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BEFORE THE BUDGET COMMITTEE

UNITED STATES HOUSE OF REPRESENTATIVES

REGARDING THE CONSEQUENCES OF CONSOLIDATION IN U.S. HEALTH CARE FROM A PHYSICIAN'S PERSPECTIVE

May 23, 2024

Chairman Arrington, Ranking Member Boyle, and distinguished members of the House Budget Committee, thank you for the opportunity to testify today on the critical topic of consolidation in our health care system. My name is Dr. Adam Bruggeman, and I am a board-certified orthopaedic spine surgeon from San Antonio, Texas. I am also chair of the Advocacy Council at the American Association of Orthopaedic Surgeons (AAOS). I am here to share my firsthand experience as a physician in private practice operating in a rapidly consolidating healthcare market. I will discuss the consequences of consolidation on our patients and the broader healthcare system, the factors driving this consolidation, and what Congress should do to address this alarming trend.

Consequences of Consolidation

The horizontal and vertical integration of practices into hospital systems carries far-reaching consequences impacting patient access and affordability. A mounting body of evidence reveals that this consolidation drives up prices for health care services, including common orthopaedic procedures like knee replacements and spinal fusions. In fact, studies show the costs for these procedures were approximately 30 percent higher in concentrated markets compared to

competitive ones.[1] This pricing escalation is not limited to orthopaedics but is a systemic issue. A comprehensive analysis found that average hospital prices soar dramatically following mergers and acquisitions.[2] Corroborating this, research indicates hospitals engaging in consolidation impose prices 40 to 50 percent higher compared to what they would have charged if they had not merged.[3] The pricing power of consolidation is further underscored by findings that hospitals without local competitors within a 15-mile radius charge 12 percent more than those operating in markets with four or more competitors.[4] Together, these studies demonstrate a clear trend highlighted throughout my testimony: consolidation leads to higher costs eroding affordability and access to care for patients and payers alike. This alarming pattern demands urgent attention and action from Congress to critically examine consolidation's impact and take decisive steps prioritizing patient interests.

In San Antonio, Texas, where my practice is located, one of my colleagues recently joined a large hospital system after facing challenges maintaining an independent practice. This consolidation comes at a huge cost to our local market and city. Now, their rates are higher due to site of service differentials triggered by the move from independent practice to employment by a large system. One surgeon in one community can cost millions in lost revenue to taxpayers and local businesses due to the impacts of consolidation. This drives up costs across the board including premiums for large employers in the area providing health insurance to their employees, straining their budgets. The downstream effects trickle all the way down to individual patients needing surgery, who now face higher out-of-pocket expenses. Employers also feel the pinch as consolidation forces them to pay more for their employees' health plans. Ultimately, increased prices resulting from this type of consolidation are affecting individual household budgets, employer finances, and even the federal budget.

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[1] JC Robinson. (2011). Hospital Market Concentration, Pricing, and Profitability In Orthopedic Surgery and Interventional Cardiology. Am J Managed Care 2011; 17(6):e241-e248

[2] Abelson, R. (2018). When Hospitals Merge to Save Money, Patients Often Pay More. *The New York Times*. https://www.nytimes.com/2018/11/14/health/hospital-mergers-health-care-spending.html

[3] Gale A. H. (2015). Bigger but not better: hospital mergers increase costs and do not improve quality. *Missouri Medicine*, *112*(1), 4–5.

[4] Schwartz, K., Lopez, E., Rae, M., & Neuman, T. (2020). What we know about provider consolidation. *KFF*. https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/

This type of integration of private practices into hospital systems is dramatically driving consolidation but is not the only factor. There are serious implications for physicians when insurance companies hold a significant portion of the market share. New research indicates that, in each state, the top three large-group insurers hold an average of 82 percent of the market share and that the largest health systems combined hold approximately 43 percent of the market share.[5] These outsized discrepancies between the market influence of hospital systems and insurers compared with the physicians who deliver patient care leads to the inability to negotiate contracts and prices that reflect the value of the care provided.

Shortfalls in the Medicare Physician Payment System

The Medicare fee-for-service physician payment system also contributes to the discrepancies in negotiating power that physicians experience. The current physician payment does not account for a doctor's training, years of experience, ability to handle complex cases, or quality of care provided. When a newly graduated physician joins a practice, they are compensated at the same rate as a seasoned physician in the same group who has been practicing for 20 years. If insurers, including Medicare, persist in this one-size-fits-all approach to physician reimbursement that disregards individual knowledge and skill levels, it will be increasingly difficult to sustain the independent practice model. Physicians will essentially be reduced to interchangeable labor, rather than respected professionals making personalized care contributions commensurate with their expertise. This standardized payment system is unique to physicians when compared with professionals in other industries ranging from law to skilled trades. This model's impact among commercial payors can already be seen as insurers are attempting to no longer pay for the level of medical complexity of a patient when reimbursing anesthesiologists. This standardization of physician payment stands in stark contrast to the Medicare payment policies of varying reimbursement based on site of service. For years, Medicare has implemented varying payment models based on where patients receive care – be

[5] Grover, A., Orgera, K., Pincus, L., Senn, S., & Redford, G. (2024). Why Market Power Matters for Patients, Insurers, and Hospitals. Research and Action Institute. https://www.aamcresearchinstitute.org/our-work/data-snapshot/why-market-power-matters

it a hospital, clinic, surgery center, or doctor's office. This site-specific approach stemmed from the notion that reimbursement should align with the total resources utilized in delivering healthcare services. Such facility-dependent payments have long been woven into the fabric of Medicare and Medicaid, exemplified by systems like the MPFS. However, this payment variation based on site of care has bred inefficiencies and fueled a wave of physician practice acquisitions by hospital networks. Moreover, it has significantly impacted patient choice by creating payment disparities, with hospital outpatient departments receiving markedly higher reimbursements for the same services offered at surgery centers or independent physician offices. These policies effectively incentivize consolidation, gradually restricting patient access to more affordable community-based care settings.

Site Neutrality

To counter the negative effects of site-based payment differentials, CMS and Congress have mulled over transitioning to site-neutral payments that disregard facility types. Such initiatives aim to minimize disparities in reimbursement for identical services provided across different care settings. Extending site-neutral policies to cover office visits, in-office procedures, and ambulatory surgical center services could further curb inefficiencies, promote patient choice, and stimulate much-needed competition within the healthcare landscape. However, such policies as currently proposed assume the current in-office rate is the appropriate payment rate for such procedures and fail to account for the economic realities as outlined above. It is therefore crucial that any cost savings generated from reforms to site neutrality are reinvested into physician payment reform to ensure long-term stability and address the inherent advantages that large healthcare systems have over independent physicians and smaller practices due to their scale and resources.

Factors Driving Consolidation

Consolidation cannot be properly addressed without first understanding the stressors that have led many of my colleagues to sell their practices. In today's healthcare landscape, physicians across America find themselves at a breaking point. A 2021 survey found that one in five

physicians intend to leave their practice altogether, and previous studies have shown that intent to leave often correlates with actual departures.[6] This is deeply concerning for the stability of our physician workforce and patients' access to care. Physicians are grappling with significant challenges that are increasingly difficult to manage. The financial pressures of rising costs and declining reimbursements are coupled with onerous and ever-growing administrative burdens that collectively make it difficult for physicians to sustain the financial viability of their practices and ultimately contribute to burnout. Unfortunately, these challenges disproportionately impact small, independent practices, rural physicians, and those serving low-income and marginalized communities thereby increasing the risk of access to care issues for some of our country's most vulnerable patients.

As the owner of a medical practice, I am regularly faced with the difficult challenge of balancing rising costs and declining reimbursement. In most practices, overhead expenses like staff, rent, supplies, and other costs are typically greater than 50 percent of practices' revenue.[7] At the same time, I hear from many of my colleagues that compensation from professional fees for seeing patients makes up less than half of their total revenue. This creates an unsustainable scenario where physician compensation alone is insufficient to keep practices viable. According to a survey conducted by the American Medical Association, salary accounted for only 30.1 percent of compensation for physicians who owned their practices, reinforcing this point.[8] To offset the losses from diminishing professional fees, many physicians will invest in ancillary business ventures – such as surgery centers, physical therapy clinics, imaging facilities, hospitals (where permitted under the current moratorium in statute), real estate, and other healthcare-related investments – most of which are insulated from the annual reimbursement cuts that directly impact physician payments. With these financial pressures in mind, it is no wonder that

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[6] Sinsky, C. A., Brown, R. L., PhD, Stillman, M. J., MD JD, & Linzer, M., MD. (2021). COVID-Related stress and work intentions in a sample of US health care workers. *Mayo Clinic Proceedings. Innovations, Quality & Outcomes*, *5*(6), 1165–1173. https://doi.org/10.1016/j.mayocpiqo.2021.08.007

[7] Appold, K. (2016). Keeping Medical Practice Overhead Down. Physicians Practice. https://www.physicianspractice.com/view/keeping-medical-practice-overhead-down

[8] Robeznieks, A. (2018). This is how physicians get paid. See where you fit. American Medical Association. https://www.ama-assn.org/about/research/how-physicians-get-paid-see-where-you-fit#:~:text=On%20average%2C%20a%20bit%20more

a recent study showed that only 40 percent of physicians would recommend a career in medicine.[9]

Budget Neutrality, Inflation, and Declining Reimbursements for Physicians

The Omnibus Budget Reconciliation Act of 1989 contained a provision which mandates that any upward payment adjustments, or the addition of new procedures that will increase spending by $20 million or more, must be offset by cuts elsewhere in the Medicare Physician Fee Schedule (MPFS). This statute on budget neutrality resulted in a 3.37 percent cut in the MPFS that went into effect January 1, 2024. Although Congress stepped in to provide some relief in March 2024, half of the cut went unaddressed, requiring physicians to absorb a 1.69 percent reduction to their reimbursement rates for the remainder of 2024.

Even worse, budget neutrality requirements force the various medical specialties to be pitted against each other over the size of their respective pieces of the MPFS pie, creating even more uncertainty for physicians and adding no value to patient care. For example, physicians in one specialty may have their payments reduced because of policy decisions aimed at a completely different specialty which have little to do with their day-to-day practice of medicine. Roughly 60 percent of the original 3.37 percent cut that CMS proposed in this year's MPFS can be attributed to one such policy decision: the implementation of the G-2211 add-on code that is directed towards primary care and other office/outpatient evaluation and management (E/M) intensive specialties.

While the gap between rising physician costs and stagnant or declining reimbursement has grown wider in recent years, the economic uncertainty it creates for physicians has been slowly building for decades. The projected 4.6 percent increase to clinicians' input costs for Calendar Year (CY) 2024—as measured by the Medicare Economic Index (MEI)—is the highest it has been this century, surpassing last year's record of 3.8 percent. Since 2001, the cost of running a medical practice has increased 39 percent, but the Centers for Medicare & Medicaid Services

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[9] The Physicians Foundation. (2023). 2023 Survey of America's Current and Future Physicians. https://physiciansfoundation.org/wp-content/uploads/PF23_Brochure-Report_Americas-Physicians_V2b-1-2.pdf

(CMS) has only increased reimbursement for physicians by 11 percent.[10] Unlike hospitals and nursing homes, physicians and other health care professionals do not receive an automatic increase to keep pace with the rate of inflation. As a result, when adjusting for inflation, Medicare physician pay has declined nearly 30 percent since 2001.[11] Given this economic climate, it is not surprising that many of my colleagues are forced to choose between closing their doors or consolidating with larger healthcare institutions that can provide the economic stability needed to continue treating patients. Providing reimbursement updates to physicians that fully account for inflation, as measured by the MEI, would help stabilize independent practices and alleviate the pressures they feel to consolidate and ultimately raise healthcare costs.

Administrative Burdens

Administrative burdens are also a major reason more physicians are choosing employment over owning their own practice. In my practice, 30 percent of my staff are now dedicated to administrative tasks, including prior authorization and records requests, created by the bureaucracy of the healthcare system. By some estimates, administrative costs account for approximately $1 trillion of annual U.S. health care spending.[12] Prior authorization, required for a wide range of services in Medicare, Medicare Advantage (MA), Medicaid managed care, and commercial health insurance plans, contributes significantly to the overall administrative burden on physicians. Each insurer has different policies and procedures, compounding the inefficiency. While ostensibly intended to control costs, prior authorization can delay necessary care and negatively impact patient outcomes. A recent AMA survey found that 34 percent of physicians reported a serious adverse event for a patient – death, hospitalization, disability/permanent bodily damage, or other life-threatening event – due to prior

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[10] American Medical Association. (2021). Medicare Updates Compared to Inflation (2001-2021). https://www.ama-assn.org/system/files/medicare-pay-chart-2021.pdf
[11] American Medical Association. (2024). 2024 Medicare updates compared to inflation chart. https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf
[12] Sahni, N. R., Gupta, P., Peterson, M., & Cutler, D. M. (2023). Active steps to reduce administrative spending associated with financial transactions in US health care. *Health Affairs Scholar*, *1*(5). https://doi.org/10.1093/haschl/qxad053

authorization delays.[13] The same report found medical practices complete an average of 45 prior authorizations per physician, per week, equating to two full business days and valuable time taken away from treating patients.[14] In April 2022, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) reported that MA plans inappropriately denied up to 85,000 prior authorization requests in 2019, with nearly 20 percent of denied payments meeting Medicare coverage rules. This included improper denials for orthopaedic patients' magnetic resonance imaging (MRIs), x-rays, inpatient admission, rehab admission, equipment, and follow-ups. To illustrate this, I have a patient who was previously in Oklahoma and received a recommendation for a cervical disc replacement. They received a second recommendation for the same procedure upon moving to San Antonio. When they came to my practice, I recommended the procedure again, now for a third time. These records were submitted to the insurance company who is now requiring an in-person office visit with an orthopedic surgeon — one who is not even trained in spine surgery — to determine if the procedure is necessary. Keep in mind that we have three orthopedic surgeons who are fellowship trained in spine surgery and all agreed with the recommendation. Now the patient has to wait several months before the authorization is reviewed, due to the time it will take to get the patient into the independent medical review. Rather than decreasing costs as promised, these unnecessary delays increase costs by diverting patients to ineffective initial treatments, unnecessary office visits, or costly urgent/emergency care when initial requests are delayed or denied but eventually approved.[15]

Impact of COVID-19 on Consolidation

While declining reimbursement and the administrative burdens of prior authorization contribute significantly to rising healthcare costs and physician burnout, the COVID-19

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[13] O'Reilly, K. (2023, March 29). 1 in 3 doctors has seen prior auth lead to serious adverse event. American Medical Association. https://www.ama-assn.org/practice-management/prior-authorization/1-3-doctors-has-seen-prior-auth-lead-serious-adverse-event#:~:text=More%20specifically%2C%20the%20AMA%20survey

[14] Ibid.

[15] American Medical Association. (2023, March 13). *Toll from prior authorization exceeds alleged benefits, say physicians*. https://www.ama-assn.org/press-center/press-releases/toll-prior-authorization-exceeds-alleged-benefits-say-physicians

pandemic served as another catalyst driving more physicians away from independent practice ownership toward employment by hospitals and corporations. During this time, independent physician practices faced sharp decreases in utilization and revenue and increases in operating costs. From 2019 to 2021, there was a 25 percent increase in hospital and corporate-owned practices and seven in 10 physicians are employed by these organizations.[16] At the completion of the study, 48 percent of all physician practices in the United States were owned by hospitals and corporations .[17] This unprecedented consolidation, as large systems rapidly acquired smaller facilities and independent practices, raises monopoly concerns about driving up costs and limiting patient choice.

Threats to Healthcare Cybersecurity

The consequences of unchecked consolidation extend beyond higher prices for common procedures. Unfortunately, we witnessed first-hand the detrimental effect of consolidation from the recent Change Healthcare cyberattack in February 2024, which directly impacted my practice and exemplified how consolidation and vertical integration can amplify disruptions across the entire healthcare system. Even under normal operations, it is well-established that consolidation has not improved patient health outcomes enough to account for the higher costs. Now we are seeing how concentrating more healthcare spending through a small number of entities creates even more points of failure. When an adverse event occurs at one of these consolidated giants, the impacts are more severe, costly, and difficult to resolve. As more claims and patient data funnel through a handful of large companies, they may become bigger targets for cyberattacks. The Federal Trade Commission (FTC) must closely examine whether vertical integration is increasing systemic vulnerability to such threats. Consolidation's risks extend beyond just anti-competitive behavior to issues of security and resilience for our entire healthcare infrastructure.

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[16] Avalere Health & Physicians Advocacy Institute. (2022). COVID-19's impact on acquisitions of physician practices and physician employment from 2019-2021. *Avalere Health*. https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf
[17] Ibid.

My concern that cyber threats will drive further consolidation is not just hypothetical. We are already seeing this play out as a direct result of the February attack. For practices whose cashflow was completely cut off and whose cash reserves were spent dry, the financial relief offered by CMS and Optum, the parent company of Change Healthcare and a subsidiary of UnitedHealth Group (UHG), was slow to arrive and insufficient. To add insult to injury, some of these practices were purchased by Optum during this situation. There were even reports of Optum using the financial emergency caused by the cyberattack on its own subsidiary as legal justification to expedite its acquisition of physician practices.[18] I find it hard to believe that Optum could not have found other ways to support those practices rather than buying them at a discount rate and consolidating further. Fortunately, my practice had sufficient cash reserves to continue operating without receiving payments during the outage. However, it is important to ensure that any sensitive financial data submitted by practices to receive advanced funds is handled properly and not misused for targeting further practice acquisitions. Any practice acquisitions stemming from this disruptive event should be closely monitored to protect against potential anti-competitive behavior. Maintaining a level playing field and safeguarding fair competition is crucial for the healthcare market to properly serve patients and communities.

Solutions to Combat Consolidation

Long-Term Reforms to Physician Payment

There are many things that Congress can do to address the alarming trend of consolidation in health care and its detrimental effects on costs and quality of care. A critical first step is to raise the MPFS budget neutrality threshold and index it to inflation going forward, as well as providing statutory guard rails to limit the year-over-year changes to the conversion factor. While we appreciate Congress' efforts to mitigate the annual cuts, short-term legislative fixes do not address the underlying instability. Next year, when both the 1.25 percent statutory adjustment from the Consolidated Appropriations Act of 2023 and the additional 1.68 percent

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[18] Templeton, A. (2024). Update: Oregon approves controversial Corvallis Clinic, Optum merger. *OPB*. https://www.opb.org/article/2024/03/13/corvallis-clinic-optum-merger-oregon-health-care/

relief from this year’s appropriations package are set to expire, physicians face yet another cut of 2.93 percent for 2025.

Unless we make long-term, structural changes to how Medicare—and by extension the rest of the private market which often adjusts its rates based on Medicare changes— values the services physicians provide, the idea of the independent physician will continue to fade from our health care system. For that model of health care delivery to be a financially viable option for physicians, we must have long-term financial security that the current patchwork of annual, short-term payment updates fails to provide those who are not salaried employees of a larger institution. The simplest thing Congress can do is provide physicians with reimbursement updates that fully account for inflation as measured by the MEI. This would help stabilize independent practices and alleviate pressures driving further consolidation that ultimately raise healthcare costs. Implementing such inflationary adjustments by passing H.R. 2474, the Strengthening Medicare for Patients and Providers Act, is a crucial first step Congress can take to promote sustainability among independent physician practices.

Speaking more broadly, Congress must work to reform how physicians and other healthcare professionals are paid under Medicare. This was Congress ’original intent when it passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which sought to incentivize the shift of U.S. healthcare spending and delivery from a fee-for-service model to a value-based care model. However, MACRA has failed to create the abundance of opportunities for physicians to participate in Alternative Payment Models (APMs) that are necessary to make the program successful, and the Merit-based Incentive Payment System (MIPS) has significant shortcomings.

As it relates to orthopaedic surgery, a shift to value-based models has proven to be complicated and costly with limited return on investment. Physicians are overloaded with administrative burden required to comply with the numerous value-based payment models, and patients are often unaware that they are participating in such arrangements, thus limiting the effectiveness of such programs and increasing the incentive to consolidate with larger entities.

Regarding MIPS, the original tournament-model design of the program, if fully implemented, risks exacerbating financial uncertainty for physician practices with wide swings in reimbursement adjustments. The current structure also risks trapping underperforming practices, particularly those in rural in underserved communities, in a vicious cycle where drastic MIPS penalties deprive them of the resources needed to improve their performance and further push them towards consolidation. Congress can address these shortcomings by mitigating the disproportionate distribution of steep penalties, incorporating clinically relevant and less burdensome metrics, and realigning the incentive structure to account for the rising costs of practicing medicine through the inflationary adjustment mentioned earlier.

Physician-Led Hospitals

Another commonsense solution is to repeal the moratorium on physician-led hospitals. Physician-led hospitals are an important component and competitive force within the American healthcare system that ensure patients receive the highest quality care at the lowest cost. Yet, current law prohibits new construction or expansion of these hospitals to meet growing community demands. In 2010, the Patient Protection and Affordable Care Act (ACA) was enacted with a provision that prohibits any new physician-led hospitals from participating in Medicare and Medicaid. The provision created an uneven playing field in our nation's health care system.

Physician-led hospitals are among the most cost-effective and efficient providers of healthcare in the country, providing complex medical care at rates far below those charged by non-physician-led hospitals. According to one study published in the Journal of the American Medical Association (JAMA), commercial negotiated prices are 33.7 percent lower and cash prices are 32.7 percent lower for the same procedures at physician-led hospitals compared to other hospitals.[19] Not to mention, health care economists from Avalon Health Economics analyzed CMS data and found that physician-owned hospitals saved Medicare $3.2 billion over

[19] Wang Y, Plummer E, Wang Y, Cram P, Bai G. (2023). Comparison of Commercial Negotiated Price and Cash Price Between Physician-Owned Hospitals and Other Hospitals in the Same Hospital Referral Region. *JAMA Network Open.* 2023;6(6):e2319980. doi:10.1001/jamanetworkopen.2023.19980

a 10-year period, including over $258 million in 2014 alone.[20] Additionally, physician-led hospitals operate in a diverse array of communities and play a vital role in improving access to care, especially in rural areas.

Repealing the ban on physician-led hospitals is an important way to combat consolidation in the healthcare industry, but it will also need to be coupled with state-level efforts to repeal certificate of need (CON) laws. CON laws, which exist in many states, require healthcare providers to obtain state approval before offering new services or expanding facilities, often acting as barriers to entry and limiting competition. Physician entrepreneurship can drive innovation, improve quality, and reduce costs for patients. As discussions around healthcare reform continue, physician-led hospitals must be considered as a cost-effective option to promote competition and expand patients' access to care.

The moratorium on building new or expanding existing physician-led hospitals must be lifted to address the above concerns of a rapidly consolidating market to drive down health care costs and improve quality of care. I urge Congress to swiftly pass H.R. 977, the Patient Access to Higher Quality Health Care Act of 2023 to increase patient choice and inject much-needed competition into the health care market which in turn will drive down health care costs.

The challenges I have outlined today are pushing many dedicated physicians to seek employment over independent practice. If we want to preserve our nation's standard of high-quality health care and patient choice, Congress must address the root causes of consolidation. Any action must be coupled with broader reforms that restore practice sustainability for all physicians. This includes updating Medicare reimbursement rates to better align with the cost of delivering quality care and cutting the red tape that burns out physicians with excessive paperwork instead of providing patient care. Only by implementing these pragmatic, physician-focused reforms can we ease the burdens driving consolidation. Policies that empower

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[20] Issar, N. (2017). Reigniting the Debate About Restrictions on Physician Owned Hospitals. *Haynes Boone*. https://www.haynesboone.com/news/publications/reigniting-the-debate-about-restrictions-on-physician-owned-hospitals

physicians to thrive in their own practices have the potential to revive America's competitive healthcare landscape, benefiting costs and quality alike. The consequences of inaction are simply too high - for patients, physicians, employers, and taxpayers across our nation. Thank you for your attention to this critical matter.