November 22, 2022

Phillip L. Swagel
Director
Congressional Budget Office
Ford House Office Building
441 D St., SW
Washington, D.C. 20515

SUBJECT: Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services

Dear Director Swagel:

On behalf of our over 400 member hospitals and health systems, the California Hospital Association (CHA) would like to comment on the recent Congressional Budget Office (CBO) report, "Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services."

CHA has the utmost respect for the analysis and reporting undertaken by the CBO. However, in the instance of this report, the recommendations put forth are grounded in a one-sided, incomplete analysis. The paper asserts — despite evidence to the contrary — that hospital and health system integration is the primary driver of increases in health insurance premiums. However, the paper fails to examine the clear role that health plans have in premium growth. Further, the analysis assumes that Medicare and Medicaid payment rates are adequate to cover physician and hospital costs and therefore an appropriate comparator for commercial rates. Nothing could be further from reality.

Based on flawed analysis and inaccurate assumptions, the paper puts forth three policy options the CBO claims will reduce health insurance premiums. However, given health plans' conduct in the market, the assumed reductions in cost would not be passed along to consumers and employers as reduced premiums. Instead, they would further pad health plans' already considerable profit margins. And, given the overwhelming financial challenges inundating many hospitals, reducing commercial cross-subsidization of governmental payer shortfalls will exacerbate existing access issues that many individuals face. These access issues would disproportionately affect those already medically underserved individuals and therefore most at risk for inequitable outcomes.

Below, please find CHA's detailed concerns with the analysis put forth in the CBO's recent report. We respectfully ask that future work in this area by CBO be conducted in the unbiased and thoughtful manner that the CBO is known and respected for.

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Hospitals Are Not Driving Excess Premium Growth

The CBO white paper asserts that hospital price increases are the driving force behind health insurance premium growth. However, that assertion doesn't match the reality found in data collected by the Bureau of Labor and Statistics (BLS). According to BLS data, hospital prices over the last decade grew by an average of 2.1%. However, over that same 10-year period, insurance premiums increased by 4.5%. For hospital prices to exert significant upward pressure on insurance premiums, their growth would need to equal or exceed the growth in health insurance premiums. However, that is clearly not the case in BLS data. Frustratingly, the report does not explore the role that changes in utilization[1] patterns, pharmaceutical costs,[2] or even insurers' behavior have on premium growth.

Instead, the paper identifies the continued development of integrated health systems as the culprit that allegedly gives relatively small health systems negotiating power over health plans whose annual revenues can easily exceed $50.2 billion or more.[3,4,5,6] However, research cited by the paper contradicts this assertion. A *Health Affairs* article referenced by the paper finds that 30% of allegedly "high-priced" hospitals were in markets that are considered unconcentrated and another 28.4% were in markets that are considered moderately concentrated based on the guidelines used by federal agencies.[7] Given that over half of the allegedly "high-priced" hospitals are not in markets that federal anti-trust guidelines indicate are concentrated, it suggests there is another dynamic — not health system integration — that leads to the variation in hospital pricing observed by health services researchers.

The narrative that health system integration automatically results in increased prices is not only false but counter-productive. A recent report[8] by the nationally renowned consulting firm Kaufman Hall finds that health system integration in California has:

- *Preserved Access*: As an example, a recent affiliation between a critical access hospital and a multi-state health system not only kept a small, rural hospital open but also allowed it to expand patient care through the addition of 32 newly recruited doctors in such specialties as orthopedics, gastrointestinal care, and cardiac services.

- *Reduced the Total Cost of Care*: Consumers in more highly integrated states may have more affordable insurance premiums and lower per-capita health care expenditures. This finding is supported by data in California, where 72% of hospitals have already partnered with larger health care systems. According to the California Health Care Foundation, per-capita health care spending in California is $7,549, more than 6% below the national average of $8,045.

- *Improved Patient Outcomes*: The link between higher volumes and improved clinical outcomes is well established. Integrated systems that cover a broader population base also will have higher

[1] https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00113
[2] CHA notes that Congress included multiple provisions designed to mitigate continued unchecked pharmaceutical cost growth on Medicare in the Inflation Reduction Act.
[3] https://www.fiercehealthcare.com/payer/cvs-health-projects-at-least-304b-revenue-for-2022
[4] https://www.sec.gov/Archives/edgar/data/731766/000073176622000004/a2021q4exhibit991.htm#:~:text=UnitedHealth%20Group's%20full%20year%202021,the%20Optum%20and%20UnitedHealthcare%20businesses.&text=Full%20year%202021%20earnings%20from,over%20half%20of%20the%20total.
[5] https://www.hcsc.com/who-we-are/statistics#:~:text=Our%20total%20revenue%20in%202021%20was%20%2450.2%20billion.
[6] https://www.elevancehealth.com/annual-report/2021/financials.html
[7] https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00001
[8] https://calhospital.org/wp-content/uploads/2021/10/KH-CHA-Benefits-of-Integration-Report_Final_Revd10-21-2021.pdf

volumes of most medical and surgical procedures. A quality-focused integration strategy often relies on access to a broader patient population. For example, since Cedars-Sinai and Torrance Memorial Medical Center finalized their affiliation in 2018, patients have benefited from greater access to specialty services and a higher level of care at Torrance Memorial. The affiliation has enabled Torrance to achieve comprehensive stroke center designation, which indicates that it is among the best-equipped hospitals to treat any kind of stroke or stroke complication. In addition to advances in neurosciences, Torrance Memorial has also been able to expand capabilities in thoracic surgery, cardiovascular surgery, cancer, and clinical trials.

CBO Must Examine the Relationship Between Health Plan Market Power and Premiums

Despite recent record profits,[9] as illustrated by the table below, health insurance premiums in the exchanges are projected to increase by 10%[10] for plan year 2023 — the most in recent years.

Health Plan	3rd Quarter Profits	% Increase
United Health Group	$5.3 billion	+28%
Cigna	$2.8 billion	+70%
Elevance (Formerly Anthem)	$1.6 billion	+7%
Humana	$1.2 billion	+20%
Centene	$738 million	+26%
Molina	$230 million	+60%

This implies two things. First, none of the profits generated by health plans are being passed along to employers or consumers. This behavior directly contradicts the CBO's assumption that any decrease in hospital prices will be passed along to consumers and employers. Second, it suggests that health plans experience little to no pressure from market forces. Given they're not using these profits to lower premiums, it suggests there is little concern their current customers will switch to carriers that offer lower premiums.

The reason health plans do not feel pressure to reduce premiums (or fear losing market share) in response to record profits is that most plans operate in markets that are already highly consolidated. Using California as an example, the individual,[11] small group,[12] and large group[13] markets are already heavily consolidated based on federal anti-trust guidelines.

- *Individual Market*: Three health plans control 80% of the individual market.
- *Small Group Market*: The small group market has a Herfindahl-Hirschman Index (HHI) of 2,995 (an HHI greater than 2,500 is considered highly concentrated). One carrier has 50% market share, but only four carriers have more than a 5% share.

[9] https://www.beckerspayer.com/payer/the-house-always-wins-health-systems-face-worst-finances-in-decades-as-payers-rake-in-record-profits.html?origin=BHRE&utm_source=BHRE&utm_medium=email&utm_content=newsletter&oly_enc_id=3425B7642190A3X
[10] https://www.healthsystemtracker.org/brief/an-early-look-at-what-is-driving-health-costs-in-2023-aca-markets/#Distribution%20of%20proposed%202023%20rate%20changes%20among%2072%20reviewed%20ACA%20marketplace%20insurers
[11] https://www.kff.org/private-insurance/state-indicator/market-share-and-enrollment-of-largest-three-insurers-individual-market/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[12] https://www.kff.org/other/state-indicator/small-group-insurance-market-competition/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[13] https://www.kff.org/other/state-indicator/large-group-insurance-market-competition/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

- *Large Group Market*: The large group market has an HHI of 3,083. One carrier has a market share of 47% and only four have a market share greater than 5%.

Further, consistent with economic theory, research shows that more consolidated health insurance markets have higher premiums.[14] The addition of a single insurer in a county is associated with a 1.2% lower premium for the average silver plan and a 3.5% lower premium for the benchmark plan in the federally run marketplaces. This is also further confirmed by the recent $2.7 billion settlement[15] agreed to by the Blue Cross Blue Shield Association. It agreed to compensate employers and their employees for long-standing anti-competitive behavior, which has increased premiums not only for BlueCross Blue Shield customers but also those of other plans because of a lack of competition in the large group market. For its part, Anthem (now Elevance), the BlueCross licensee in California, has committed to paying $594 million[16] as its share of the anti-trust settlement.

Hospital Financial Challenges Exacerbated by Inadequate Governmental Payment

While health plans are experiencing unprecedented profits, hospitals' financial struggles are forcing many facilities to reduce services or outright cease operations. These financial struggles are driven by continued inadequate governmental payment rates, rapid inflation in key expense categories, and an inability to cross-subsidize the shortfalls of Medicare and Medicaid patients with revenue from commercial patients.

A recent analysis by Kaufman Hall[17] estimates that even after federal support, California's hospitals lost more than $12 billion in 2020 and 2021. Median expenses per discharge for California hospitals rose 15% in 2021, outpacing the 11% national average. These cost increases were largely driven by higher labor costs (+16%) and supply chain shortages impacting pharmaceuticals (+41%) and medical supplies (+19%).[18]

CHA notes that labor is the single largest expense item in a hospital's cost structure. It accounts for approximately 68% of a hospital's costs nationally. Further, pharmaceuticals make up a significant portion of a hospital's cost structure. Even before the recent bout of inflation, these pharmaceutical costs have experienced unchecked growth. Between 2015 and 2017, total hospital and health system spending on drugs increased — on average — by 18.5% per admission. This includes a jump of 28.7% per outpatient adjusted admission, following a record 38.7% increase in prescription drug spending in the inpatient setting from 2013 to 2015.[19] Hospital efforts to contain this growth are hamstrung, given that for many of these compounds there are no clinically effective substitutes.

As a result of increasing costs per adjusted discharge that outstrip payment updates, 51% of California's hospitals had negative margins in 2021. We anticipate that the number of hospitals experiencing negative margins in 2022 will be even greater. The shortfalls are most pronounced on patients who are covered by Medicare and Medicaid. Nationally, combined underpayments were $100.4 billion in 2020, up from $75.8 billion in 2019. The 2020 underpayment includes a shortfall of $75.6 billion for Medicare and $24.8 billion

[14] https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2015.0548
[15] https://www.healthcarefinancenews.com/news/bcbs-27-billion-settlement-receives-final-approval
[16] https://www.healthcarefinancenews.com/news/anthem-paying-594-million-settle-blues-antitrust-settlement
[17] https://www.kaufmanhall.com/sites/default/files/2022-04/KH_CHA-2021-Financial-Analysis-Ebook.pdf
[18] Expense increases based on per adjusted discharge.
[19] https://www.aha.org/drug-prices/home

for Medicaid.[20] As illustrated below, on average California hospitals lose 21 cents on the dollar for Medicare patients and 24 cents for Medicaid patients. These two payers comprise almost 60% of California hospital revenue.

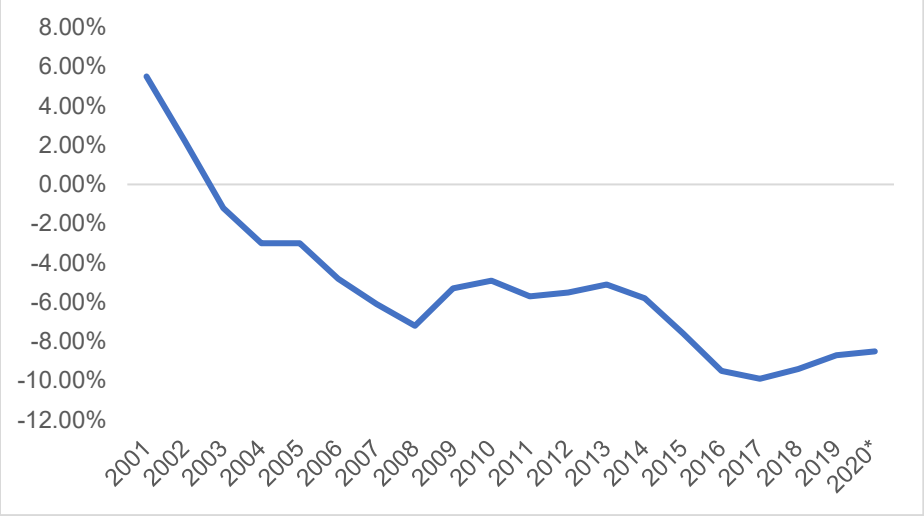
California Hospitals' Governmental Payer Volume and Margins

Payer Bucket	% Net Patient Revenue	Payer Specific Operating Margin
Medicare	28%	-21.00%
Medi-Cal	30%	-24.00%

Given shortfalls on Medicare, CHA is deeply concerned the CBO paper suggests that any price caps on commercial payments could be set "much closer to the prices paid by Medicare FFS." Not only do Medicare payments to hospitals fail to cover the cost of providing care today, but statutory requirements make it impossible that payment updates will even keep pace with input cost inflation. This means that hospital shortfalls on Medicare patients will continue to grow.

The input and process used by the Centers for Medicare & Medicaid Services (CMS) to determine the annual hospital inflationary update (the market basket update) chronically fail to keep pace with hospitals' input cost growth. Despite sustained cost reduction and efficiency efforts by hospitals, Medicare margins have declined over the last 20 years — as illustrated below.

IPPS Hospital Medicare Margin: 2001 to 2020[21,22]



*Includes Provider Relief Funds

As illustrated in the table below, Medicare under-reimbursed hospitals by 4.4%[23] when comparing the market basket update to the growth in risk-adjusted beneficiary per discharge costs for the same period in the final rules from 2016 to 2020.

[20] https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid
[21] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch3_SEC.pdf
[22] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar18_medpac_ch3_sec.pdf
[23] CHA analysis of Medicare cost report data

IPPS Final Rule Market Basket Update vs.
Medicare Risk Adjusted Per Discharge Cost Growth:
FFY 2016 – 2020

	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	Summary
Forecast Used in the Update[1]	2.40%	2.70%	2.70%	2.90%	3.00%	
CMI Adj. Medicare Per Discharge Cost Growth	0.93%	2.63%	2.03%	4.52%	7.99%	
Difference[2]	1.47%	0.07%	0.67%	-1.62%	-4.99%	-4.40%

Notes:
1) These figures do not reflect total factor productivity or other legislative adjustments.
2) Positive values indicate CMS' final market basket overstated cost growth between fiscal years, meaning that CMS overpaid the hospitals. Negative values indicate CMS understated growth between fiscal years and, as a result, underpaid hospitals.

The insufficient inflationary updates illustrated in the table above are one component of inadequate payment rates that result in negative hospital margins. The productivity cuts mandated by the Affordable Care Act are the other component.

Section 3401 of the Affordable Care Act requires that the inpatient prospective payment system (IPPS) operating market basket update be adjusted by changes in economy-wide productivity for federal fiscal year (FFY) 2012 (and each subsequent FFY). The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity. The table below provides the productivity adjustments used to reduce the hospital inflationary update (and therefore hospital payments) since 2012.

Medicare IPPS/OPPS Productivity Adjustment: FFY 2012-23

	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23
Productivity Adjustment	1.0	0.7	0.5	0.5	0.5	0.3	0.6	0.8	0.4	0.0	0.7	0.3

Notes:
1) The productivity adjustment is subtracted from the market basket update, meaning a positive productivity adjustment reduces the market basket update.

The productivity adjustment to the market basket update assumes that hospitals can increase overall productivity — producing more goods with the same or fewer units of labor — at the same rate as productivity increases in the broader economy. However, providing acute care to patients is highly labor intensive, as CMS' projection of the labor-related portion of the federal rate — 67.6% — implies in the FFY 2023 final rule.

Hospital care must be provided on-site and has a high "hands-on" component. Therefore, hospitals cannot improve productivity using strategies like offshoring or automation that are commonly deployed in other sectors of the economy. For example, sectors that produce goods can utilize robotic automation of manufacturing plants and service industries such as dine-in restaurants can use automated ordering systems to reduce overall staffing count. CMS' own research, conducted prior to the COVID-19 public health emergency, indicates that hospitals can only achieve a productivity gain that is one-third of the gains seen in the private, nonfarm business sector.[24]

[24] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf

Clearly, Medicare rates are an inappropriate benchmark for commercial health plan payments to hospitals given that both CMS' methodology and the Medicare statute result in payments that do not cover the cost to provide care.

Impact on Patient Access to Care

In its report, the CBO suggests that hospitals may be forced to close some services if the recommendations to cap commercial rates were adopted. In light of the current financial challenges facing hospitals, we are already seeing this. As a result of ongoing, unsustainable margins, hospitals across the country are eliminating service lines that have negative margins. These closures have disproportionately impacted access to labor and delivery, inpatient pediatric, and emergency department services.[25] If negative margins persist for hospitals (or the number of hospitals experiencing them increases as a result of reduced cross-subsidization of governmental shortfalls from commercial payers[26]), more hospitals and health systems will be forced to discontinue services that are financially unsustainable or risk insolvency.

Beyond simply reducing access to some services, sustained negative margins result in hospital closures. Historically, hospital closures have most frequently occurred in rural areas. A hospital payer mix that includes high rates of uninsured patients and those covered by governmental payers are frequently cited as key drivers of the closure of rural hospitals.[27] Between January 2013 and February 2020, over 100 rural hospitals closed;[28] three of those facilities were in California. Another 631 rural hospitals (13 in California) are deemed at risk of closure.[29]

This is completely unacceptable. Residents who live in areas affected by a rural hospital closure are more likely to live in poverty (13.3% vs. 9.3%). Further, Medicare beneficiaries who live in areas that have experienced a rural hospital closure are more likely to suffer from one or more of the 10 most common chronic conditions. And the closing of these facilities significantly reduces access to care for all patients. The distance patients are required to travel to access inpatient services increases by 20 miles; for services like treatment for substance use disorder, it increases by almost 40 miles.

Even more concerning, the trend of closures has expanded to safety-net hospitals.[30,31] Recent examples include Hahnemann University Hospital in Philadelphia, and Atlanta Medical Center (AMC) in Atlanta.[32] Beyond the loss of access for those in the surrounding community, the Hahnemann closure started a domino effect in the market, which nearly resulted in the closure of another hospital — Mercy Philadelphia Hospital.[33] However, a coalition of organizations stepped in to preserve some services.[34] While AMC recently ceased operations, the impact is already being felt by the community. Volumes at adjacent, already overcrowded hospitals are rising. Atlanta's remaining trauma center has seen a 30% increase in trauma patients. And emergency departments at nearby hospitals have been so overcrowded

[25] https://www.beckershospitalreview.com/care-coordination/18-hospitals-scaling-back-care.html?
[26] https://jamanetwork.com/channels/health-forum/fullarticle/2760166
[27] www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/
[28] https://www.gao.gov/products/gao-21-93
[29] https://www.beckershospitalreview.com/finance/631-rural-hospitals-at-risk-of-closure-by-state.html
[30] https://www.beckershospitalreview.com/finance/19-hospital-closures-bankruptcies-in-2022.html?
[31] https://www.beckershospitalreview.com/finance/ohio-hospital-closing-earlier-than-planned-due-to-patient-safety-concerns.html?
[32] https://www.beckershospitalreview.com/finance/wellstar-ceo-atlanta-medical-center-closed-after-exhaustive-search-for-partners.html?
[33] https://www.nejm.org/doi/full/10.1056/NEJMp2002953
[34] https://whyy.org/articles/penn-med-phmc-lead-coalition-to-save-mercy-philadelphia-hospital/

they were forced to divert ambulances to other hospitals that were further away.[35] Based on conversations with our own members and colleagues in other states, we believe this is the tip of the iceberg as many more safety-net hospitals are currently at risk for closure unless their margins improve significantly.

CHA is aware of several California safety-net hospitals — including the state's largest district hospital[36] — that are experiencing severe financial distress. Without material margin improvement they will be forced to discontinue operations. If the CBO's recommendations to cap commercial payments to hospitals are implemented, it would all but guarantee these hospitals' closures. These closures would severely limit access to care for the disadvantaged populations they serve, further exacerbating already inequitable outcomes.

In future work, CHA respectfully asks that the CBO base any recommendations related to constraining health insurance premiums on a complete analysis of factors contributing to rate inflation. Failing to do so — as it has in this paper — will result in recommendations that are not only ineffective at addressing health insurance premium inflation but will further jeopardize access to care for some of America's most vulnerable citizens if implemented. CHA appreciates the opportunity to provide comments on the CBO's recent work. If you have any questions, please contact me at cmulvany@calhospital.org or (202) 270-2143.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy

[35] https://www.beckershospitalreview.com/care-coordination/atlanta-hospital-reports-30-more-patients-4-days-after-wellstar-closure.html
[36] https://www.beckershospitalreview.com/finance/california-hospital-ceo-asks-newsom-for-financial-aid.html