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Xavier Becerra
Secretary
Department of Health and Human Services

Lina M. Khan
Chair
Federal Trade Commission

RE: Request for Information on Consolidation in Health Care Markets (Docket No. ATR 102)

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

Thank you for the opportunity to provide comments on the Department of Justice (DOJ), Department of Health and Human Services (HHS) and Federal Trade Commission's (FTC) Request for Information (RFI) on Consolidation in Health Care Markets. We greatly appreciate your interest in addressing the problem of high health care prices driven by industry consolidation and anticompetitive practices.

PBGH is a nonprofit organization representing 40 public and private purchasers that collectively spend $350 billion annually on health care and provide health benefits to over 21 million workers and their families. PBGH's mission is to advance a health care system that delivers quality outcomes and a seamless patient experience that is equitable and affordable for consumers and purchasers. Our goal is to be a change agent by creating and enabling increased value in the health care system through purchaser collaboration, innovation, action and by facilitating the adoption of best practices. PBGH's members represent diverse private sector industries as well as public sector purchasers.

The problem of high health care costs is widely recognized and well-documented. Many experts have cited anticompetitive conduct and industry consolidation as a driver of high health care prices, which play a primary role in increases to health insurance premiums and patients' out-of-pocket costs. Employers and employees have continued to suffer the burden of these high and ever-increasing costs, which crowd out business investment, job growth and wages.[1] Over a 35-year history, PBGH and its members have directly experienced the impact of anti-competitive practices, increased market power and high prices as a result of health plan and provider group consolidation across the country. The

[1] Arnold and Whaley (Jun. 24, 2020) "Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages" [Link] and Hager et al., (Jan. 16 2024) "Employer-Sponsored Health Insurance Premium Cost Growth and its Association with Earnings Inequality Among U.S. Families," *JAMA Network Open* Vol. 7, No. 1 [Link]

2019 settlement of *Sutter Health v. UFCW & Employers Benefit Trust and the State of California* highlighted anti-competitive negotiating tactics such as all-or-nothing contracting and gag clauses. PBGH provided evidentiary support and worked hand-in-hand with its members, alongside the California Department of Justice and then-Attorney General Becerra to achieve a historic settlement for California employers and unions and to address anti-competitive practices.

PBGH strongly believes that healthy competition among health plans, hospitals, integrated health systems and provider groups, as well as pharmacy benefit managers (PBMs), drug manufacturers and others across the pharmaceutical supply chain, is essential to providing lower costs, improved quality and better value. Unfortunately, there is inadequate competition in many health care markets, and the federal government must step in to ensure that health care markets function appropriately in the public interest. Furthermore, employers, public purchasers and consumers seldom have access to the complete information they need, which is essential for a functioning market.

Below are our responses to the RFI's inquiries. We look forward to future conversation on these issues.

1. Effects of Consolidation

Hospital and provider consolidation

The cost of health care in the U.S. is unaffordable for families and employers, and the health outcomes are poor. High health costs also come at the expense of core business investments, hold down wages and squeeze family budgets. For public entities, health expenditures compete with other social services and important economic investments. Consolidation harms consumers through higher health insurance premiums and out-of-pocket costs, without demonstrable improvement in quality outcomes.[2]

Research has made clear high health care costs are driven by high prices – not increased utilization. According to the Health Care Cost Institute (HCCI), overall health care prices grew 14% from 2018 to 2022 while utilization grew only 4%.[3] Hospital prices in commercial plans across the U.S. in 2018 averaged 247% of Medicare payments and the gap has been increasing, with 2022 data showing employers and private purchasers paid, on average, 254 percent of what Medicare would have paid for the same services at the same inpatient and outpatient hospital facilities[4]. A recent Congressional Budget Office

[2] Beaulieu et al. (Jan. 1, 2020) "Changes in Quality of Care After Hospital Mergers and Acquisitions" *NEJM* [Link]

[3] HCCI (Apr. 2024) "2022 Health Care Cost and Utilization Report." *Health Care Cost Institute* [Link]

[4] Whaley et al. (May 13, 2024) "Prices Paid to Hospitals by Private Health Plans: Findings from Round 5 of an Employer-Led Transparency Initiative" *RAND* [Link]

study also quantified the persistent cost shift to commercial payers for both hospital and physician services.[5] Even worse, HCCI data reveals an even greater cost-shift of as much as 8% for large self-funded purchasers.[6] This trend is largely the result of industry consolidation and use of anti-competitive contracting practices by hospitals, health systems and provider groups to gain market power.[7]

A RAND Corporation review from 2022 found that estimated price increases associated with hospital mergers have ranged from 3% to 65%.[8] In addition to increases in the prices that commercial insurers pay providers, consolidation among hospitals and provider groups can also lead to higher Medicare payment rates, as the program often provides greater payment for a given service when provided in a hospital outpatient department versus a freestanding physician office.[9]

While researchers for decades have studied the effects of hospital mergers and there is substantial evidence that mergers drive up prices, numerous studies fail to find evidence of benefits to consumers in terms of clinical outcomes or patient experience and conversely, many studies link more hospital competition to higher quality. While the research on physician mergers and consolidation is more limited, it mirrors the findings of hospital consolidation literature.[10]

UFCW & Employers Benefit Trust et al. v. Sutter Health

As mentioned above, PBGH played a pivotal role in catalyzing *UFCW & Employers Benefit Trust et al. v. Sutter Health* through its initial testimony about affordability and hospital contracting practices at a City and County of San Francisco Board of Supervisors meeting in 2011. PBGH contributed significant in-kind resources to engage its membership, supported research and delivered evidentiary documentation to advance UEBT's case over the course of a decade. PBGH's historical role was well-documented in our June 2020 Declaration to oppose Sutter's motion for a continuance. PBGH worked actively to support its class members in tracking the progress of the settlement and meeting the class

[5] Cohen and Pelech (Jan. 2022) "The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services," *Congressional Budget Office* [Link]

[6] Sen et al. (Sep. 2023) "Health Care Service Price Comparison Suggests that Employers Lack Leverage to Negotiate Lower Prices" *Health Affairs,* No. 9, Vol. 42 [Link]

[7] Whaley et al. (Sep. 18, 2020) "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative" *RAND* [Link]

[8] Liu et al. (Sep. 30, 2022) "Environmental Scan on Consolidation Trends and Impacts in Health Care Markets" *RAND* [Link]

[9] MedPAC (Mar. 15 2022) "2022 Report to the Congress" [Link] at p. 55.

[10] Dafny (Oct. 18, 2023) "Testimony of Leemore S. Dafny, Ph.D before the U.S. Senate Committee on the Budget" *U.S. Senate Committee on the Budget* [Link]

filing deadlines through many webinars summarizing Plaintiff's efforts, administrative procedures and the claims submission process. More recently, PBGH also submitted a Brief in support of the Plaintiff's Appeal in *Sidibe v. Sutter Health*.[11]

PBGH was able to bring valuable data and direct experience from its group HMO rate negotiations and its members' efforts to improve affordability and access for employees. PBGH demonstrated how Sutter's market power and monopolistic business practices increased costs for employers and employees, which ultimately helped lead to the settlement. For example, Sutter's profit from commercially insured patients averaged over $1.5 billion annually, representing a 43% margin more than the previous decade. Additionally, average hospital inpatient procedures in Northern California cost $223,278 compared to $131,586 in Southern California.[12] In addition to securing a $575 million payout, the settlement included potentially greater dollar value wins for employers and purchasers through 10-year injunctive relief on anti-competitive contracting including limiting chargemaster increases, reducing surprise billing, and preventing "all-or-nothing" contracting practices.

PBM consolidation

Another area of concerning consolidation in the health care industry is in the PBM industry, where PBMs have been merging horizontally with each other and vertically with insurers and pharmacies. Over the past few years, the PBM market has become highly concentrated, with just three PBMs—CVS Health, Express Scripts, and OptumRx—controlling more than 76% of the market.[13] One key function of PBMs is to negotiate discounts with drug manufacturers to reduce the drug costs for payers and consumers; however, having the plan, the PBM, the pharmacy and related health care businesses consolidated under one entity creates conflicting incentives that can drive up spending and undermine legislative and regulatory cost constraining measures. For example, vertically consolidated entities can reclassify expenses, fees, and revenues across its business to evade the ACA's medical loss ratio requirements; offset costs across its self-funded and fully insured accounts due to its control of various financial levers; and suppress access to meaningful cost and price data across the supply chain, limiting purchasers' ability to more meaningfully compare among market alternatives.

Currently, there is a fundamental lack of visibility into pricing practices across the drug supply chain. For example, despite requirements under Section 204 of the Consolidated

[11] PBGH (Oct. 11, 2022) "Brief of Amicus Curiae by Purchaser Business Group on Health in Support of Plaintiffs-Appellants," No. 22-15634 [Link]

[12] Covered California (May 17, 2018) "Covered California Board Meeting: Reports and Research" [Link]

[13] Damberg (May 17, 2023) "Health Care Consolidation: The Changing Landscape of the U.S. Health Care System" *RAND* [Link]

Appropriations Act of 2021 ("CAA"), which mandates insurance companies and employer-based health plans submit information about prescription drugs and health care spending (known as RxDC reports), employers have had difficulty obtaining their own accurate and complete data from PBMs and plan administrators. PBMs also engage in anti-competitive behavior such as steering patients to their own pharmacies and reducing payments to others. Additionally, PBM (and health plan) tactics to capture margin through "spread pricing" results in higher costs to both employers and consumers, as well as states and other purchasers.[14] This behavior is contributing to our country's spiraling drug costs as PBMs and their insurer parent companies exert enormous and often-harmful influence over drug costs and access.

2. Claimed Business Objectives for Transactions:

Proponents of vertical integration in the provider space have argued that integration will lead to benefits such as administrative efficiencies, clinical care redesign and integration, greater investment in infrastructure to improve care, communication and analytics, and ultimately increases in quality and better patient outcomes. However, as discussed above, evidence has not found this to be the case and instead shows that consolidation leads to increased costs without resulting improvements in quality. Similarly, in the case of rural hospitals that are absorbed by large health systems, neither their financial stability nor performance are improved, and clinical integration is also not promoted.[15] Increased accountability and reporting surrounding claimed business objectives for transactions – including meaningful upfront explanations of expected market impacts and assessment of post-transaction realization of goals and objectives is vital. Transparency in ownership is also vital due to the concerning conflicts of interests seen across both vertical and horizontal mergers, and to ensure we pull back the veil on profit-seeking entities in an effort to hold them better accountable for their actions.

3. Notable Transactions:

In addition to the hospital, health system, provider and PBM mergers discussed above, a key concern is with private equity ("PE") involvement in certain health care service provider transactions. We applaud the FTC's recent efforts to examine the role of PE investment in health care markets and share the concern of many commissioners and witnesses. The focus of PE on short-term revenue and profits frequently leads to an increase in the volume of profitable services provided, a shift towards more highly compensated mix of services and procedures, and increased prices. PE firms consolidate health care providers to gain market power and extract higher payment rates, driving up

[14] "Spread Pricing 101," *NCPA* [Link] (*Documenting the extent to which public purchasers have experienced excessive health care spending for which taxpayers pay as a result of PBM spread pricing*)

[15] Stremikis (Dec. 17, 2020) "Health Industry Consolidation in California: What's Left to Settle?" *California Health Care Foundation* [Link]

health spending and undermining competition despite promises higher-quality, more efficient care.

Moreover, other practices can damage the financial sustainability of those entities that PE-backed firms claim to be supporting. For example, a common practice is for PE firm owning a hospital to sell the land the hospital is on and lease it back to the hospital at a high interest rate. The money from the sale is paid out to PE investors and the hospital is saddled with debt, quality often suffering during the process.[16] We applaud the FTC and others for exploring these types of entities and arrangements and urge continued exploration and oversight. A recent report also found that the number of PE acquisitions of physician practices has grown six-fold between 2012 and 2021. Some markets have been highly penetrated by PE, with a single PE firm holding more than 30% in one or more physician specialties. In those markets, prices are 1.5 to over 3 times higher.[17] Increased attention to the competition impacts of PE in physician markets specifically is urgently needed as the pace at which PE is entering these markets and monetizing medicine make it an imperative.

4. Need for Government Action:

Although PBGH and our purchaser members prefer market-based solutions to the problem of high costs and unsatisfactory outcomes, many parts of the health care market are fundamentally broken. A functional market does not regularly drive families into bankruptcy; it does not depend on Go-Fund-Me campaigns for treatment costs, and it does not absorb a decade of US wage growth. A functional market does not require the world's largest employers to absorb annual cost increases of 4-20% with no corresponding increase in quality or outcomes.

Government action is needed to ensure healthy competition among providers, health plans, suppliers and manufacturers in the health care sector. This includes:

Stronger anti-trust enforcement: In some market segments and geographic areas, the potential for healthy competition exists, but has been thwarted by dominant industry players. In these situations, government needs to strengthen antitrust enforcement and explicitly prohibit anti-competitive practices that have been the driver of high prices. According to a recent study, the FTC challenged only 13 of 1,164 mergers that took place over the 20-year period ending 2020, across 5,000 acute-care hospitals examined.[18] PBGH applauds the FTC and DOJ's updated Merger Guidelines and believe strongly in provisions

[16] Cutler (May 9, 2024) "Financial Games in Health Care—Doing Well Without Doing Good," *JAMA Health Forum* [Link]

[17] Scheffler (Jul. 10, 2024) "Monetizing Medicine: Private Equity and Competition in Physician Practice Markets" *American Antitrust Institute* [Link]

[18] Brot-Goldberg (Apr. 2024) "Is There Too Little Antitrust Enforcement in the U.S. Hospital Sector?" *American Economic Review* [Link]

aimed at ensuring mergers do not significantly increase concentration in highly concentrated markets, create market structures that exclude competition, further a trend toward concentration or entrench a dominant position. We also believe it is critical to address mergers that are a part of a series of multiple acquisitions that individually may "fly below the radar" of antitrust review but still result in increased market power. PBGH and other purchasers are hopeful that the revised guidelines are a step in the right direction towards enabling more anticompetitive mergers to be challenged in the future.

PBGH is also supportive of proposed changes to the Hart-Scott-Rodino (HSR) Act, including lowering the required asset value and revenue thresholds. The existing reporting requirements have been insufficient to monitor small and mid-sized transactions – such as those involving ambulatory surgical centers ("ASCs") and serial acquisition which cumulatively can result in significant industry consolidation and market power. We also support changes that require merging parties to submit narrative responses in the new "competition analysis section," requiring parties to explain the rationale behind their transaction and projected impact on the market. Changing the "burden of proof" for entities proposing to merge or acquire other entities, requiring them to demonstrate – not just posture – that the transaction would not result in higher costs, impaired quality, increased inequities or reduced access to services, could also mitigate and shine a light on potential harms.

Finally, the agencies should consider imposing requirements to demonstrate post-merger adherence to stated claims. For example, similar to how T-Mobile's acquisition of Sprint in 2020 was approved conditionally on T-Mobile not raising prices for a number of years, such requirements could be put on health care mergers regarding costs, quality, equity, and access, with penalties for those that do not meet the requirements and compensation for impacted purchasers and patients. However, further consideration should be given to how to ensure these promises are not short-lived, as has been reported in the T-Mobile example.[19]

Addressing the root causes of consolidation (e.g., payment distortions): In addition to stronger anti-trust enforcement, we also must address the factors that are driving consolidation including perverse payment incentives, anti-competitive contracting, and lack of transparency. One key lever for HHS to consider is its authority to expand site-neutral payments under the Bipartisan Budget Act of 2015 and work with Congress to explore an expansion of this important competition-enhancing policy. Current Medicare payment policy incentivizes health care consolidation and hinders competition, resulting in higher health care costs for employers, employees, payers and taxpayers. Critically,

[19] Blumenthal (May 26, 2024) "T-Mobile Raises Rates on Select Legacy Plans, Here's the Deal" *CNET* [Link]

various studies have found that payment differences across sites of care are associated with an increase in hospital-physician consolidation.[20]

According to the Medicare Payment Advisory Commission ("MedPAC") in their June 2022 report to Congress, for example, Medicare paid 141% more in a hospital outpatient department ("HOPD") than in a freestanding office for the first hour of chemotherapy infusion. Additionally, MedPAC notes that partly in response to these incentives, hospitals have acquired more physician practices in recent years, and hospital employment of physicians has increased – lessening market competition and increasing costs with no resulting increase in quality of care. If expanded, site-neutral payments could reduce the incentives for vertical consolidation by lowering the rates at which acquired providers bill Medicare for a larger set of services. MedPAC estimated expanding site-neutral payment polices in Medicare could generate $6.6 billion in annual savings for Medicare and taxpayers and lower cost-sharing for Medicare beneficiaries by $1.7 billion.

Additionally, we thank HHS for its actions to advance value-based payments, including through the Center for Medicare and Medicaid Innovation ("CMMI") and through changes to the Medicare Shared Savings Program ("MSSP") to encourage additional provider participation and success. We believe that moving to value-based care will serve as another key lever to reduce the incentives for consolidation, as our fee-for-service system incentivizes profit-minded companies to drive utilization of high-cost, sometimes lower-value services, and undermines the utility of services such as primary care. PBGH is working with our members to embrace alternative payment models that depart from fee-for-service, align incentives among physicians and hospitals, and incentivize physicians to provide valuable, not unnecessary or low-value, care (see more detail below).

Reduce anti-competitive negotiation and contracting practices: While anti-trust enforcement is one policy lever to promote competition, its effectiveness is limited in addressing markets that are already concentrated. Thus, other actions to address anti-competitive practices are also needed. We strongly support legislation at the federal and state levels that would remove gag clauses on the sharing of price and quality information by providers; ban anti-competitive contracting practices including "anti-tiering" or "anti-steering" clauses; ban "all-or-nothing" contracting which demands higher payment rates for the entire system; and other anti-competitive clauses such as most-favored nation (MFN) clauses, leveraged by dominant insurers to ensure they receive the lowest prices, often to the detriment of smaller purchasers. PBGH President and CEO Elizabeth Mitchell has before the Senate Committee on Health, Education, Labor and Pensions on the importance of advancing these provisions. In addition to such anti-competitive behavior being used to gain market power and raise prices, it also hinders purchasers' ability to create innovative, high-value programs such as high-performance networks, which

[20] Post et al. (Feb. 2021) "Hospital-physician integration and Medicare's site-based outpatient payments" *PubMed* [Link]

incentivize patients to use specific providers and facilities with higher quality and lower prices.

States have also moved to restrict the anticompetitive contracting practices at the heart of California's complaint against Sutter. Although state attorneys general may be able to prosecute anticompetitive behavior – such as the use of anticompetitive contracting provisions by dominant systems – legislation prohibiting these contract clauses is necessary to improve state enforcement authority and disrupt the distorted bargaining dynamic. For example, Michigan and North Carolina ban specific anti-competitive practices, while Massachusetts has empowered an agency to publicly review contracts for monopolistic terms on an ongoing basis. Rhode Island and Colorado have capped rate increases exceeding specified growth targets to impede unequal bargaining power that can lead to market failures.[21] While Sutter removed many of these anti-competitive terms from its contracts, they are still being used as a tactic in private provider-insurer negotiations. Thus, any state or federal legislation must aim to address not just anti-competitive language in contracts but also underlying anti-competitive behavior throughout the negotiations process. More recent state legislation – such as that in Washington state (HB 2066) – has aimed to enable states to regulate what health plans do through contracts as well as other anti-competitive behavior.

In addition to your support for this legislation at the federal and state levels, we also urge the FTC and DOJ to explore prosecution for anticompetitive behavior that hinders access to high-quality, low-cost care and support state AGs in their efforts to do so.

***Improve and build on price transparency efforts*:** PBGH believes that full and transparent information regarding provider performance on cost, quality outcomes and patient experience is imperative for a healthy competitive marketplace. Our purchaser members want to ensure their dollars are being spent on high-value care, and they need access to the full spectrum of data to make informed benefit design decisions. Further, patients cannot determine what to expect from care if this information is not readily available. Consumers and purchasers want to see meaningful price transparency that reflects total cost of care and simplifies the complexities of our payment and cost-sharing systems. We applaud CMS for its efforts to increase hospital price transparency, including the recent policy changes aimed at standardizing files and data elements and strengthening enforcement and oversight. Full transparency of all price data is critical to ensuring market competition. However, additional action is needed to make this information more usable for purchasers, patients and other stakeholders.

First, we urge HHS to consider ways to expand price transparency efforts to non-hospital sites of care such as HOPDs, ASCs and free-standing physician offices. This is arguably even more important for consumers, as they are more likely to have choice and ability to

[21] King (Nov. 17, 2020) "Addressing Health Care Consolidation: Policy Solutions" *Assembly Health Committee* [Link]

shop across care at these types of outpatient facilities than in a hospital. True transparency across all sites of care is critical to ensure patients and employers have the full picture of pricing across their market, spurring competition and driving value.

Second, we urge CMS to consider additional updates to improve the usability of price transparency data and explore potential options to facilitate its use. As we have learned from mandatory reporting of charge master detail, a machine-readable file with a massive list of contracted pricing information is insufficient to unlock affordability and market competition. While health plans and hospitals are already leveraging competitor information to optimize their negotiated rates (and not to the benefit of self-funded employers or their workers), purchasers require a more robust data set to fully assess total cost of care, including the volume of services, length of stay and better information about contractual payment structures, including carveouts. Hospital Price Transparency and Transparency in Coverage (TiC) data needs to be used in conjunction with a reference data base and self-funded employer data. Initial observations from publicly available data sets show clear rate differentials based on product lines (Individual and Family Plans ("IFP"), Medicaid Managed Care, Medicare Advantage and commercial). However, IFP and commercial products include a wide range of broad and narrow network configurations, as well as exclusive provider arrangements. Preliminary analysis by PBGH shows significant variation by carrier, region (urban/rural, Northern/Southern California) and hospital type (academic, systems, community and critical access hospitals). Additional action is needed to improve the quality and integrity of data reporting to support the utility of the transparency data sets for self-funded employers and consumers, including additional rulemaking beyond the currently defined July 2024 changes. Examples include improved classification of product types and payment structures, including designation of drugs, prosthetics and other supplies that are carved out from negotiated rates. Self-funded employers and their covered employees and families will benefit from increased price transparency that informs health plan selection, benefit design, and provider network design. Additionally, self-funded employers are hopeful that further access to transparent price data will expose the unfair practice of price-shifting onto their plans.

Third, we urge continuous monitoring of compliance. For example, while some systems we work with had good compliance early on, in some cases PBGH has found that certain hospitals now require a patient to go through a portal – and sometimes need to input personal identifying information – to get access to the pricing data. It was also recently reported in industry press that some hospitals are backsliding on their compliance with requirements, further complicating the usability of information for consumers.[22] This is

[22] Wooldridge (May 30, 2024) "Most Hospitals Not in Compliance with Federal Price Transparency Rules" *Benefits Pro* [Link]

against the spirit of the requirements and takes the ability to shop off the table.[23] We thank CMS for continuing to press forward on this matter and hope to continue to iterate on the best path for all purchasers – and ultimately consumers – to make meaningful use of this data to build more competitive markets.

In addition to price transparency, we also support greater transparency surrounding hospital billing to ensure patients and payers can see the location where care was provided, not just who provided the care. Current Medicare and private health insurance payment policies make it difficult to tell where a service was provided. Hospitals that own HOPDs will use the main hospital's NPI and address on all claim forms, even when care is provided outside the hospital at a hospital-owned doctor's office or facility. HHS should require individual off-campus HOPD to have their own unique NPI, allowing patients and purchasers to be able to tell exactly where the care was provided. California's All Payer Claims Database requires additional layers of transparency that are extremely useful for more granular analysis of costs and outcomes, including requiring NPIs for rendering, billing and referring providers.

Finally, we urge additional transparency into health care industry transactions and ownership. This is vital in understanding the impact of the corporate transformation of U.S. health care. Purchasers and patients deserve transparency into the ownership of the places where they are seeking and purchasing care and the impact on quality, costs and access. To do this, it is critical to expose the chain of corporate ownership and web of financial interests that are now almost totally opaque to patients, purchasers, policymakers, researchers, and regulators. The inclusion of only price and billing transparency (as seen in the House-passed Lower Costs More Transparency Act), misses a key opportunity amid an increasingly consolidated health care landscape. Ideally, ownership transparency would involve the development of a modern data system to collect data and the identity and attributes of entities with an ownership stake in health care facilities and track changes resulting from horizontal and vertical mergers, acquisitions, and joint ventures between health systems, health insurers, retailers, and PE firms.[24]

Lack of ownership transparency allows health care consolidation to continue unchecked. Currently CMS does not collect information about health care providers' parent company, complex organizational structures, or affiliations. Private equity companies are exempt from Securities and Exchange Commission disclosure requirements, and publicly traded

[23] Notably, the Hospital Price Transparency Rule uses the phrase "consumer-friendly" in its price comparison tool requirements, which is defined in part as having the information "prominently displayed," "without charge," and "**without having to register or establish a user account or password**" *(emphasis added)*.

[24] Singh and Brown (Sep. 23, 2023) "The Missing Piece In Health Care Transparency: Ownership Transparency" *Health Affairs* [Link]

companies do not disclose enough information to identify specific physician practice acquisitions.[25] Making transparency into ownership and transactions a reality would be of enormous value to enforcement agencies at the federal and state levels, as well as for policymakers, academic researchers, purchasers and the general public. We thank HHS and the FTC for their initial actions to lift the veil – such as through nursing home transparency efforts – but more steps must be taken.

***Streamlining of meaningful, aligned quality metrics and data standards*:** To ensure true transparency and promote competition in a way that encourages high-value care, we need robust and aligned quality data – not just cost – across all payers. As the largest payer in the U.S., how CMS approaches quality measures has a cascading effect across the entire system. We thank CMS for its efforts to date – such as through its Meaningful Measures Initiative – to ensure alignment across CMS programs, as well as steps toward reducing the burden of quality reporting across programs. PBGH was the recipient of a CMS award and was one of seven organizations developing patient-reported outcomes measures ("PROMs") for accountability and performance-based payment under the MIPs program. We applaud CMS' efforts to advance PROMs and encourage continued advancement of e-PROs in CMS programs and innovation efforts. Purchasers have long advocated for meaningful measures of health care quality to help patients choose providers and hospitals and to help employers choose health plans and reward provider networks that deliver superior care. Today providers, health plans and governments report an abundance of measures, yet most do not tell patients and health care purchasers what they need to know about whether people are getting high quality care.

PBGH is a national leader in redesigning how quality is measured and reported as the basis of a transformed, patient-centered health care system. Whether helping patients and employers compare providers and health plans, assessing patient experience and outcomes, or quantifying performance for specific interventions and procedures, PBGH's efforts are designed to increase accountability and improved value across the health care continuum. For example, PBGH's Comprehensive Maternity Care Workgroup is defining comprehensive maternity care purchasing standards, which ensure high-quality, equitable maternal and infant health outcomes.

To help identify hospitals and practices that have implemented these attributes, PBGH utilized a multistakeholder process to define a measure set focused on equity, patient experience of care and health outcomes. These measures were selected based on their alignment with national measure sets and accreditation organizations and their ability to identify and evaluate high-performance in maternity care. In May 2024, the working group released the first edition of their Comprehensive Maternity Care (CMC) Common Purchasing Agreement, outlining comprehensive maternity care attributes, purchasing principles, a measure set and a common purchasing agreement. These purchasing

[25] Ibid.

standards can be implemented by public and private purchasers in partnership with health plans and/or providers directly. This goal is to accelerate the advancement of maternity care and birth equity in the employer-sponsored insurance market.

We urge CMS to continue to ensure that purchasers are at the table when metrics are developed, and that publication of outcomes data is advanced across all federal programs. Full transparency on prices, quality and equity is needed across providers for purchasers to ensure value for their employees, as well as standardized measures of quality, patient experience, appropriateness, and total cost of care. These data sets are invaluable to assess the potential impact of proposed transactions. This includes not just reporting at the hospital or system level, but by provider quality metrics at the brick-and-mortar level, which truly shine a light on the quality of care that a patient can expect to receive. We also need expanded meaningful measures around critical areas such as mental and maternal health, which are severely lacking despite the urgent need to address issues with quality and access. For example, a 2021 white paper by the National Committee for Quality Assurance (NCQA) reviewed 39 active federal programs and found disjoined measures for behavioral health, highlighting a need for aligned, standardized and meaningful behavioral health quality measures. It is critical to ensure behavioral health and other quality measurements that truly hold entities accountable for improve care access and outcomes.[26]

***Addressing transparency and anticompetitive behavior for PBMs and drug manufacturers*:** In addition to price transparency for payers and providers, PBGH strongly supports enhanced transparency and reporting requirements for PBMs and across the drug supply chain. Transparency is essential to containing costs since much of the drug supply chain is opaque to consumers due to complex payment arrangements and gag clauses. Contracts between PBMs and employers typically do not provide details about fee or rebate schedules, information about amounts, prices, and fees generated from manufacturers and other parties, drug definition criteria, or amounts charged to pharmacies. Sometimes PBM control of information extends to an employer's effort to enforce contract compliance, as they may either place onerous audit restrictions on an employer or require a PBM-designated auditor. This lack of transparency makes it nearly impossible to negotiate for lower prices.

We are eager for long-needed reforms to PBMs and welcome provisions that restore some transparency and competition into the market. In addition to enhanced reporting to plan sponsors and transparency into contracts and practices, we support reforms that address the complex rebate structure and misaligned incentives and "spread" pricing models that lead to higher prescription drug costs. These steps will help to align the PBMs' business models with the needs of consumers and purchasers, thereby leading to a fairer and freer

[26] Niles and Olin (May 2021) "Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care" *NCQA* [Link]

market and, in turn, lower drug costs. Employers have a legal responsibility as plan fiduciaries – they are bound by law to act in the exclusive interest of the plan's beneficiaries and to be financially responsible of plan assets. If employers are to succeed in their fiduciary role, they require PBM partners who are unconflicted and who do not place unreasonable and anticompetitive restraints on them.

Additionally, PBGH supports addressing anti-competitive behavior by drugmakers that results in increased prices and a lack of competition. Specifically, we support efforts to increase transparency and require drugmakers to provide advance notice and justification for significant price increases, reduce barriers to generic and biosimilar drug development and use, and prohibit abuse of the patent system to extend exclusivity for brand-name drugs. The agencies should also explore how to incentivize truly innovative drug development and prevent companies from exploiting the system for profit by deploying resources, instead, to blocking generic and biosimilar competition. We applaud recent action by the FTC to target junk patent listings for high-cost diabetes, weight loss and COPD drugs which hinder competition and drive-up prices and their investigation into the pharmaceutical supply chain, as well as HHS's work to carry out provisions of the Inflation Reduction Act and address drug shortages. We strongly believe that policies to rein in drug costs should address drivers of high drug costs across the system rather than focusing on a single payer group, such as Medicare. PBGH also adamantly believes drug policies should not simply shift costs to purchasers and consumers.

Holding down costs and spending growth through surprise billing enforcement and spending targets: Sometimes, in areas where the market is fundamentally broken and it is nearly impossible to address costs through competition, the government must step in to curtail harmful pricing practices. PBGH is supportive of the efforts made by Congress and HHS to carry out the No Surprises Act, aimed at protecting patients from surprise medical bills and limiting exorbitant out-of-network charges. However, it is critical that HHS ensure effective implementation and that there is enhanced oversight of entities that may be leveraging the independent dispute resolution (IDR) process as a revenue strategy. Several recent studies show that, for example, private equity backed firms account for a vast majority of IDR cases. One study showed that practices affiliated with just four such companies (TeamHealth, SCP Health, Envision, and Radiology Partners) generated 74% of line items.[27] Oversight and rightsizing of this process is critical to ensure it is reducing burden for smaller entities engaging in good faith negotiation and that the intent of the legislation is carried out.

We also urge the departments to learn from efforts at the state level – as Congress did to craft the No Surprises Act – to address health care spending growth. In California, the Office of Health Care Affordability passed legislation in 2022 that sets targets for health

[27] Fiedler and Adler (Mar. 27, 2024) "A First Look at Outcomes Under the No Surprises Act Arbitration Process" *Brookings Institute* [Link]

care spending growth, including strong accountability measures through financial penalties for not meeting targets. It also requires cost and market impact review of proposed mergers and acquisitions. In April of this year, California's Health Care Affordability Board approved its first statewide spending targets. The initial target will be a 3.5% increase in 2025, phasing-in gradually to a 3.0% increase by 2029. Hospitals, provider groups and health insurers will have to submit spending data to the state to demonstrate that they are complying with the cap and the affordability office also has authority to enforce penalties, including performance improvement plans and fines, for organizations that exceed the benchmark. It will not enforce penalties until 2029. Importantly, the cost targets are accompanied by other incentives such as those that drive value-based payment. PBGH and its member organizations played an influential role in this important achievement and look forward to sharing more about the program once it is implemented.

Enable purchasers to innovate: Finally, we support policies and interventions that enable private purchasers to innovate, removing barriers to employers and other private purchasers to advance efforts in value-based care and contracting, increasing competition, reducing costs and driving quality and patient satisfaction. PBGH's member organizations demonstrate an unwavering commitment to innovate benefit offerings and purchase high-quality care. This includes embracing alternative payment models that depart from fee-for-service and incentivize physicians to provide valuable, not unnecessary or low-value, care; prioritizing advanced primary care by building the infrastructure when health insurers will not, to lower their population's cost of care and improve health; creating new direct payment models for rural hospitals where employers band together to pay hospitals directly to keep critical departments open and viable; forming direct contracts with large, integrated health systems around the country, eliminating administrative waste, streamlining care delivery and sharing the financial gains with employees through no copays, no cost-sharing on generic drugs, HSA contributions, and more. Critically, ERISA preemption is vital in safeguarding these types of pro-competitive innovations and must be preserved. Preemption ensures that multi-state purchasers are able to offer a uniform, consistent, and reliable set of benefits across state lines. It lessens the administrative burden of providing health and welfare benefits to participants. And it supports the ability of multi-state employers to flexibly design and maintain benefit offerings that are tailored and equitable to employees, regardless of where they are located.

We urge HHS to consider ways to better align with purchasers through organizations like PBGH and our partners to ensure we are all rowing in the same direction. Public and private payers too often work in silos to achieve higher value care for their populations, despite often working towards the same goals. One way this can be done is by creating pathways to engage private purchasers in CMMI models more meaningfully to promote multi-payer collaboration and encourage public-private partnerships that improve quality, reduce costs, and move the whole system forward. Under the current landscape,

where providers have significant market power, there is little incentive to transition toward value-based payment, especially with smaller employers. More meaningfully including employers and others in the commercial market will promote multi-payer collaboration.

We are encouraged by the recent announcement by CMMI to launch pilot programs for advanced primary care models. In addition, we believe Medicare should authorize payment models and increase payment rates for advanced primary care models that achieve high quality outcomes and reduce total cost of care. MedPAC and other experts have observed that certain procedures and specialty services are overpriced, based on the relative value units (RVUs) used to calculate payment rates to physicians. Congress and HHS should consider structural and process changes to correct this imbalance.

Additionally, some employers are being hindered from adopting value-based care at the state level due to and a complex patchwork of regulatory oversight for health insurance that has evolved over time in service of several goals, some of which can be at odds with each other. Purchasers need more clarity from the Department of Labor on capitated payment arrangements in self-funded plans in California, specifically, in order to move forward with the promise of value.

Conclusion

In summary, PBGH's proposed government actions for DOJ/HHS/FTC include:

- **Stronger anti-trust enforcement** to ensure mergers do not significantly increase consolidation or market power and change the burden of proof so entities have to demonstrate that the transaction will not result in higher costs, impaired quality, increased inequities or reduced access to services.

- **Address the root causes of consolidation** through expansion of site-neutral payment policy and additional actions aimed at advancing multi-payer adoption of value-based payment.

- **Reduce anti-competitive negotiation and contracting practices** through support of policy at the federal and state levels that would remove gag clauses on the sharing of price and quality information by providers; ban anti-competitive contracting practices including "anti-tiering," "anti-steering" or "all-or-nothing" contracting; and address anti-competitive behavior in contract negotiations.

- **Improve and build on price transparency efforts** through strengthening, standardizing and making more accessible cost transparency data, including

extending to non-hospital sites of care, bolstering compliance efforts, and ensuring additional transparency of transactions and ownership data.

- **Streamline quality metrics and data standards** to ensure a robust and aligned quality approach across all payers through a multi-stakeholder process, ensuring adequate access to the data for purchasers and patients.

- **Increase transparency and address anticompetitive behavior for PBMs and drug manufacturers** through requiring transparent contracts and reforms that address complex pricing models such as spread pricing and complex rebate incentives, while also addressing anti-competitive drug manufacturer behavior such as abuses of the patent system.

- **Address spending growth through surprise billing enforcement and spending targets,** including ensuring the No Surprises Act IDR process is not being used as a provider revenue strategy and supporting efforts at the state level to set and enforce spending targets.

- **Enable purchasers to innovate** by removing barriers for employers and other private purchasers to advance efforts in value-based care and contracting; more meaningfully including employers and other purchasers in care innovation; and preserving ERISA preemption to ensure this type of pro-competitive innovation can continue.

Thank you for this opportunity to offer comment. and please reach out to us if you have any questions or need additional information.

Thank you for the opportunity to provide comments, and we look forward to working with you on this and other issues of importance. If you have any questions or wish to collaborate on these issues further, please contact Bill Kramer, Senior Advisor for Health Policy, at wkramer@pbgh.org.

Sincerely,

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