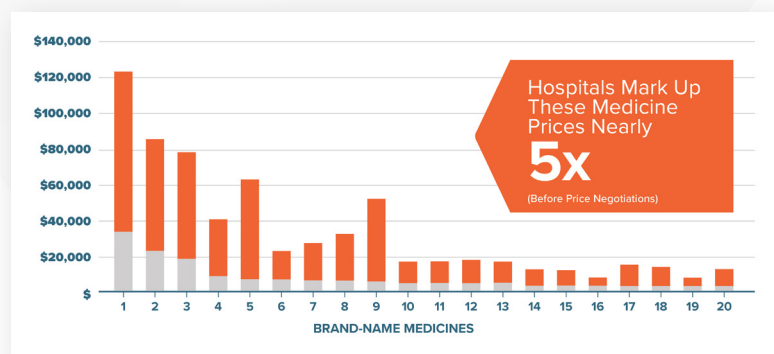


# HOSPITAL CONSOLIDATION INCREASES HEALTH CARE COSTS FOR PATIENTS AND THE HEALTH CARE SYSTEM

Hospitals are the largest and fastest growing contributor to health care costs. In 2019, hospital care is projected to total \$1.25 trillion and represent nearly a third of health care spending; this number is expected to increase to nearly \$2 trillion by 2027.<sup>I</sup> Much of this growth is due to rapid consolidation in the provider market over the past decade as hospitals buy up physician practices and clinics. Because of this, care has shifted away from physician practices and into more expensive hospital outpatient departments. This shift in site of care, and the high price markups hospitals demand due to their large size and market power, leads to higher costs and access problems for patients.

## HOSPITAL MARKUPS ON MEDICINES

Hospitals markup medicine prices, on average to nearly 500% of their acquisition cost<sup>II</sup>—meaning hospitals bill patients and their insurers about five times what the hospital paid to purchase the medicine. And one in every five hospitals marks up the price of a medicine by at least 700%. For a medicine with a list price of \$150, this 700% markup could result in patients being billed \$1,050 or more.<sup>III</sup>



Hospitals have incentives to increase markups as markups on medicine prices often lead to higher reimbursement by health plans. In fact, after negotiations with commercial payers, hospitals still receive nearly 2.5 times what they paid to acquire the medicine. More than half of commercial payers reimburse hospital outpatient departments as a percentage of billed charges, yet uninsured patients face the full charge.<sup>IV</sup>

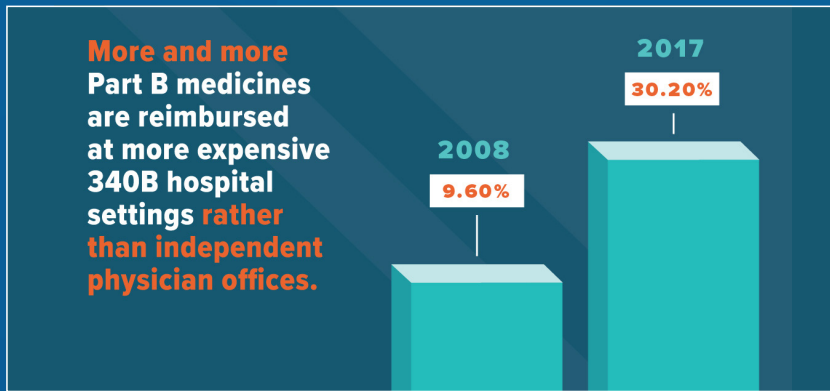
## HOSPITAL CONSOLIDATION

Hospitals use their large market power to negotiate higher payments than physician offices for providing many of the same items and services. Markups on medicines in the commercial market are a key example: hospitals increasingly consolidate and purchase physician groups to capture even more of the market and increase their profits, which undermines private market competition and greatly increases the cost of health care.

From 2004 to 2011, hospital ownership of physician practices doubled from 24% to 49%.<sup>V</sup> Hospitals' rapid acquisition of physician practices enables them to demand higher prices from commercial payers. As a result, insurers pay higher prices for equivalent services that previously were delivered in less-expensive, independent physician offices.

Research shows that as hospitals merge, prices increase 20% to 40%, with greater price increases in concentrated markets.<sup>VI</sup> Further research confirms that a 1% increase in the proportion of medical providers affiliated with hospitals and/or health systems was associated with a 34% increase in average annual costs per person and a 23% increase in the average per person price of treatment.<sup>VII</sup>

## THE 340B DRUG DISCOUNT PROGRAM



The misaligned incentives of the 340B program also fuels hospital consolidation. Over the years flawed policies in this program have created incentives for hospitals to buy up community-based physicians practices and shift care to higher-cost settings. Congress created the 340B program to assist federal grantees and true safety-net hospitals that serve uninsured or otherwise vulnerable patients. Under the program, certain hospitals and safety net clinics that meet certain eligibility criteria are entitled to steep discounts for medicines.

Current 340B rules are lax, enabling participating 340B hospitals to make a profit by dispensing medicines that were obtained at a discounted rate, requesting reimbursement at the non-discounted rate and then pocketing the difference without any accountability for how the profits are used or if the money is used to benefit patients. Hospitals leverage their ability to generate revenue from 340B discounts for medicines by buying up community-based physician practices.<sup>viii</sup> These shifts in ownership and the site of treatment not only undermine community-based practices but also contribute to concentration in provider markets, leading to higher prices for payers, the government and patients.

The 340B program was intended to ensure access to discounted drugs for vulnerable or uninsured patients through true safety-net facilities. But all signs point to the program doing the opposite in many cases. While hospitals that participate in the program are given significant discounts on medicines—which average 50%—it doesn't appear all 340B hospitals use the money to benefit patients and there are no requirements to report to the government how the money is used. Simply put, a lack of transparency has allowed the program to continue to grow without any evidence patients are benefitting. Many hospitals justify their large 340B purchases by saying it enables them to provide an increasing amount of charity care, but the data show that is not what is happening. Between 2013 and 2017, the American Hospital Association reported a \$8.4 billion decrease in the amount of uncompensated care provided by hospitals. In fact, as a percentage of total hospital expenses, uncompensated care declined from 5.9% to 4% over this period.

Over the years, the 340B program has grown astronomically with hospitals bringing in more and more 340B revenue—reaching \$24.3 billion in 2018, a 26% increase over the previous year. Yet charity care rates and uncompensated care rates have declined raising questions around how the revenue is being used and if the program meets Congress' intent.<sup>ix</sup>

Reforms are needed to address misaligned profit incentives which fuel hospital markups, provider consolidation and growth in the 340B program. Addressing these misaligned incentives presents an opportunity to reduce health care costs and promote sustainability in our health care system.

<sup>i</sup> Sisko AM et al. National Health Expenditure Projections, 2018–27: Economic and Demographic Trends Drive Spending and Enrollment Growth. Health Affairs. 2019 Feb 20;10-377.

<sup>ii</sup> The Moran Company. Hospital Charges and Reimbursement for Drugs: Analysis of Markups Relative to Acquisition Cost. October 2017.

<sup>iii</sup> The Moran Company. Hospital Charges and Reimbursement for Medicines: Analysis of Cost-to-Charge Ratios. September 2018.

<sup>iv</sup> American Hospital Association. Uncompensated Hospital Care Cost Fact Sheet. January 2019.

<sup>v</sup> Cutler, D., and Morton, F.S. (2013) Hospitals, Market Share, and Consolidation, 310:1964, Journal of the American Medical Association.

<sup>vi</sup> Gaynor, M., and Town, R. The impact of hospital consolidation-Update. Robert Wood Johnson Foundation. 2012.

<sup>vii</sup> Health Care Cost Institute & National Academy for State Health Policy, The Impact of Provider Consolidation on Outpatient Prescription Drug-Based Cancer Care Spending (April 2016).

<sup>viii</sup> S. Desai and J.M. McWilliams, "Consequences of the 340B Drug Pricing Program," N Engl J Med 2018.

<sup>ix</sup> A. Fein, "EXCLUSIVE: 340B Program Purchases Reach \$24.3 Billion—7%+ of the Pharma Market—As Hospitals' Charity Care Flatlines," The Drug Channels Institute. May 2019.