLEMENTATION OF THE NO SURPRISES ACT

The No Surprises Act (NSA), signed into law in 2020, was designed to protect patients from surprise medical bills and lower health care costs. However, litigation by providers — some of whom are backed by private equity — and abuse of the NSA's Independent Dispute Resolution (IDR) process have weakened the law and its ability to reduce health care costs. To mitigate the impact of these abusive efforts, HHS should:

- **Finalize the Federal IDR Operations proposed rule** to make the process more efficient, usable, and less burdensome for both providers and plans and reduce administrative costs associated with using the IDR process.

- **Increase transparency over payment determinations made by IDR entities (IDREs)** to understand the impact certain IDR decision factors — such as pre-NSA rates for out-of-network care — have on payment determinations. IDR entities should be required to provide a narrative explanation of which factors and data informed their payment decision in a clear, uniform written description.

- **Provide additional guidance to IDREs** to ensure they are properly assessing eligibility of NSA claims and using consistent and appropriate factors in determining payments.
- **Audit IDREs** and their compliance with rules and guidance for making payment determinations to ensure non-relevant information is not being considered.

For more information on these priorities, please contact Erica Socker, Vice President of Payor Reform (esocker@arnoldventures.org) or see Arnold Ventures Commercial Sector Prices for more information.