Maine Medical Association

Maine Osteopathic Association

TESTIMONY OF THE MAINE MEDICAL ASSOCIATION

AND

THE MAINE OSTEOPATHIC ASSOCIATION

AGAINST

L.D. 1972, AN ACT TO ENHANCE THE TRANSPARENCY AND VALUE OF SUBSTANTIAL HEALTH CARE TRANSACTIONS BY CHANGING THE REVIEW AND APPROVAL PROCESS FOR THOSE TRANSACTIONS

Joint Standing Committee on Health Coverage, Insurance & Financial Services

Room 220, Cross State Office Building, Augusta, Maine

Tuesday, May 20, 2025, 1:00 p.m.

Good Afternoon Senator Bailey, Representative Mathieson, and Members of the Joint Standing Committee on Health Coverage, Insurance & Financial Services:

My name is Andrew MacLean and I am CEO of the Maine Medical Association. I am testifying against L.D. 1972, *An Act to Enhance Transparency and Value of Substantial Health Care Transactions by Changing the Review and Approval Process for Those Transactions* on behalf of the Maine Medical Association (MMA) and the Maine Osteopathic Association (MOA).

The Maine Medical Association (MMA) is a professional organization representing over 4,000 physicians, residents, and medical students in Maine. MMA's mission is to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine people. The Maine Osteopathic Association (MOA) is a professional organization representing more than 1,200 osteopathic physicians, residents, and medical students in Maine whose mission is to serve the Osteopathic profession of the State of Maine through a coordinated effort of professional education, advocacy, and member services in order to ensure the availability of quality osteopathic health care to the people of this state.

We appreciate Representative Zager's effort to develop a legislative response to these concerns and the assistance of Meg Garrett-Reed, Executive Director of the Office of Affordable Health Care, in drafting L.D. 1972. We have been soliciting feedback from our members since the bill was printed and referred, and we have received a full range of opinions on it.

While there are elements of this bill that we support, we must regrettably oppose its current form as it unfairly impedes physician innovation and their ability to provide exceptional care. The intent of the bill to protect Maine patients from unfair and profit-motivated businesses is laudable and one that our Associations will always support. We hope with iteration this bill can achieve this goal without hindering the independent practice of medicine in the state of Maine - the bedrock of assuring quality, affordable care for Mainers.

Our two physician professional organizations understand policymakers' concerns about the impact on patient care of trends in the health care marketplace across the country and here in Maine, including greater concentration of market power, the role of private equity financing, and increasing financial pressure on health care organizations, especially since the COVID-19 pandemic. Policymakers have expressed deep concern about the financial collapse of Steward Health Care in neighboring Massachusetts, transactions in two Maine health systems involving large national entities, the closure of OB service lines in Maine hospitals, and the appearance of private equity financing in Maine.

As such, we urge the Committee to carry over the bill to the 2026 legislative session and direct stakeholders to work on the topics raised in the interim, as it presents important and timely issues for discussion and debate. We would welcome the opportunity to participate in a stakeholder process.

State government certainly has an interest in the extraordinary financial pressure on our health care organizations and the impact of market dynamics on patient access to and quality of care. But, State government's appropriate role in response to these concerns needs further study and discussion. Adequate federal and state funding of our health care system that covers providers' cost of care is necessary and is a top priority. Better funding of current health care regulatory agencies in the state is another appropriate response to support the enforcement of current law. If a new regulatory law is appropriate, it should be drafted as narrowly as possible and applied carefully.

I will make some general observations about the bill based on the feedback from members so far, but these are not limited to and should include the other legitimate concerns raised during the public hearing.

First, the scope of the bill must be narrowed substantially, both the types of entities and the types of transactions subject to review. Independent, private physician practices, regardless of their workforce size or capitalization, should be excluded from the bill. The administrative and cost burden on physician practices in the regulatory review of transactions involving private capital would be excessive. Please see the attached letter dated June 5, 2024 from the AMA to the Federal Trade Commission, the Department of Health & Human Services, and the Antitrust Division of the Department of Justice regarding the factors influencing physicians' decisions to leave independent, private practice.

Second, the MMA historically has been very skeptical about the value of the Certificate-of-Need (CON) process as a health planning tool, and, in fact, we achieved a successful vote on repeal of Maine's CON statute in one chamber of the legislature in 2002 (L.D. 1545, 120th Maine Legislature). The attached letter, dated April 12, 2022, from the AMA to the South Carolina legislature outlines the arguments against CON. If the Committee decides to proceed with this bill, we urge a comprehensive review of the entire CON statutory and rulemaking framework because of the market changes witnessed during the past two decades.

Specifically, the Committee should consider three principal triggers for CON review –

1. The dollar threshold for review of "capital expenditures"
2. The dollar threshold for review of "major medical equipment";
3. And the concept of requiring CON review of a "new health service."

Members of the MMA's Independent Practice Section (IPS), including traditional practices both large and small and direct contracting practices, such as Direct Primary Care (DPC) practices are greatly concerned about a lack of referral options for surgery or other specialty care services because the health systems are focused on serving their own established patients.

Finally, we object to the proposal in Section 3 of the bill that physician practices have a data reporting obligation to the Maine Health Data Organization (MHDO).

L.D. 1972 is a complex bill proposing an enormous regulatory expansion in our health care sector. The factors that have caused the consolidation of our health care market are many and complex. Any state regulatory response must be thoughtful and nuanced to avoid further harm to vulnerable health care organizations. MMA and MOA, and our affiliated state medical specialty organizations, will assist the Committee and participate in your work on the bill as you deem appropriate.

Thank you for considering our views on L.D. 1972.

Andrew MacLean, JD

AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT

June 5, 2024

The Honorable Lina Khan
Chair
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

The Honorable Jonathan Kanter
Assistant Attorney General
Antitrust Division, Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for Information on Consolidation in Health Care Markets: Response by the American Medical Association

Dear Chair Khan, Assistant Attorney General Kanter, and Secretary Becerra:

The American Medical Association (AMA) appreciates the opportunity to provide comments on the March 5, 2024, Request for Information on Consolidation in Health Care Markets issued by the United States Department of Justice Antitrust Division (DOJ), the Federal Trade Commission (FTC), and the Department of Health and Human Services (HHS). Here we provide the physicians' perspective on how consolidation in health care markets harms competition and may incentivize some physician practices to enter into transactions with private equity firms in an attempt to retain their independence.

Independent Physician Practices Made Vulnerable by Consolidation in Health Care May Turn to Private Equity

Consolidation in the health care industry, both of market power health insurers and of health care services by major corporations, exacerbates the vulnerability of independent physician practices. For example, independent physician practices find it difficult to compete for health insurance contracts in a consolidated market; these practices need certain reimbursement rates to remain financially viable, but they often cannot negotiate these rates effectively with insurers on their own. The harms of consolidation across multiple sectors of the health care system are detailed below; however, we stress at the outset that the trend towards consolidation in the health care industry has directly led to the closure of independently operated private physician practices, which historically have provided personalized and locally responsive health care services.

Private equity is well-positioned to capitalize on the vulnerability of independent physician practices. Growth in the demand for health care services, coupled with an aging population and the development of innovative treatments, has made the health care sector attractive to private equity investors. At the same time, an array of factors—including changes in payment and delivery models, physician payment

challenges, and increased administrative and regulatory burdens, all of which contribute to physician practice instability and physician burnout—have driven some physicians toward private equity transactions. There are benefits and risks to this decision.

Private equity acquisition can be an attractive option for physician owners because the transaction may promise to free physicians up from management, financial, and administrative responsibilities, leaving more time for them to focus on patient care.[1] Other benefits of private equity acquisition include financially lucrative deals for physicians looking to exit ownership of their practices; access to capital for practice expenses or expansions, which may relieve physicians' financial pressures; potentially reduced medical liability costs; and centralized resources for certain functions such as information technology, marketing, or human resources.

Private equity may attempt to guarantee physicians greater efficiencies in the provision of patient care, but at the same time, when private equity firms fund or purchase hospitals, physician practices, or health systems, their primary goal is to produce profit.[2] Typically, after taking total or partial control of a physician practice, private equity funds make cost-cutting operational changes to the business with the goal of selling it for a profit in three to seven years. The effort may also reduce the ability for prior physician owners to make governance decisions. Thus, risks to physicians associated with private equity acquisitions include loss of control over the physician practice, its development and future revenues; loss of some autonomy in decision-making; an emphasis on profit or meeting financial goals; potential conflicts of interest; and potential uncertainties for non-owner early and mid-career physicians. Decisions made by private equity investors may also impact the provision of patient-centered care. For example, there is evidence that, in an effort to reduce costs, private equity acquired practices hire physician assistants, nurse practitioners, and other nonphysician providers to replace physicians at higher rates than non-private-equity acquired practices,[3] and health systems across the country are using staffing agencies to replace anesthesiologists with certified registered nurse anesthetists.[4] However, removing physicians from the care team and employing non-physicians to practice without adequate physician supervision poses a risk to patient safety. Private equity acquisition models that preserve a high degree of physician leadership in decision-making around the provision of patient care are most likely to support physician-led, patient-centered care and are preferred.

The AMA recognizes that employment preferences vary greatly among physicians and has long-standing policy supporting a physician's right to choose their mode of practice and type of employment. Crucially, though, if a physician elects to pursue an investor partnership, that choice should be freely made. **Many physicians do choose to enter into private equity agreements that prove successful and preserve**

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[1] Matthews S, Roxas R. Private equity and its effect on patients: a window into the future. Int J Health Econ Manag. 2023 Dec;23(4):673-684. doi: 10.1007/s10754-022-09331-y. Epub 2022 May 23. PMID: 35604628; PMCID: PMC9125965.

[2] *See, e.g.,* Borsa A, Bejarano G, Ellen M, Bruch J D. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review BMJ 2023; 382 :e075244 doi:10.1136/bmj-2023-075244.

[3] *See, e.g.,* Bruch JD, Foot C, Singh Y et al., *Workforce Composition in Private Equity-Acquired Versus Non-Private-Equity-Acquired physician practices.* Health Affairs 2023;42(1); https://doi.org/10.1377/hlthaff.2022.00308.

[4] *See, e.g.,* Mari Devereaux, *How private equity-backed staffing companies impact providers.* Modern Healthcare. March 27, 2024. Available at: https://www.modernhealthcare.com/providers/private-equity-staffing-firms-hospitals; *See also* supra note 1.

high-quality patient care; however, we urge the Biden administration to reject the assumption that any independent physician practice that sells to private equity does so willingly and without reservation. Indeed, the AMA is deeply concerned that elements of the current health care environment deprive physicians of meaningful choice when it comes to how they practice and operate—we perceive that market forces emerging from increasing consolidation across multiple facets of the health care system can threaten physicians' ability to survive in the market for health care services and interfere with the provision of the highest-quality care to patients. Altogether, it is it imperative to implement supportive measures that preserve the operation and integrity of private practices, ensure that health care remains accessible and tailored to community needs, and protect physician autonomy in providing high-quality, patient-centered care.

Factors Driving Physicians Toward Private Equity

Physician practices confront chronic challenges that threaten their ability to provide patient care and leave some with no viable option but to enter into a private equity agreement. The shift towards private equity-backed models is not just a matter of convenience for physicians but a symptom of deeper issues in our health care system: for example, the severely broken Medicare payment system threatens the sustainability of physician practices; unmanageable administrative processes systematically imposed by health insurers hamstring physicians and deprive patients access to the care they need; and inefficient quality reporting systems are necessary for physician practices to survive but are difficult to maintain. All of this makes it hard for physicians to compete in consolidated markets and drives physicians toward private equity. Addressing challenges that threaten physician practices would help to neutralize the health care environment for independent physicians and curb those private equity acquisitions that are not in the best interests of physicians or their patients.

Payment challenges: a broken Medicare physician payment program

A major reason why physician practices may feel compelled to turn to private equity is a broken Medicare physician payment program. The physician payment system is on an unsustainable path that threatens patients' access to physician services. As noted above, physicians in 2024 faced yet another round of real dollar Medicare payment cuts triggered by the lack of any statutory update for physician services tied to inflation in medical practice costs and flawed application of Medicare budget neutrality rules. Congress acted last March to partially mitigate the 3.37 percent reduction that was imposed in January but did not stop the cuts entirely. These cuts come on the heels of two decades of stagnant payment rates. Adjusted for inflation in practice costs, Medicare physician payment rates plummeted 29 percent from 2001 to 2024 because physicians, unlike other Medicare providers, do not get an automatic yearly inflation-based payment update.

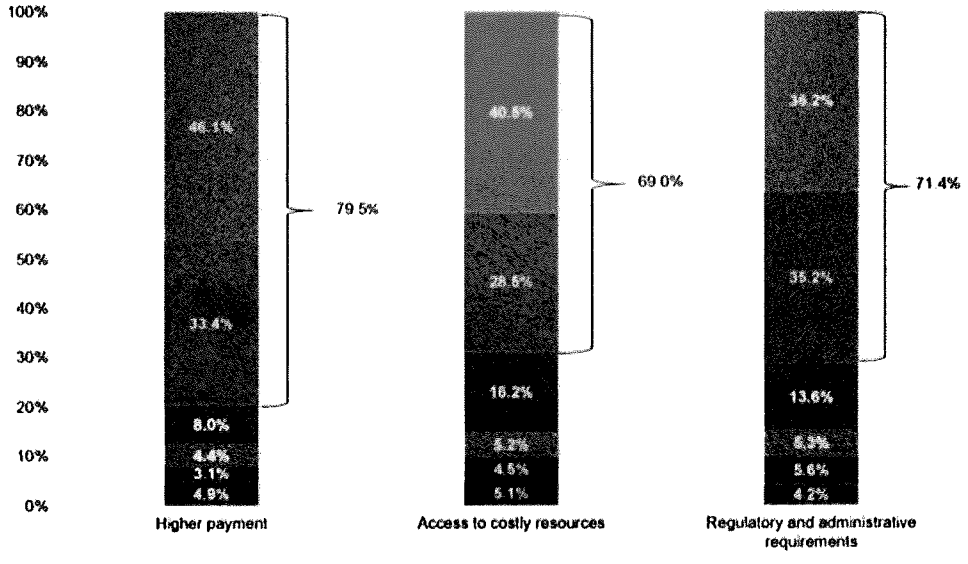
In its 2024 annual report, the Medicare Trustees warned that the program faces "challenges," notably that physician payments are not based on underlying economic conditions—such as inflation—and are not expected to keep pace with the cost of practicing medicine. The Trustees warned of the gap created between rising costs and physician payments, noting that the "quality of health care received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private health insurance."

The Trustees further cautioned that "absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."

The lack of an adequate annual physician payment update within the current Medicare physician payment system is particularly destabilizing as physicians, many of whom are small business owners, contend with a wide range of shifting economic factors when determining their ability to provide care to Medicare beneficiaries. Physician practices compete against health systems and other providers for staff, equipment, and supplies, despite their payment rates failing to keep pace with inflation. In fact, the government's measure of inflation in physicians' costs, the Medicare Economic Index (MEI), rose 4.6 percent this year.

The need for higher payment was the number one reason physician practices sold to a hospital, according to AMA research. Next there was a need to better manage payers' regulatory and administrative requirements and the need to improve access to costly resources. Included below is an excerpted figure with more detail. The AMA strongly supports policies that promote market competition and patient choice. Payment adequacy is necessary for physicians to continue to practice independently.

Exhibit 3. Top three reasons for selling to a hospital



Source: Author's analysis of AMA 2022 Physician Practice Benchmark Survey.
Note: These estimates are based on physicians whose practices had been acquired by a hospital or health system after 2012 and who were practice members at the time of that acquisition (N=282). The bracketed percentage is the sum of important (4) and very important (5).

While we appreciate that Congress passed legislation that mitigated a portion of the severe Medicare payment cuts, this pattern of last-minute stop gap measures must end.

We also note that widening Medicare payment differentials across outpatient sites of service, including physician offices, hospital outpatient departments (HOPDs), and ambulatory surgery centers (ASCs), negatively impact physicians and have anticompetitive effects. Medicare payments to hospital-owned facilities have incentivized hospital acquisition of physician practices and ASCs and made it difficult for private physician practices to compete. Although the choice of outpatient setting for many services and procedures has no discernible effect on patient care, it significantly impacts what Medicare pays for a service as well as the amount of cost-sharing expenses incurred by patients. With some exceptions, payments for outpatient services furnished in hospital-owned facilities are generally higher, and sometimes significantly higher, than rates paid to physician offices or ASCs for providing the same service. Once acquisitions are completed, hospital-acquired practices and facilities are routinely converted into HOPDs and paid higher rates under Medicare, thereby increasing the price of services, the amount of patients' cost-sharing expenses, and overall health spending.

We are urging Congress to address the pressing need for adequate payments to physicians. Specifically, the AMA along with the entire House of Medicine is supporting H.R. 2474, the "Strengthening Medicare for Patients and Providers Act." H.R. 2474 provides a permanent annual update equal to the increase in the MEI. H.R. 2474 is bipartisan legislation that currently has 142 bipartisan cosponsors. Such an update would allow physicians to invest in their practices and implement new strategies to provide high-value, patient-centered care and enable the Centers for Medicare & Medicaid Services (CMS) to prioritize advancing high-quality care for Medicare beneficiaries without the constant specter of market consolidation or inadequate access to care. The passage of H.R. 2474 will also help physicians avoid the tremendous budgetary stress that characterizes the last-minute nature of annual bills that temporarily stop or reduce scheduled payment cuts, and thus alleviate Congress from having to devote precious legislative time to short-term fixes and, in turn, permit greater focus on other pressing health care needs.

Further, the AMA is urging Congress to address inadequate Medicare payments by passing H.R. 6371, the "Provider Reimbursement Stability Act," another bipartisan bill that would reform the statutory budget neutrality requirements applicable to Medicare. The frequent and significant payment redistributions, sometimes resulting from overestimations of RVU impacts on service utilization, undermine financial stability. The outdated $20 million threshold that triggers budget neutrality adjustments, set in 1989 and unadjusted for inflation, should be raised to $53 million to reflect current economic realities. Moreover, implementing a look-back period would allow CMS to adjust for past misestimates, ensuring a fairer and more accurate payment system.

Updating Medicare physician payments to adequate levels, would enable many small practices to stay independent without having to seek recourse in private equity firms. Assisting practices in this way would foster competition in many U.S. health care markets already bereft of competition.

Administrative burdens: a threat to physician practices and patient care

Oppressive administrative burdens such as prior authorization (PA) processes, electronic funds transfer fees, and electronic health records have also driven many physicians to become employed or welcome private equity for assistance. In particular, PA is one of the most harmful and onerous administrative burdens placed on physician practices. The extensive administrative duties associated with managing PA requests typically require dedicated staff, increasing overhead costs for private

practices. This scenario is particularly burdensome for smaller practices, which may not have the resources to handle such extensive administrative tasks efficiently.

The implications of PA extend beyond administrative inconvenience. Existing PA procedures have serious repercussions for patient care, and this is of great concern to the AMA. The delays caused by PAs can lead to serious health consequences for patients, including prolonged suffering and the progression of diseases. Physicians surveyed by the AMA consistently report the continuing negative impact of these requirements on patient health.[5] For example, 94 percent of more than 1,000 physicians surveyed in 2022 stated that PA delays care, and 89 percent report that the process has a negative impact on patient clinical outcomes. Most alarmingly, 33 percent of surveyed physicians reported that PA has led to a serious adverse event for a patient in their care. In addition to these quantitative findings, the devastating patient and physician stories captured on the AMA's grassroots reform website FixPriorAuth.org highlight the human cost of the PA problem.

We must also stress the enormous amount of practice resources wasted fulfilling health plan administrative requirements such as PA. In the AMA's most recent physician survey, practices reported completing 45 PAs per week, per physician, with this weekly workload for a single physician consuming nearly two business days of physician and staff time. Given these demands, we should not be surprised that 35 percent of physicians report having staff who exclusively work on PA tasks. The complexity and lack of transparency in PA processes exacerbate this burden. Each health plan has its own unique PA requirements, often proprietary and subject to frequent changes, leaving providers in the dark and scrambling to comply. The result is a continuous back-and-forth between practices and payers, involving extensive manual effort, often through outdated methods like faxes and portals. Adding to the challenges posed by PA are issues like payment clawbacks and retroactive denials, which can severely disrupt the financial stability of medical practices.

Growing dissatisfaction with the current state of practice management is influencing the health care market. Faced with the unrelenting demands of PA, other administrative burdens, and continuously decreasing federal reimbursement, many physicians are finding it increasingly untenable to operate independently. Private equity-backed practices, which promise to shoulder these administrative burdens, are thus becoming more appealing. Private equity firms, with their resources and infrastructure, may promise physicians some relief from PA-related practice burdens that have become simply unsustainable. This relief may outweigh necessary relief from unsustainable PA-related practice burdens, despite other costs associated with private equity acquisition.

Administrative burdens contribute to a burnout epidemic among physicians. Prior to the COVID-19 pandemic, physician burnout, depression, and suicide already were major challenges for the U.S. health care system, impacting nearly every aspect of clinical care. Recent studies show a national burnout rate of 43.9 percent among physicians in practice,[2] including private practice, academic medical centers, outpatient clinics, and many other clinical settings.[3] More than 40 percent of physicians do not seek help for burnout or depression for fear of disclosing it to a state licensing board or other entity. Nine percent of physicians said they have had thoughts of suicide.[4] These trends show no sign of abating. Physicians feel demoralized and overburdened, which may lead them to look for avenues to reduce their engagement in administrative tasks. Private equity is one potential option.

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[5] American Medical Association. 2022 AMA prior authorization (PA) physician survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

The AMA supports immediate and effective legislative actions in line with AMA's PA Principles.[6] These principles advocate for streamlining PA processes through automation, ensuring transparency, upholding clinical validity, maintaining continuity of care, and reducing the volume of PA requirements. Implementing these recommendations is not just about easing administrative workload; it is about preserving the viability of independent medical practices, ensuring quality patient care, and maintaining a balanced health care system where independent and private equity-backed practices can coexist without disadvantaging the other.

Further, enactment of the Improving Seniors' Timely Access to Care Act, which is expected to be re-introduced this year, will address some of the negative aspects of PA and would be a step in the right direction in easing the administrative burden on independent practices.

Inefficient quality reporting requirements with anticompetitive effects

Health care payment is transforming from volume to value. One of the common features of value-based payment is the need to measure quality and to offer consumers actionable information about provider performance. Unfortunately, the burdens and anticompetitive ramifications associated with current quality measurement and reporting practices are significant, and the status quo is untenable. Quality measurement and reporting is today a standalone, retrospective exercise rather than integrated into care delivery. Moreover, a proliferation and lack of alignment in quality measures and reporting required by different payers (e.g., Medicare, state Medicaid agencies and health insurers) have become so burdensome that they are likely taking away from patient care.

The status quo is also anticompetitive because it disadvantages small independent practices that increasing evidence shows provide higher quality of care (such as fewer preventable hospital admissions), at lower costs, than practices owned by hospital systems. However, these small independent practices are less likely to have the administrative infrastructure and staffing to shoulder the inefficient quality reporting requirements. Research observes that the burden associated with value-based payments adversely affects the ability of small independent practices to stay in business, forces them to merge into larger hospital-led systems, or leads to early retirement.[7] This may lead to market consolidation and a decrease in the number of physician practices.

AMA involvement in efforts to standardize physician quality measurement and reporting utilized by health plans has been centered on the Core Quality Measures Collaborative (CQMC), a broad-based coalition of health care leaders that "aims to promote quality measure alignment across public and private payers, reduce provider measure reporting burden, offer consumers actionable information about provider

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[6] American Medical Association. Prior Authorization and Utilization Management Reform Principles. Available at https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf.

[7] *See* Gaynor, Mostashari and Ginsberg, "*Making Healthcare Markets Work: Competition Policy for Health Care*", Carnegie Mellon University/Center for Health Policy, Brookings/USC Schaeffer Center for Health Policy and Economics (April, 2017), https://www.brookings.edu/research/making-health-care-markets-work-competition-policy-for-health-care/?utm_campaign=Economic%20Studies&utm_source=hs_email&utm_medium=email&utm_content=50778822.

performance, and improve care quality and health outcomes."[8] CQMC has made little or no progress toward achieving its goals. AHIP suggests in recent documents that CQMC efforts are hampered by antitrust concerns. AHIP calls upon HHS, the Treasury Department, and the Department of Labor to request antitrust guidance from the FTC and the DOJ on the best ways "to ensure that pro-consumer efforts to streamline quality measure collection, reporting, benchmarking and display are not inappropriately chilled by antitrust concerns."[9] AHIP has also separately recommended that the FTC and DOJ be asked to "create an antitrust safety zone whereby payers can collaborate on quality measure alignment and to develop standardized quality reports without violating antitrust laws."[10]

AMA Research Demonstrates that Health Care Markets are Highly Concentrated

Where insurers exercise market power, health plan premiums may be higher, and payments to physicians and the quality of health care may be lower than where health insurance markets are competitive. High market concentration tends to lower competition and facilitate the exercise of market power. A market is considered highly concentrated if its Herfindahl-Hirschman Index (HHI) value is greater than 1800.[11] The vast majority of health insurance markets in the United States are highly concentrated, as documented in a comprehensive study of U.S. markets.[12] The study finds that 95 percent of commercial health insurance markets in metropolitan statistical areas (MSA) were highly concentrated in 2022.[13] The average market had an HHI of 3496. A Blue Cross Blue Shield (BCBS) insurer had the largest market share in 82 percent of MSAs, and UnitedHealth Group was the largest at the national level.

There is high concentration in Medicare Advantage (MA) markets as well. Ninety-seven percent of MA markets were highly concentrated (HHI>1800) in 2022. The average market had an HHI of 3183. UnitedHealth Group had the largest share in 42 percent (161) of MSAs, and it is also the largest MA insurer nationally.

We also note that competition in hospital markets is critical for the well-functioning of the U.S. health care system. A new paper assesses competition in hospital markets and calculates hospital market shares and concentration levels in MSAs across the U.S.[14] The paper finds that most MSA-level markets have

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[8] *See* AHIP March 1, 2019 recommendations authored by Matthew Eyles, President and CEO of AHIP, to the Hon. Lamar Alexander, Chairman, Senate Health, Education, Labor, and Pensions Committee, at 16.

[9] *See* Letter from AHIP to Secretaries Mnuchin, Scalia and Azar at 16 (Jan.29, 2020), https://www.ahip.org/wp-content/uploads/AHIP-Transparency-in-Coverage-Comment-Letter-Final-1-29-20.pdf.

[10] AHIP Recommendations for the Quality Measurement Enterprise at the U.S. Department of Health and Human Services (HHS) Quality Summit.

[11] The HHI is the Herfindahl-Hirschman Index--a commonly used measure of market concentration. The new 2023 Department of Justice (DOJ) and Federal Trade Commission (FTC) Merger Guidelines lowered the threshold for a market to be highly concentrated from 2500 to 1800.

[12] Guardado, J., Kane, C. *Competition in Health Insurance: A Comprehensive Study of U.S. Markets. 2023 Update.* American Medical Association Division of Economic and Health Policy Research. 2023. Available at https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf. Accessed April 9, 2024.

[13] This 95 percent statistic is based on the new DOJ and FTC 2023 Merger Guidelines, which were released after publication of the *Competition in Health Insurance* study.

[14] José R. Guardado. Competition in Hospital Markets, 2013-2021. AMA Policy Research Perspectives 2024-1. Available at https://www.ama-assn.org/system/files/prp-competition-in-hospital-markets.pdf. Accessed April 9, 2024.

hospitals or hospital systems with large market shares, and the fraction of markets with large hospitals has been growing over time. Indeed, virtually all hospital markets are highly concentrated. In 2021, 99 percent of 389 MSA-level markets were highly concentrated. Only 5 markets were not. These results indicate low levels of competition in hospital markets as well as a decrease in hospital market competition over time, which has the important antitrust implications discussed below.

Harms Associated with Consolidated Markets

Most health insurance markets are ripe for the exercise of health insurer market power, which, in turn, may harm consumers and physicians.

The exercise of monopsony power may threaten independent physician practices

Where a health insurer has market power in its output market of health insurance (as noted above), it is very likely it also has monopsony power in its input market of physician services. This is because geographically these markets roughly coincide. Health insurers with buyer power may depress payments to physician practices that are lower than competitive levels. Payments below competitive levels not only harm the financial viability of physician practices; they may impact patients by leading to diminished service or eroding quality of care. And because health insurers are frequently also monopolists, cost savings resulting from these lower payments are not necessarily even passed on to patients.

One might wonder why physicians cannot solve the problem of non-competitive monopsonist payments by just dropping the insurer. Frequently, though, physician practices may have little choice but to accept payments below competitive levels. Some have argued that physicians who are unhappy with the fees they receive from a powerful insurer could turn away from that insurer and instead treat more Medicare and Medicaid patients. But as noted above, Medicare payments (as well as Medicaid payments) significantly underpay physicians, so physicians can hardly increase their revenue from Medicare and Medicaid in response to a decrease in commercial health insurer payments.

Further, terminating network contracts with insurers is also a very difficult decision for physicians because it impacts their patients and disrupts their practices. The patient-physician relationship is a critical aspect of the delivery of high-quality health care. It is a very serious decision both personally and professionally for physicians to disrupt this relationship by dropping a health insurer. But even if a physician is willing to terminate its participation agreement with a health insurer that is depressing payment below competitive levels, doing so might be futile in a highly concentrated health insurance market if other health insurers are also exercising their buyer power to lower payments below competitive levels.

The power that monopsonist health insurers hold over the physicians with whom they contract allows them to implement policies and practices that degrade working conditions for physicians at virtually no risk to the insurer. Administrative practice requirements that interfere with patient care and take physicians' time away from patients, discussed in detail above, are one way that degradation manifests.[15] Among other harms, physician practices may also suffer a range of uncertainties at the hand of the health plan: insurers often make material changes to physician contracts without providing any notice or conspicuous notice, and physicians may be bound by policies that the insurer is free to amend at any time.

[15] *See supra* note 7.

The AMA strongly contends that the Biden administration must protect physicians against health insurer mergers that may substantially lessen competition for the purchase of physician services and that degrade physician working conditions. The AMA applauds the success of the DOJ in stopping anti-competitive health insurer mergers, e.g., the proposed Anthem-CIGNA and Aetna-Humana mergers. The AMA encourages the DOJ to continue taking aggressive enforcement action in this area to ensure that monopsonistic health insurers are not created nor further empowered.

The competitive harm of health insurer consolidation is not limited to horizontal mergers—UnitedHealth Group purchase of Change Healthcare

The AMA urged investigation into the acquisition of Change Healthcare by UnitedHealth Group in 2022. Although Change Healthcare was not a well-known entity until after this acquisition, it is a health care giant. Even before UnitedHealth Group's (UHG's) subsidiary Optum purchased Change Healthcare, the company facilitated over 15 billion health care transactions and approximately $1.5 trillion in adjudicated claims—more than one-third of all U.S. health care expenditures annually.[16]At the same time, UHG, through Optum, stored claims data for 250 million insured lives.[17] UHG's exclusive control of all these data made it a ripe target for cyberattack in early 2024. Indeed, the consolidation of an enormous amount of sensitive data with UHG's acquisition of Change Healthcare essentially consolidated the risk of a cyberattack around a single point of failure that had tentacles reaching far and wide across the U.S. health care system.

The cyberattack—and the resulting shutdown of Change Healthcare's revenue cycle management operations—caused crises among physician practices, as shown in an informal AMA survey conducted in late April 2024.[18] Despite UHG's assertions that services had been restored by that time, 60 percent of survey respondents reported problems verifying patient eligibility, 75 percent still faced barriers with claim submission, 79 percent still could not receive electronic remittance advice, and 85 percent continued to experience disruptions in claim payments. **A shocking 62 percent of respondents indicated that they were still using personal funds to cover practice expenses.** The AMA has heard from physicians that the cash flow interruptions caused by the cyberattack have led physicians to consider selling when they otherwise would not have, stating for example, "I am now going to get acquired by a hospital system because I just can't bear the financial responsibility."

The repercussions of this crisis will be felt by communities long after Change Healthcare is fully back up and running. Smaller practices without sufficient reserves will be forced to close or sell. There are disturbing reports that UHG has leveraged the situation to its advantage to speed acquisition of practices

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[16] Change Healthcare Annual Report (Form 10-K) for year ended Dec. 31, 2020, available at https://ir.changehealthcare.com/node/7326/html#tx904010_8.

[17] UnitedHealth Group, Optum Overview, 2020, at 15, https://www.unitedhealthgroup.com/viewer.html?file=/content/dam/UHG/PDF/investors/2020/investorconference/IC20_Optum_Overviews_QandA.pdf (Report to Investors).

[18] American Medical Association. Change Healthcare cyberattack impact: Key takeaways from informal AMA follow-up survey. April 29, 2024. Available at https://www.ama-assn.org/system/files/change-healthcare-follow-up-survey-results.pdf.

in dire straits in the wake of the Change Healthcare service outage.[19] As the health care industry determines what additional protections and redundancies are necessary to avoid and/or weather future attacks, many smaller, lesser-resourced practices will likely be challenged to afford these additional safeguards—leading to further closures, practice acquisitions, and consolidation.

We strongly urge the Biden administration to consider why consolidation in the health insurance and technology market is permitted to the extent that a single company can have indisputable dominance over the entire health care system such that that when it is attacked, the entire system goes down. **More specifically, we urge the Biden administration to include a cybersecurity risk assessment as part of all future merger and acquisition reviews.** Such evaluations should include a thorough assessment of the involved parties' technology systems and respective vulnerabilities, enumeration of any redundancies in the event of system outages, and a detailed analysis of the interrelatedness of the entities' products and services with the entirety of the U.S. health information technology infrastructure.

The Change Healthcare acquisition is just one example of how a vertical acquisition may contribute to harm to physicians and patients. Broader trends in vertical integration are still being discovered, among them some research suggesting that vertical integration may cause physicians to alter the care they provide.[20] We encourage the Biden administration to continually assess and evaluate the potential impact of vertical integration—including the cumulative impact of serial acquisitions—on physicians and patients, and we urge the Biden administration to weigh in their antitrust analysis the practical implications of vertical integration on physician practices.

Hospital consolidation may increase physician involvement in private equity

Although it is well documented that increased levels of hospital market concentration may lead to increased health costs and reduced health care quality, highly concentrated health insurance markets may encourage physician receptiveness to offers from private equity.

In highly concentrated hospital markets, a hospital-employed physician may have few hospital employment alternatives, and independently bargaining a second or third contract with a hospital can be a difficult experience. Moreover, covenants-not-to-compete often exist in a physician's hospital employment contract, and these covenants may further contribute to a bargaining advantage that a hospital employer with market power may possess. Such circumstances may place physicians in situations analogous to dealings with a monopsonistic health insurer as previously noted. In concentrated hospital markets where little, if any, competition exists, hospitals may depress wages below competitive levels because they do not have to compete with respect to physician compensation and benefits. Further, hospitals may have little incentive to compete with respect to practice conditions or respond to physicians' concerns about patient care, and this is particularly the case if physicians are bound by covenants-not-to-compete—if as a practical matter a physician cannot leave employment, then there may by little incentive to treat physicians better—a circumstance that contributes greatly to

[19] UnitedHealth Exploits an 'Emergency' It Created. Maureen Tkacik. The American Prospect. March 10, 2024. Available at https://prospect.org/health/2024-03-10-unitedhealth-exploits-emergency-change-ransomware-oregon/.

[20] *See, e.g.,* Soroush Saghafian & Lina Song & Joseph Newhouse & Mary Beth Landrum & John Hsu, 2023. "The Impact of Vertical Integration on Physician Behavior and Healthcare Delivery: Evidence from Gastroenterology Practices," Management Science, vol 69(12), pages 7158-7179.

the physician burnout epidemic, as previously discussed.

Fostering greater competition by dismantling the statutory barrier to physician ownership of hospitals would help preserve physician practices and provide patients with another option to receive high-quality care through integrated, coordinated care delivery. To this end, the AMA supports H.R. 977/S. 470, the "Patient Access to Higher Quality Health Care Act of 2023." This bipartisan, bicameral legislation permanently eliminates the near prohibition the Affordable Care Act placed on physician-owned hospitals. We discussed in more detail the benefit of physician-owned hospitals in testimony last fall.

Competition in pharmacy benefit manager (PBM) markets, vertical integration with insurers, and implications for drug prices

PBMs can stimulate price competition among drug manufacturers by shifting demand among competing substitute drugs. In turn, manufacturers offer rebates to PBMs for their drugs to be placed favorably in a drug formulary. PBMs are then supposed to pass on those rebates to insurers or employers. Importantly, PBM markets need to be competitive for rebates to be fully passed on. However, it is not clear whether PBMs are (fully) passing on those rebates.

A 2023 study assessed competition in commercial PBM markets and the extent of vertical integration of health insurers with PBMs in national and local markets across the U.S.[21] The study's findings suggest low levels of competition in PBM markets. It found that commercial insurers largely use an external PBM for three services: rebate negotiation; retail network management; and claims adjudication (rather than conducting them in-house). It found that, at the national level, the four largest PBMs had a collective market share of 68 percent in 2021. This 68 percent share increased from 64 percent in 2020, largely due to the Aetna-CVS merger, given that both Aetna and CVS already had PBMs prior to the merger. In virtually all state- and MSA-level markets, there was a high degree of concentration.[22] Specifically, 96 percent to 98 percent of state-level markets were highly concentrated (depending on PBM service), and 99 percent of MSA-level markets were highly concentrated.

The study also finds significant vertical integration between health insurers and PBMs. It found that 70 percent of drug lives at the national level are covered by an insurer that is vertically integrated with a PBM. On average, 63 percent of state-level drug lives and 65 percent of MSA-level lives are vertically integrated. However, there is wide variation across states and MSAs, with some areas having almost no vertical integration, while others are almost entirely vertically integrated. Notably, six of the 10 largest PBMs are used exclusively by one insurer or a set of BCBS insurers.

The findings in the study have antitrust implications, such as whether proposed mergers among PBMs and between insurers and PBMs should raise or should have raised antitrust concerns. For example, vertically integrated insurers may not allow non-vertically integrated insurer competitors to access their PBMs, or they could raise the cost of those PBM services. This could adversely affect non-vertically integrated insurers and ultimately patients through higher insurance premiums.

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[21] José R. Guardado, Competition in Commercial PBM Markets and Vertical Integration of Health Insurers with PBMs, AMA Policy Research Perspectives 2023-5. Available at https://www.ama-assn.org/system/files/prp-pbm-shares-hhi.pdf. Accessed April 9, 2024.

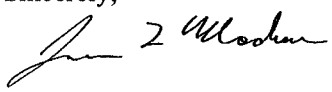
[22] The following statistics are based on the new 2023 Merger Guidelines. The findings in the study were still based on the older (2010) Horizontal Merger Guidelines.

Conclusion

Systemic issues in the health care system drive physicians away from private practice and toward private equity, despite the fact that private equity acquisitions are not always preferred by physicians and may interfere with the physicians' ability to autonomously provide patient-centered care. To neutralize the environment for independent physicians competing in consolidated markets, underlying key challenges that threaten physician practices must be addressed.

The AMA recognizes that consolidation in the U.S. health care system causes certain harms to physicians and patients, including but not limited to the degradation of working conditions by insurers holding monopsony power and a lack of employment options in highly concentrated hospital markets. In monitoring mergers and acquisitions, the AMA's position is that each health care entity consolidation must be examined individually, taking into account case-specific variables related to market power and patient needs. AMA policy strongly supports and encourages competition in all health care markets to provide patients with more choices while improving care and lowering the costs of that care. Markets should be sufficiently competitive to allow physicians to have adequate practice options.

Sincerely,



James L. Madara, MD

AMA
AMERICAN MEDICAL ASSOCIATION

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April 12, 2022

The Honorable J. Gary Simrill
Chairman
Certificate of Need Ad Hoc Study Committee
South Carolina House
518 Blatt Bldg.
Columbia, SC 29201

Re: Senate Bill 290 to Repeal Certificate of Need in South Carolina

Dear Representative Simrill:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I am pleased to support Senate Bill 290 (S 290) that would fully repeal certificate of need (CON) in South Carolina.

South Carolina's purpose in enacting CON was to promote cost containment, prevent unnecessary duplication of health care facilities, and guide the establishment of health facilities and services to best serve public needs.[1]

Since the program has been in place, however, numerous studies have shown that CON laws have failed to achieve their intended goal of containing costs.[2] Instead, CON has taken on particular importance as a way to claim territory and to restrict the entry of new competitors.[3] It should go without saying that competition requires competitors. By restricting the entry of competitors, such as physician-owned facilities, CON laws have weakened the market's ability to contain health care costs, undercut consumer choice, and stifled innovation. Thus, the AMA joins the South Carolina Medical Association in urging the passage of S 290.

Only the full repeal of CON, as provided by S 290, will encourage more cost-effective, innovative, and higher quality health care options.

Legacy of a Cost-Based Health Care Reimbursement System

South Carolina (in 1971) and the federal government with the passage of the 1974 National Health Planning and Resources Development Act (NHPRDA)[4] adopted an odd approach to controlling health

[1] S. C. Code Ann. § 44-7-120 (2015).
[2] Michael A. Morrisey, *State Health Care Reform: Protecting the Provider*, in American Health Care: Government, Market Processes, and the Public Interest 243-66 (Roger D. Feldman ed., Transaction Publishers 2000); Furrow et. alia, Health Law Seventh Edition, 979-981 (2013).
[3] Ibid, Tracy Yee et al., *Health Care Certificate-of-Need Laws: Policy or Politics,* Research Brief 4, National Institute for Health Care Reform (May 2011).
[4] 42 USC Sections 300k-300t.

care costs–constricting supply.[5] The NHPRDA required states to adopt CON legislation to avoid losing certain federal funding. Eventually 49 states adopted CON laws.[6] These laws were enacted when the United States had a cost-based health care reimbursement system. The champions of CON thought that demand for medical treatment would increase as supply increases, and without lowering costs.[7] Health care institutions wanting to expand or to acquire new health technology had to obtain government approval–a "certificate of need"–from politically appointed health planning boards.

By 1987, however, the health care reimbursement system had changed substantially from the cost-based system existing in 1974, and the federal government abandoned the CON strategy by repealing the NHPRDA. The repeal freed states to alter or eliminate CON. As of today, 12 states have fully repealed their CON programs.[8] States like South Carolina that have thus far retained CON laws most often regulate hospitals, outpatient facilities, and long-term care facilities.[9]

Top Physician Concerns

Most commentary is highly critical of CON regulation on the grounds that it imposes obstacles to the efficient reorganization of health care markets, invites obstructionist behavior, is incompatible with the evolution of competitive health care markets, and invites abuse and corruption.[10] We highlight below some major concerns from the physician perspective.

The CON Process Suppresses Physician-Led Outpatient Facility Market Entry

The AMA has long advocated for the abolishment of CON. CON programs are a significant barrier to the market entry of freestanding physician-owned outpatient facilities, including ambulatory surgical centers (ASCs).[11] As a class of provider, physician-owned ASCs have been found in numerous studies of quality to have complication rates that are low and patient satisfaction that is high.[12] For example, a study published in *Health Affairs* concluded that ASCs, "provide a lower-cost alternative to hospitals as venues for outpatient surgeries."[13]

The efficiencies of ASCs and their added benefit of raising the performance of competing community hospitals also have been acknowledged by the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ):

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[5] The South Carolina program requires providers to obtain a CON from a state department before initiating a wide range of projects. Among the covered projects are the construction or expansion of acute care hospitals and ambulatory surgery facilities. S.C. Code Ann. §§ 44-7-130, 44-7-160 (2015). Additionally, facilities must obtain a CON before adding certain services, acquiring certain medical equipment, and making certain capital expenditures. S.C. Code Ann. § 44-7-160 (2015) In reviewing an application for a CON, the state department considers, among other factors, the need for the project. S.C. Code Ann §44-7-190 (2015); For a discussion of the history and coverage of CON in South Carolina, *see* State Testimony of Mathew D Mitchell of the Mercatus Center at George Mason University, "South Carolina's Certificate of Need Program: Lessons from Research" (May 10, 2021), available at https://www.mercatus.org/publications/certificate-need-laws/south-carolinas-certificate-need-program-lessons-research (Mercatus Lessons from Research).

[6] CHRISTINE L. WHITE ET AL., Antitrust and Healthcare: A Comprehensive Guide 527 (2013); Furrow, *supra* note 2.

[7] Fed. Trade Commission and U.S. Dept of Justice, IMPROVING HEALTHCARE: A DOSE OF COMPETTION, Ch.8 at 2 (2004)

[8] See, National Conference of State Legislatures, *Certificate of Need State Laws*. Available at https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx

[9] Ibid. CON is still alive, in some form, in the District of Columbia and in 35 states, including South Carolina. *See, National Conference of State Legislatures at https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx*

[10] *See* discussion and citation to authorities in Furrow, Greaney et alia, Health Law, West, 979-981 (2013)

[11] ASCs are required to have a CON in South Carolina. *Sees supra,* footnote *5*

[12] *See* Casalino L *et al. Focused factories? Physician-owned Specialty Facilities*, Health Affairs (Millwood) 2003; 22 (6) 56-67

[13] *See* Munnich and Parente, *Procedures Take Less Time at Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up*, Health Affairs, 33 no. 5 (2014): 764-769.

> Ambulatory surgery centers offered patients more convenient locations, shorter wait times, and lower coinsurance than hospital departments. Technological innovations, such as endoscopic surgery and advanced anesthetic agents, were a central factor in this success. Many traditional acute care hospitals have responded to these market innovations by improving the quality, variety, and value of their own surgical services, often developing on- or off-site ambulatory surgery centers of their own.[14]

Notwithstanding the potential of a physician-owned outpatient facility to offer new, lower cost, more convenient or higher quality services, the facility faces the added time, cost, and uncertainty of the CON approval process. To win approval, applicants must have the deep pockets to spend exorbitant amounts on lawyers and consultants to prepare CON applications.[15] The process for obtaining a CON can take years and can cost tens or even hundreds of thousands of dollars in preparation costs.[16] Ultimately, the process could prohibit entry or expansion outright if the CON is denied.[17] Consequently, the onerous cost and process of undergoing CON review and the uncertain outcome has a distinct chilling effect on physicians seeking to enter markets in competition with incumbent providers.[18] Thus, states such as South Carolina that require CONs for ambulatory surgical centers have, on average, *14 percent fewer such centers*.[19]

The South Carolina legislature should consider the benefit to consumers of repealing CON such that physician-owned outpatient facilities would stand a better chance of entering markets dominated by big hospitals. Moreover, these hospitals, faced with the ongoing threat of new competitor market entry, would be continuously motivated by the potential competition to improve service and lower prices.

The CON Process is a Hospital Tool for Blocking New Physician-Owned Facility Competition

A National Institute for Health Care Reform study of CON concluded that, "hospitals initially had mixed views about the benefits of CON but banded together to support the process after realizing it was a valuable tool to block new physician-owned facilities."[20] The CON process places physicians wanting to expand or to enter markets in competition with local hospitals at a substantial disadvantage. Physician applicants must contend with a CON decision-making process that is controlled by local planning boards that are subject to the political pressures imposed by big local hospitals. Nationally recognized Northwestern Professor David Dranove, PhD, MBA, and University of Pennsylvania Professor Robert Lawton Burns, PhD, MBA, have studied the CON process and in their new book, observe that hospitals hold enormous sway in their local communities.[21] They are among the largest employers. All of this has given local hospitals political clout. According to Dranove and Burns, "planning board members gained nothing for their political handlers if they approved outsiders' proposals, and they would gain the enthusiastic support of their clout-heavy constituents if they said 'no.' All of this is still true today."[22]

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[14] Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform (September 15, 2008).
[15] See David Dranove and Lawton R. Burns, BIG MED: Megaproviders and the High Cost of Health Care in America 22-23, University of Chicago Press, 2021.
[16] Mercatus, Lessons from Research at 1.
[17] "In sum, not only have CON laws been generally unsuccessful at reducing health care costs, but they also impose additional costs of their own." Federal Trade Commission & Department of Justice, Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform (Sept. 15, 2008),
[18] Senate Interim Committee on Certificate of Need, State of Missouri, Report of the Senate Interim Committee on Certificate of Need 13-14 (Dec. 2006).
[19] Mercatus, Lessons from Research at Table 2
[20] Tracy Yee et al., *Health Care Certificate-of-Need Laws: Policy or Politics?* Research Brief 4, National Institute for Health Care Reform (May 2011)
[21] David Dranove and Lawton R. Burns, *supra* note 15.
[22] Ibid.

CON Creates Entry Barriers to Already Highly Concentrated Hospital Markets

Many hospital markets are highly concentrated and noncompetitive.[23] This is partly the result of significant hospital market consolidation occurring throughout the country.[24] Moreover, embedded hospital market concentration is fast becoming an intractable problem for which antitrust provides no remedy.[25] Fortunately, South Carolina can take steps to encourage new entry.[26] "Low hanging fruit" in this area would include removing barriers to health care facility market entry such as CON that the government itself has erected. The CON process is used by "have" hospitals with significant market share and resources to prevent outsiders from entering the state entirely.[27] In one study, hospitals acknowledge tracking CON applications as a way to "keep tabs" on competitors and block new entrants.[28]

The sorts of concerns discussed above explain why the FTC and DOJ have reviewed CON laws, including South Carolina's, and found them to be anticompetitive.[29] Accordingly, and most pertinently, the two antitrust enforcement agencies urged South Carolina to repeal its CON laws.[30]

The CON Restraints on Market Entry and Competition Cannot be Justified by Consumer Cost Savings, Improved Health Care Quality or Access

CON Laws Have Weakened the Market's Ability to Contain Health Care Costs

Competition in health care markets is not wasteful. Instead, it produces lower prices.[31] Because CON erects barriers to entry, it impedes competition. Consequently, the program has failed to achieve its

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[23] *See* Martin Gaynor, *Antitrust Applied: Hospital Consolidation Concerns and Solutions,* Statement before Subcommittee on Competition Policy, Antitrust, and Consumer Rights subcommittee of U.S. Senate, 117th Cong. 6, (May 19, 2021).

[24] Id at 2; Emily Gee, *The High Price of Hospital Care*, Center for American Progress https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/.), Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation-Update, the Synthesis Project*, Robert Wood Johnson Foundation (June 2012)

[25] *See e.g.,* Greaney, *The Affordable Care Act and Competition policy: Antidote or Placebo,* 89 OR. L. R EV 811 (2011). ("Antitrust does not break up legally acquired monopolies or oligopolies.")

[26] *Id.*

[27] Tracy Yee et al., *Health Care Certificate-of-Need Laws: Policy or Politics?* Research Brief 4, National Institute for Health Care Reform (May 2011)

[28] Ibid.

[29] *See, e.g.,* Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Caroline House Bill 3250 Jan. 11, 2016), https.//www.justice.gov/atr/file/812606/download; Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice to the Virginia Certificate of Public Need Work Group (Oct. 26, 2015), htlps://www.ftc.gov/system/files/documents/ advocacy documents/ joint-statement-federaltrade-commission-antitrust-division-u.s.deparbnent-justice-virginia-certificate-public-needwork-group/151026ftc-dojstmtva copnl.pdf; Letter from Marina Lao, Dir., Office of Policy Planning, Fed. Trade Comm'n, et al, to The Honorable Marilyn W. Avila, N.C. House of Representatives Guly 10, 2015), hltps://www.ftc.gov/system/files/documents/advocacy dotuments/ftc-staff-commentconcurring-comment-com.missioner-wright-regarding-north-carolina-house-bill200/150113ncconadv.pdf; Prepared Statement of the Federal Trade Commission Before the Florida State Senate (Apr. 2, 2008) [hereinafter FTC Florida Statement], https://www.ftc.gov/sites/default/files/documents/advocacy documents/fie-prepared~ statement-florida-senate-concerning-florida-certificate-need-laws/v080009florida.pdf; Statement of the Antitrust Division, U.S. Department of Justice, Before the Florida Senate Committee on Health & Human Services (Mar. 25, 2008), http://www.justice.gov/atr/comments-competitionhealthcare-and-certificates-need; Prepared Statement of the Federal Trade Commission Before the Standing Committee on Health, Education, & Social Services of the Alaska House of Representatives (Feb. 15, 2008) [hereinafter FTC Alaska Statement], https://www.ftc.gov/sites/default/files/documents/advocacy documents/ftc-writtentestimonv-alaska-house-representatives-concerning-aJaska-certifICate-need

[30] Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Caroline House Bill 3250 (Jan. 11, 2016), https.//www.justice.gov/atr/file/812606/download

[31] Martin Gaynor, *Antitrust Applied: Hospital Consolidation Concerns and Solutions,* Statement before Subcommittee on Competition Policy, Antitrust, and Consumer Rights subcommittee of U.S. Senate, 117th Cong. 6, (May 19, 2021); Martin Gaynor & Robert Town, Competition in Health Care Markets, 2 Handbook of Health Economics 499,637 (2012), Martin Gaynor *et al,* The Industrial Organization of Health-Care Markets, 53 J. Econ. 2 Literature 235, 284 (2015)

intended goal of containing costs. This conclusion is supported by substantial health care economics research.[32]

For example, health economics scholar Michael A. Morrisey, PhD, has concluded that "while certificate of need has attracted many empirical studies, they find virtually no cost containment effects. However, they do show higher profits and restricted entry...."[33]

Moreover, a Center for Health Services Research study at Georgia State University found that states having the most rigorous CON regulation had levels of competition associated with higher costs.[34]

Finally, the Mercatus Center of George Mason University, a not-for-profit university-based research center, has studied the effects of CON in South Carolina. Critically, the Mercatus Center finds that the state's CON laws are associated with per capita health care spending that is higher than it would be without CON.[35]

CON Laws Have Harmed, Not Improved, the Quality of Health Care Services

As CON has failed as a cost containment mechanism, the primary justification for CON, therefore, must rest on an ability to improve or maintain quality and/or access to care.[36] There is however a common-sense flaw in relying upon alleged quality of care benefits to justify CON's anticompetitive effects. Health economists Christopher J. Conover, PhD, and Professor Frank A. Sloan, PhD, express it this way: "It may make little sense to rely on CON to carry out quality assurance functions that might be better approached by more direct and cost-effective means such as regulation and licensing and/or outcome reporting to the public."[37]

In any event, the Mercatus Center has considered whether CON impacts health care quality. It does, and not for the better. Specifically, the Mercatus Center reports that the most recent research,

> suggests that deaths from treatable complications following surgery and mortality rates from heart failure, pneumonia, and heart attacks are all statistically significantly higher among hospitals in CON states than hospitals in non-CON states. Also, in states with especially comprehensive programs such as South Carolina, patients are less likely to rate hospitals highly.[38]

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[32] See e.g., Patrick A. Rivers, et al., *The Effects of Certificate of Need Regulation on Hospital Costs*, 36 J. HEALTH CARE FIN. 1, 11(2010) (finding a positive relationship between the stringency of CON laws and health care costs per adjusted admission and concluding that the "results, as well as those of several previous studies, indicate that [CON] programs do not only fail to contain [hospital costs], but may actually *increase* costs as well" *See also* discussion and sources cited in Furrow et. alia, Health Law Seventh Edition, 979-981(2013)

[33] Morrisey, *supra* note 2. *See also* Patrick A Rivers, Myron D. Fottler & Mustafa Z. Younis, Abstract, *Does Certificate of Need Really Contain Hospital Costs in the United States?* 66 Health Education Journal 3, 229-44 (Sept. 2007 ("CON laws had a positive, statistically significant relationship to hospital costs per adjusted admission. Findings suggest not only that CON do not really contain hospital costs but may actually increase them by reducing competition.")

[34] Center for Health Services Research, Georgia State University, Report of Data Analyses to the Georgia Commission on the Efficacy of the CON Program 7-9 (Oct. 2006)

[35] Certificate of Need Laws, South Carolina state profile, Mercatus Center, available at https://www.mercatus.org/publications/certificate-need-laws-south-carolina-0

[36] Christopher J. Conover & Frank A. Sloan, *Evaluation of Certificate of Need in Michigan*, Center for Health Policy, Law & Management., Duke University (May 2003).

[37] Ibid.

[38] Mercatus, Lessons from Research at Table 2 and Certificate of Need Laws, South Carolina state profile, Mercatus Center, available at https://www.mercatus.org/publications/certificate-need-laws-south-carolina-0

Finally, one national study found that, "[O]btaining CONs for new technology may take upward of 18 months, delaying facilities from offering the most-advanced equipment to patients and staff. Such issues also reportedly affect providers' ability in some states to recruit top-tier specialist physicians."[39]

CON Laws Have Not Improved Access to Health Care

Access to health care in rural areas is in critical condition.[40]And in South Carolina, more than a quarter of the population risks dying sooner from a preventable death simply because where they live is rural.[41] With more than 744,000 rural residents statewide, inadequate rural health care is a South Carolina crisis requiring a state solution.[42]

It is the AMA's belief that one tangible and truly impactful solution to the access to health care issue in South Carolina is to repeal CON. The Mercatus Center has concluded that CON programs are associated not just with fewer hospitals overall, but also with fewer rural hospitals, fewer rural ASCs, and fewer rural hospice care facilities.[43] Moreover, without CON, South Carolina would have 43 percent more rural hospitals than currently.[44] This simply cannot be ignored.

Conclusion

To be clear, CON represents a failed public policy. It may have made sense when most reimbursement was cost-based, and health care market participants would be paid for increasing supply regardless of demand and the actual needs of patients. Today, however, managed care forces providers and physicians to be efficient.

CON invites obstructionist behavior and is incompatible with the evolution of competitive health care markets.[45] In the changed and now competitive environment, the continued existence of CON, despite overwhelming evidence of its ineffectiveness as a cost control device, suggests that "something other than the public interest is being sought."[46]

Physicians are frustrated by CON programs that tend to be influenced heavily by political relationships, such as a provider's clout, organizational size, or overall wealth and resources, rather than policy objectives.[47] Ultimately, the CON laws undercut consumer choice, stifle innovation, and weaken markets' ability to contain health care costs.[48]

The AMA strongly urges South Carolina to conclude that CON does not work and consequently to enact S 290 and repeal CON.

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[39] Yee.et al., *supra* note 3
[40] See Clemson News, Jan 6, 2020, available at *https://news.clemson.edu/clemson-and-musc-working-to-improve-health-in-rural-south-carolina-2/*
[41] Ibid.
[42] Ibid.
[43] Mercatus, Lessons from Research at Table 2.
[44] Ibid.
[45] *See* ,e.g., Patrick McGinley, Beyond Health Care Reform: Reconsidering Certificate of Need Law in a Managed Competition System, 23 Fla St. U. L. Rev.141, 167-68 (1995)
[46] Morrisey, *supra* note 2.
[47] Yee et al., *supra* note 16.
[48] *See, e.g.,* Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Caroline House Bill 3250 Gan. 11, 2016). https.//www.justice.gov/atr/file/812606/download

Thank you for the opportunity to provide these comments. If you have any questions, please do not hesitate to contact Henry Allen, JD, MPA, Senior Attorney, AMA Advocacy Resource Center, at henry.allen@ama-assn.org.

Sincerely,

James L. Madara, MD

cc: South Carolina Medical Association
Gerald E. Harmon, MD
Harris Pastides, PhD, MPH