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THE STRUCTURE OF THE HOSPITAL INDUSTRY IN THE 21ST CENTURY

HEARINGS

BEFORE THE

JOINT ECONOMIC COMMITTEE CONGRESS OF THE UNITED STATES

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

JUNE 17 AND 24, 1992

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THE STRUCTURE OF THE HOSPITAL INDUSTRY IN THE 21ST CENTURY

WEDNESDAY, JUNE 17, 1992

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON INVESTMENT, JOBS, AND PRICES,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Subcommittee met, pursuant to notice, at 11:00 a.m., in room 2237, Rayburn House Office Building, Honorable Fortney Pete Stark (chairman of the Subcommittee) presiding.

Present: Representative Stark.

Also present: David Podoff, Dee Martin, Doneg McDonough, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE STARK, CHAIRMAN

REPRESENTATIVE STARK. I apologize for being late, and to those who would rather be watching Mr. Yeltsin, but I think we have an equally important issue, albeit somewhat more complex.

We are going to begin hearings on the structure of the hospital industry in the next century, and we have scheduled them because the hospital industry, which uses about 40 percent of our over $800 billion health care bill, will have to change rapidly to meet the challenges of the next century.

Without any change, we are on track to leave 50 million Americans without health insurance. The spending will run to over $1.5 trillion by the end of the decade. While many of us are working on health insurance reforms that will both increase access and contain costs, it is going to be up to the various providers to adjust to getting less of our gross national product than they are anticipating now.

In this effort, we have to pay particular attention to the hospital sector not only because of its size, but also because of the enormous changes that are taking place in the way acute-care medicine is practiced.

We often seem to have too many hospital beds and high-tech devices nationwide, but then growing shortages in rural and inner-city areas. If changes in the practice of medicine continue, the question is, will the situation get worse or better?

In the two hearings scheduled for today and next Wednesday, we will focus on the role of public hospitals and on government policies with respect to hospital mergers and joint ventures. To put these two issues in perspective, we have asked a panel of health analysts to participate in today's session and to present an overview of the hospital industry.

What are the implications for access of hospital closures and declining occupancy rates? How many closures are there?

What are the occupancy rates?

What are the implications of the changing mix of inpatient and outpatient hospital services?

How will alternative approaches to health insurance cost containment affect the structure of the hospital industry in the future?

In sum, how many hospital beds will we need in the year 2000, and will they be where we need them?

The second panel will highlight the unique role of public hospitals and underscore the need to provide additional sources of capital for these institutions. I have introduced legislation, "The National Health Safety Net Infrastructure Act of 1992." I wish could think of a simpler name. This act is intended to ensure adequate investment in public hospitals. Through the use of federal loan guarantees, interest rate subsidies and matching grants and loans, the bill would increase the supply of capital available for public hospitals.

In today's hearing, we will not focus on the specific provisions of this legislation. Instead, as is appropriate for the Joint Economic Committee and its subcommittees, we will focus on broader questions related to the capital needs of public hospitals.

Specifically, we hope the second panel will address these questions:

What are the capital requirements of public hospitals and how have they changed over the last 30 years?

Is the "capital crunch" that public hospitals are experiencing symptomatic of the "capital crunch" with respect to other public services in their communities?

And how would alternative approaches to health insurance reform or health payment plans and cost containment affect the role of public hospitals?

Let's now turn to our distinguished group of witnesses. The first panel is comprised of a group of health care analysts, including:

Stuart H. Altman, Dean of the Florence Heller Graduate School for Social Policy at Brandeis University, and Chairman of the Prospective Payment Assessment Commission, a commission upon which members of Congress involved in health care administration rely for impartial and objective advice on how to deal with hospitals;

Gerard F. Anderson, Director of the Center for Hospital Finance and Management, Johns Hopkins University;

James L. Scott, President of the American Health Care Systems' Institute; and

Dr. James R. Kimmey, who is Professor of Community Health, and Dean at the St. Louis University School of Public Health, and Professor of Community Medicine at the St. Louis University School of Medicine.

We welcome the members of the panel to the committee and ask that you shoot for perhaps five minutes in your opening statement, and expand on your written testimony, explain it to me as patiently as you can, and we will put your prepared statements in the record in their entirety. We will let Stuart lead off.

STATEMENT OF STUART H. ALTMAN, DEAN, FLORENCE HELLER GRADUATE SCHOOL FOR SOCIAL POLICY, BRANDEIS UNIVERSITY; AND CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Mr. Altman. Thank you, Mr. Chairman.

As usual, it is a pleasure to testify before you. As you indicated and know well, I have had the privilege of serving this Congress as the Chairman of the Prospective Payment System for the last eight years, and during that eight years, and working with our staff and the commission, I have had the opportunity to get a good picture of the current dynamics of the current hospital system.

In my prepared testimony and in my summary this morning, I will make extensive use of the statistics that we generated at ProPAC, but I want to make it very clear to you and your staff and anyone else in the audience that I speak here as a private citizen and not as the Chairman of ProPAC. I haven't cleared this testimony with our staff or even discussed it very much with the other commissioners.

So it is my spin on these numbers. And let me just very briefly summarize what I tried to say in the testimony.

If you take an overarching look at the American hospital system in terms of its financial situation, it looks pretty good. Overall profit margins are up over 4 percent. In the last couple of years they have improved quite significantly. They are significantly higher than they were at any time during the 1970s.

While they are somewhat lower than what they were in 1984 and 1985, when the Federal Government shipped carloads of dollars unexpectedly through PPS to them—we didn't plan on such large payments—it just took time to create the right payments. If you took a look at those overall statistics, you would say, pretty good industry, not doing too badly; maybe, a little too expensive, but they are in pretty good shape for the 21st century.

But I think that would be an unduly rosy picture. I think we need to go below those statistics. It is rather ironic that here we have a situation where hospitals are doing so well; yet, we see a decline in inpatient days of care, as fewer and fewer patients are coming to the hospitals as inpatients, and the ones that do stay a shorter length of time.

In addition, we have a decline in occupancy rates. As you have pointed out several times, for such an expensive resource as a hospital to have at any moment in time of upwards of 35 percent of our beds empty is a situation that doesn't lead to an efficient system.

Also, we have a situation where government, both at the federal and state level, have created fairly tight payment systems, at least relative to what hospitals think—I want to emphasize "think"—their payments should be. That is, if you used an accounting definition, they would argue, and the statistics would support them, that Medicare and Medicaid are not paying their definition of full costs.

And also, as you pointed out in your opening remarks, we have a situation for many of our inner-city and rural hospitals where more and more of their patients come without the ability to pay their bills, leading to rising uncompensated care expensive.

So, if you just look at those statistics, you would say to yourself, how is it possible for the hospital industry, faced with that set of negative forces, to possibly be surviving in this world? And there we have to look to the third set of statistics.

One is that the hospital of 1992 is not at all the hospital of 1982 or 1972. It is increasingly an outpatient care facility. It is increasingly generating its profit margins from outpatient services and relying less and less on its traditional inpatient care as the basis of its financial being.

In addition, since federal and state governments have been unwilling to pay higher rates, hospitals have been charging their private patients significantly higher rates than their costs. In a recent report which ProPAC sent to you, Mr. Chairman, in your other hat as a Subcommittee Chairman of the Ways and Means Committee on Health, we documented that this so-called extra billing has generated an extra cost on American business of $22.5 billion—$22.5 billion!

Finally, we see a situation where, even within Medicare, PPS is redistributing money, taking money away from suburban hospitals and putting it into inner-city teaching hospitals, rural community hospitals and hospitals that treat large numbers of disproportionate share patients.

While some might say that is not correct, I strongly support such redistribution. I think, had PPS not done that, those hospitals that we count on to provide access to our Medicare beneficiaries, our best teaching hospitals, our inner-city disproportionate share hospitals, and our rural sole community hospitals would be in serious shape, because they lack the ability to shift costs and generate high payments from outpatient care. So, this kind of shifting is allowing a rough justice to prevail.

What I am trying to say is that under this rosy picture there is a very complicated and, I think, potentially troubling payments system for American hospitals. You really have to question how much longer outpatient care will continue to grow, or how much longer can hospitals charge higher and higher rates for their outpatient care, when down the street, increasing numbers of clinics and outpatient surgery centers are

charging lower rates because they don't have to overcharge for outpatient services to make up the losses on inpatient care.

As government and managed care systems look for cheaper ways, I think hospitals are going to find it increasingly difficult to charge higher rates for their outpatient care. Also, how much longer can we continue to cross-subsidize in the Medicare program to make up for the shortfalls from uncompensated care?

And finally, how much longer will American businesses put up with paying 40, 50, 60, 70, 80, even 100 percent over cost? I think, at some point, they are going to figure out a way not to do it.

Therefore, I believe that the hospital industry, for its own survival, needs to take a very hard look and begin to bring its cost structure back in line with overall growth in economic conditions.

The issue before the Subcommittee is, how can that happen? You raised the issue of whether we should begin to look formally at the idea of reintroducing some form of certificate-of-need or planning apparatus.

As you know, I served in the Administration in the 1970s and supported such a system. But the Administration and the Congress had, I think, mixed feelings. They were unwilling to tie certificate-of-need to the total reimbursement system. I actually am more sympathetic to a tough reimbursement system than I am to certificate-of-need.

I think that the reimbursement system needs to be an all-payer system. I think all payers need to play so as to put financial pressure on hospitals.

The problem I have with certificate-of-need is not that we don't have competent planners, but that the political process, particularly at the state level, often was not there to back up the planners. When the planners said, close that hospital, those hospitals went right to the source of power in the state, and those planners found themselves without a base and ultimately without a job.

The nice thing about a tough reimbursement policy, it is much more difficult to put your finger on who does it. That is what the market people support and, in fact, there is some truth to it.

REPRESENTATIVE STARK. The AMA never had a problem figuring it out.

MR. ALTMAN. You also can manipulate the reimbursement system, but it is harder.

Finally, I believe we need to get hospital costs under control for the hospitals own sake and also for the sake of our federal budget and the economy. I think the best way to do it is through a tight reimbursement system, and as you know, I strongly favor a mechanism for all payers to be built into an all-payer system and to balance it out, not only across payers but across hospitals.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Altman follows:]

PREPARED STATEMENT OF STUART H. ALTMAN

Good morning Mr.Chairman. It is a pleasure to appear before the Joint Economic Committee to discuss the hospital industry, its current structure and what it might look like in the 21st century. As you know well, Mr. Chairman, I have had the privilege of chairing the Prospective Payment Assessment Commission for the past eight years. In that capacity I have looked closely at the American hospital system and the impact the Medicare PPS system has had on its financial situation. Much of my testimony this morning is derived from information generated by ProPAC. But I wish to make clear to the committee that the analysis of this information is my own and does not necessarily represent the views of ProPAC, its staff, or the Commission.

The Financial Picture of the American Hospital

Americans spent $290 billion for hospital services in 1990, a growth of almost 150 percent in a decade. While this growth rate is substantial, it is actually smaller than the growth rate for overall health care spending. Nevertheless, the average hospital is more financially sound today as measured by the size of its net operating margins. Yet, underneath this rosy picture is a hospital system exposed to much greater financial risk.

During the 1960's and 1970's the hospital increasingly became the center of the American health care system. Just prior to the passage of the Medicare and Medicaid programs in 1965, spending for hospital services equaled about one-third of total national health expenditures. The relative spending rate for hospital services expanded quickly following the enactment of these two national programs, growing to 37.0 percent of the total by 1970 and 41.0 percent by 1980. In the 1980's the importance of the hospital, as measured by its relative contribution to total health care spending fell somewhat, back to what it had been in the early 1970's.

Table 1
Percent of Total Health Expenditures
for Hospital Care

Year	Total Hospital
1965	33%
1970	37%
1975	39%
1980	41%
1985	40%
1989	38%
1990	37%

The fall in relative importance of the hospital within the U.S. health care system would have registered more significantly if the revenue measure was just for inpatient hospital services. In 1980 inpatient revenues accounted for 67 percent of total hospital revenues or 27.5 percent of total health care expenditures. By 1990 inpatient revenues had fallen to 64 percent of hospital revenues which equalled 23.7 percent of total health care expenditures. The relative decline in inpatient care was generated in part by the

decline in hospital admissions which fell 6.6 percent in the 1980-85 period and 7.0 percent in the 1985-1990 period. This decline in the number of admissions occurred despite a 10.0 percent increase in the U.S. population. During the same period outpatient visits rose by 7.3 percent and 30.5 percent respectively. Will this decline continue or have we reached a plateau? Is it possible that we will see a resurgence of inpatient care as the center piece of the U.S. health system?

The answer to these questions relate, in part, to the changing medical technologies and techniques of the U.S. health care system. But it relates equally importantly to the financial factors which shape our health care delivery system. Whereas conventional wisdom of the 1970's and 1980's strongly advocated the shifting of patient care from the inpatient setting to outpatient care as a way-to both reduce costs and improve quality, the consensus view of today is less clear cut. On a procedure by procedure basis the cost of care is clearly lower in an ambulatory setting. The open-ended nature of outpatient care and its easy access by patients, however, gives rise to the use of many more outpatient procedures. For example, whereas the number of inpatient surgical procedures declined by 30 percent between 1979 and 1989, the number of ambulatory surgical procedures rose by 261 percent in the same period. Some of the growth in ambulatory procedures resulted from a shifting in the site of care as for example for hernia repair. Much of it, however, was the addition of new types of services whose growth was accelerated by the ready availability of new capacity and the uncontrolled environment to deliver such services.

The extensive utilization controls for inpatient care set up by government (PRO's) and the private sector (second opinion, pre-admission review) do not exist yet for outpatient services. And there is concern that it will never be possible to develop such techniques to control the utilization of outpatient services to the same extent as inpatient care. That is, as long as outpatient services are paid on a per unit fee-for-service basis. If this is true, then managed organized delivery systems and the government might rethink their emphasis on shifting care to the outpatient sector. In the short-run, however, the trend towards outpatient services will almost certainly continue.

Who Pays the Bill

The decline in relative importance of the hospital in our medical system and the potential for further decline in the years ahead is only one indication of the confusing picture facing today's hospital. The most serious is the complicated situation with respect to who pays the bill for the care provided and who will pay in the future. Although hospital revenue margins were relatively similar in 1980 to what they are today, the underlying structure was quite different.

At the federal level the Medicare program was still using a slight modification of its original cost-based reimbursement system. For most hospitals this meant that the payment for Medicare patients were roughly in line with the costs of treating those patients. For a few very expensive hospitals, the limits imposed by section 223 of the 1971 Medicare amendments restricted Medicare payments to levels below the cost of care. But there were few of these hospitals and the limits were not too strict. This is not to say that hospitals were pleased with the Medicare payment system. Constant haggling over retrospective adjustments in the payment amounts were a source of continual

annoyance to many institutions and the changing interpretations of what an allowable Medicare cost was kept most hospital financial officers quite busy.

At the state level, most Medicaid programs used the Medicare cost-based system as their payment methodology. State payments were therefore somewhat comparable to the costs of treating Medicaid patients. States and cities were also more likely to be subsidizing the care for uninsured welfare patients with payments more in line with the costs of that care. On a negative note, at least with respect to hospital financing, several more states than today operated all-payer rate setting systems which restricted what hospitals could charge for their Medicaid and privately insured patients. Discounts for patients in managed care plans was a rarity. For the most part, private patients either paid full charges (commercial insurance) or some form of cost plus payments (Blue Cross).

All this has changed. First, the number of uninsured has grown from 15 million in the mid 1970's to 36 million in 1990. With respect to the hospital financial picture this growth has translated into uncompensated care expenses growing from $3.0 billion in 1980 to $10.0 billion in 1989. Subsidies from government during that same period for the care of the uninsured grew much less rapidly leaving hospitals with a shortfall in expense over revenues of $8.0 billion.

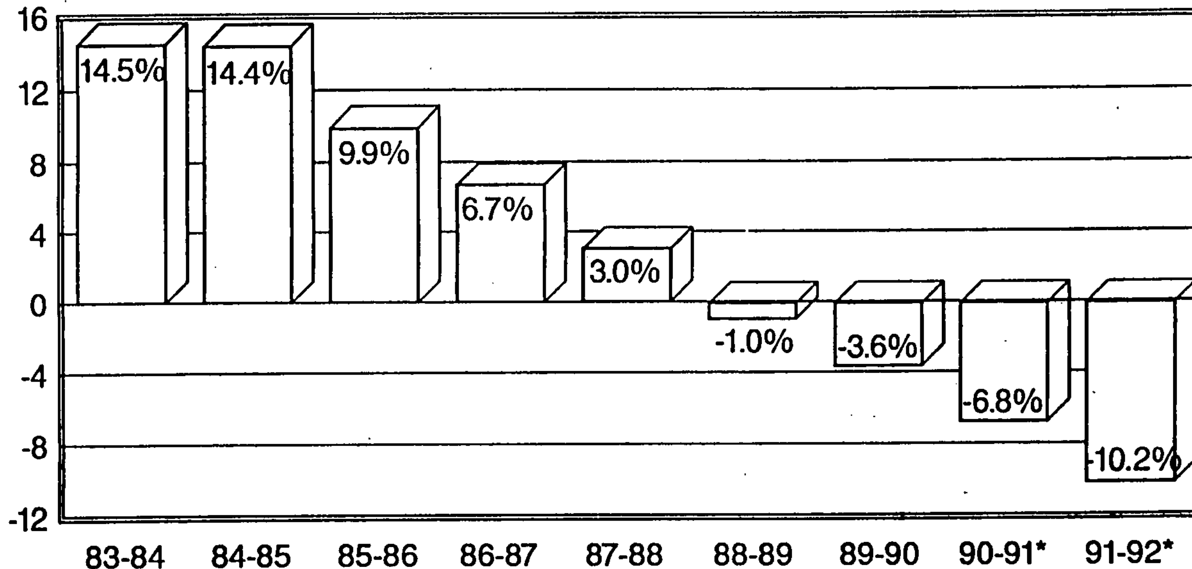
At the state level, Congress passed legislation in 1981 which permitted states to use their own hospital payment system for their Medicaid patients if they wished. Most states have taken advantage of this legislation. One result is a decline in the relationship between Medicaid payments and the estimated cost of that care as defined by the hospital. In 1989, the payment rate of Medicaid averaged 78 percent of the cost of treating such payments. These cost estimates are based on information supplied by hospitals to the American Hospital Association. Some states, on the other hand, contend that their cost estimates suggest that the actual cost of care for Medicaid patients are lower than those indicated by the hospitals and that their state payments are in line with "true" Medicaid costs. Using the AHA cost figures, the Prospective Payment Assessment Commission calculated the percentage of costs paid by the respective state Medicaid programs. The variation was considerable, with Arizona, Maryland and New Jersey paying more than 100 percent of costs, and Oregon and Illinois less than 70 percent. One characteristic of the three top paying states is that all are states which have a state wide payment system which regulates the payment levels for payers of hospital care.

The biggest change in hospital payment system occurred in the federal Medicare program with the passage of the DRG Prospective Payment System. As you know, Mr. Chairman, beginning in 1983, Medicare payments were designed to provide hospitals with a predetermined amount per patient based on the expected complexity of treating that patient. This payment amount was to be the same for all hospitals after a 4 year transition period, except for certain adjustments. The original adjustments were for teaching hospitals and for hospitals in high labor cost areas. In later years adjustments were added for hospitals that treat a relative large proportion of poor patients (Disproportionate Share Adjustment) and sole community rural hospitals. The initial DRG payment rate was designed to be budget neutral with respect to what Medicare would have paid under the old system. During the first two years of that program, however, Medicare payments far exceeded costs (see Chart 1), generating a large surplus for most hospitals. Since then the annual increase of Medicare payments has been less than inflation and substantially less than increases in hospital costs per admission. In 1988

Chart 1

Aggregate PPS Operating Margin
First Nine Years of PPS

Aggregate Margin %



*Margin estimated for PPS 8 & PPS 9.

Source: ProPAC analysis of Medicare Cost Report data, June, 1992.

average Medicare payments dropped below costs and current estimates by ProPAC suggest that the shortfall for 1991-92 was 10.2 percent. From the federal perspective, this shortfall results primarily because of the failure of hospitals to constrain their per admission cost increases which has been growing by 8.0 to 10.0 percent per year. Of course, from the hospital perspective these are their costs and failure to receive sufficient payment by the Medicare program has pushed them to seek higher payment from other patients, mostly those who are privately insured.

These higher charges, by hospitals for their private patients resulted in the average mark-up of charges over costs equalling 48.4 percent in 1989. Again, the mark-up rate varied substantially by state with Maryland and New Jersey having the lowest mark-up and Alabama and Nevada the highest. Because not all private patients pay fully their charges actual payments by private patients averaged 128 percent of costs. These higher payments by private patients generated a net surplus of $22.5 billion, about equal to the 22.4 billion in underpayments as defined by hospitals, for Medicare, Medicaid and the uninsured. As shown in Table 2, although the payment rate is higher for Medicare than Medicaid because of its size, the Medicare shortfall amount is almost double.

This cost shifting to private patients is only part of the story in terms of the change in who now pays the hospital bill. Within the annual Medicare PPS budget of 54.9 billion in FY 1992, about 5.3 billion or almost 10 percent is redistributed from the overall payment total to two classes of hospitals; teaching hospitals and disproportionate share hospitals. In addition significant extra sums are reallocated to rural sole community hospitals. Such redistribution is the result of explicit government policy to pay these hospitals above the normal PPS payment amounts and above the actual cost of treating their Medicare patients.

As indicated previously, when PPS was first implemented, it was determined that teaching hospitals would require a special payment to compensate them f or the extra costs associated with operating education programs. While the direct costs of such programs were relatively easy to estimate, the added indirect expenses on patient care was more difficult. The initial indirect teaching adjustment substantially overshot the mark, helping to generate operating profits for teaching hospitals for Medicare patients in excess of 20 percent. After several downward revisions, the adjustment rate settled at a level which still results in larger payments being sent to teaching hospitals. Much controversy now surrounds just what the right adjustment rate should be. Based on calculations by the Bush Administration these extra payments are still twice as much as should be paid for the extra indirect expenses on patient care of educating future health professionals.

ProPAC disagrees with the administrations low estimate of the teaching adjustment, but also believes that the current adjustment are too high. Nevertheless, ProPAC has urged caution in reducing these extra teaching hospital payments. Whereas, major teaching hospitals generated an operating margin for Medicare patients of 7.8 percent in the seventh year of PPS, when all patient revenues and expenses are included, the margins for major teaching hospitals dropped to 2.0%. In contrast, the reverse picture was true for non-teaching hospitals. They had negative operating margins for Medicare patients, but positive margins for all patients. The difference reflects, in part, the larger proportion of private pay patients and the smaller amount of uncompensated care in the

Table 2

Payments for Hospital Care by Payer Group in 1990

Payer Group	Payment to Cost Ratio	Payment Under or Over Costs (Billions)
Below-cost Payments		
Medicare	89.6%	($8.2)
Medicaid	80.1%	($4.6)
Uncompensated Care	21.0%[1]	($9.6)
Total		($22.4)
Above-cost Payments		
Private Insurers	127.6%	$22.5
Other Govt. Payers	106.4%	$0.2
Total		$22.7

[1]Operating subsidies from state & local govt. included as payments.

Note: Includes all inpatient & outpatient services.

Source: AHA, ProPAC, 1992.

non-teaching institutions. Teaching hospitals are also the institutions more likely to treat our most complicated social issue patients, e.g. AIDs, drug abuse, etc.

The cross subsidization within Medicare does not stop with teaching hospitals. As indicated previously extra PPS payments also exist for disproportionate share hospitals and many rural hospitals. As can be seen in Chart 2, in total they have a substantial impact on the bottom line of the different types of hospitals. As of today, a type of rough justice prevails with respect to the total operating margins of the four classes of hospitals. There are important political forces, however, that are opposed to the continued redirecting of Medicare funds away from other hospitals to pay these higher amounts. Suppose they are successful in stopping or reducing these cross-subsidies? And suppose managed care plans that insure private patients become more successful in forcing hospitals to give them larger discounts? And suppose Medicare and Medicaid continue to restrict their payment increase to amounts below the increase in hospital costs while the number of uninsured patients grow? What will the financial picture of hospitals then look like?

There are those who suggest that the hospital should become the center of the health care delivery system of the future. Others question however, whether the hospital as we know it today will even be needed in the future. They point to the revolution taking place in the biomedical/biotechnical fields which will permit more patients to be treated in an outpatient setting or even at home. While this debate is centered on the technical aspects of patient care, my concern is with the financing of hospitals. Can we be sure that the series of cross subsidies that currently underpin our hospital system will continue in the future?

An additional potential problem facing hospitals are forces which are redirecting the ambulatory patient away from their outpatient centers. Increasingly, Federal and third-party payment policies are introducing financial incentives that encourage the continued growth and diversification of ambulatory care facilities that directly compete with hospitals. Currently, the leading competition with hospitals for providing surgical procedures is thE free standing ambulatory surgical centers (ASC). The number of these ASC's grew from 239 in 1983 to 1,383 in 1990--a growth of 478 percent. The number of procedures provided at ASC's increased by over 500 percent. Future advances in technology will encourage even greater use of ASC's, including less invasive alternatives to surgery, new types of medications and drug therapies that improve recovery time and reduce the risk of infection, as well as advances in anesthesia.

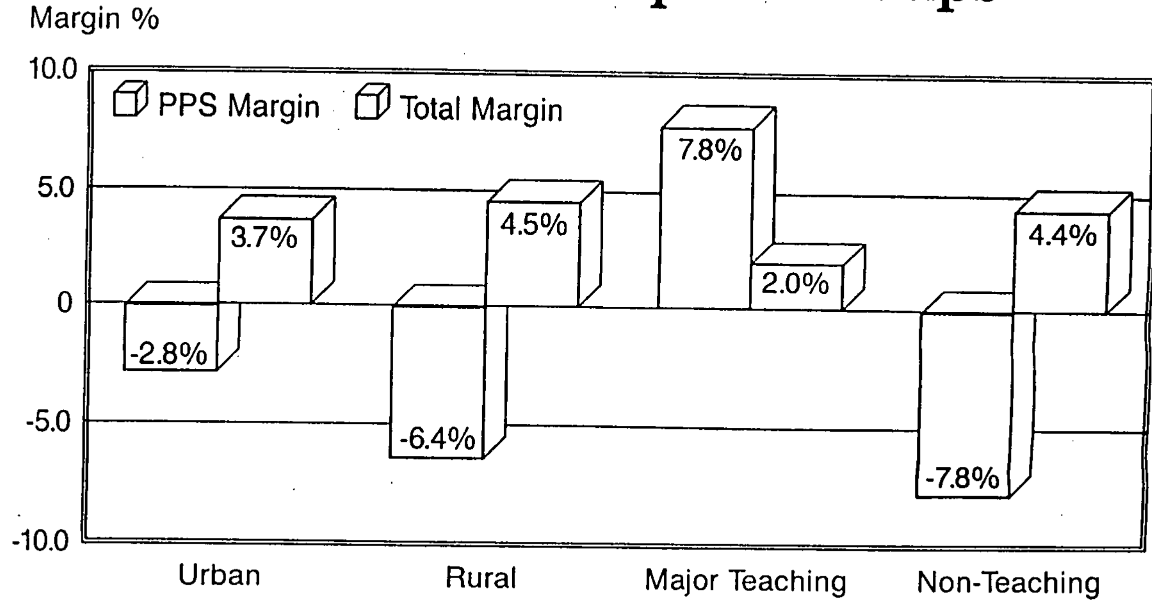
Competition for the hospital outpatient department is also noL coming form the physician's office (clinic) and from new types of diagnostic centers. The growth of these alternative delivery sites has been aided by private third party payers, particularly integrated managed care plans, who are seeking to provide comprehensive range of health care services to their subscribers.

If these trends accelerate will the hospital of the future be able to use its outpatient department as a profit center to counter losses on the inpatient side? If it cannot, how will hospitals cope with declining incomes?

Conclusion

The U.S. hospital system has changed dramatically in the decade of the 1980's. While the number of certified inpatient beds fell by almost 100,000 from the high point

Margins in the Seventh Year of PPS[1] for Selected Hospital Groups



Source: Medicare HCRIS.

[1]Data for PPS7 are preliminary.

in 1983, the occupancy rate for the remaining beds fell as well, reaching a low of 63.5 percent in 1991. Nevertheless, hospitals continue to add personnel and the growth in operating cost per admission grew by 8 to 10 percent per year. In spite of these negative trends, the bottom line of the average hospital is stronger today than in the late 1970's. But as I outlined in my testimony the financial strength of today's hospitals is being supported by substantial cross subsidies that could evaporate. In the end, I believe hospitals will have to ge their costs more in line with other sectors of the economy.

One question the committees asked is whether the negative cost picture would have been different if this country had a certificate-of-need program during the decade. I'm afraid my best answer is maybe. It depends on how committed those in control were to closing hospitals and how much political backing the CON process received. Also an important factor is which hospital would have closed.

The history of the 1970's with CON was not an overvhelming success. While I believe those who operated the CON system tried to do a good job in balancing access with costs, the political process often let them down. Examples are numerous of where the CON professionals recommended that a particular project not be approved and where the political forces in the governors office or state legislature overruled the decision. There are also many examples of where low cost primary care hospitals closed forcing patients to seek such care in much more expensive tertiary care facilities. Whether over the long-run such closings saved money or at least led to higher quality care has never been proven.

As an alternative to recreating a CON system I would recommena that we continue to tighten the reimbursement system for all payers of hospital care. This will force hospitals themselves to deal with their excess capacity. The effectiveness of this strategy depends on private payers joining with government to keep total hospital payments tight. It also depends on constraining reimbursement for outpatient hospital services. Also by paying more for certain types of hospitals which are deemed to be providing needed services for the community, e.g., rural sole community hospitals or urban disproportionate share hospitals, we can use the reimbursement system to both limit the total size of the hospital system and assure the survival of certain types of facilities that would not make it under our current uneven insurance system.

To keep overall financial pressure on hospitals and the total health system I would recommend the establishment of a National Health Care Expenditure Board and a system of regional Health Care Expenditure Boards. Such a system could be set up similar to the Federal Reserve System and be independent of the day-to-day activities of government.

So as to eliminate the cost shifting schemes now in effect, all insurance companies or managed care plans would be required to pay a provider the same amount for the same service. An individual plan could be less costly by choosing lower cost providers of by managing the care used by their enrollees more effectively. They could not use their market power, however, to extract from a provider the same service for less money. This limitation would also apply to government programs. For example, each plan would pay the same rate for the same illness in the same hospital. But, if a plan had their patients stay a shorter time in the hospital or if it consistently used less services or procedures for the same diagnosis, the plan and the hospital could negotiate for a lower rate.

Within each region, negotiating units of providers and payers would be established to determine the basic rate structure for each type of service. The regional Boards would monitor these activities to make sure that the rate structures do not generate expenditures in excess of thelimits.

The National Board would oversee the entire system and determine the total expenditure constraint. The established revenue target should be related to the growth in the nation's income, but I would not create an arbitrary fixed relationship. Instead, I would allow the Board discretion to set the limit consistent with the assessment about the trade-of fs between the growth in health spending and other national priorities. I would also require them to assess what level of expenditure is needed to support a cost effective health care delivery system.

Such a system, I believe would force individual providers and communities to deal effectively with excess capacity. It would also provide incentives for such groups to seek more efficient ways to provide needed health services. By using overall reimbursement policy to control costs, it would be more difficult for individual providers to seek special political favors. Although as you know well, Mr. Chairman, special pleading by individuals or groups is fundamental to any governmental system.

REPRESENTATIVE STARK. We will hear next from Gerald Anderson, who lives in a state where they have an all-payer system, and hospitals have managed to squeak by.

MR. ANDERSON. And I work across the street from a hospital——

REPRESENTATIVE STARK. Called by *U.S. News and World Report* the best. Welcome to the Joint Economic Committee.

STATEMENT OF GERARD F. ANDERSON, DIRECTOR CENTER FOR HOSPITAL FINANCE AND MANAGEMENT, JOHNS HOPKINS UNIVERSITY

MR. ANDERSON. Thank you.

This hearing is about forecasting the 21st Century, and while some people don't do windows, I don't do forecasts. I was trying to figure a new perspective on some of these issues, and what I want to focus on is the role of the courts in determining the future of the hospital industry.

I focus on the role of the courts for two reasons. First, they have an increasingly important role in many of these issues that we are talking about today. And second—and why it is important for the Joint Economic Committee—is that many of these recent court decisions are lowering the technical and allocative efficiency in the hospital industry.

In my written testimony, I present four examples of recent court decisions and how they are affecting the hospital industry, but given the time, I am only going to use one of these examples.

There is a longstanding debate of whether or not closing hospitals and beds is going to increase hospital costs or decrease hospital costs, increase quality of care or decrease quality of care. The courts are very involved in these issues right now.

The FTC and the Justice Department have adopted the standard economic view that you will have more competition when you have more beds and more hospitals ,and competition will drive down cost and——

REPRESENTATIVE STARK. Is that like, if you have more beds, then you and I would go in and have our appendix out because you could get it this week for a thousand dollar rebate?

MR. ANDERSON. Yes. You have a sale.

REPRESENTATIVE STARK. Makes sense to me!

MR. ANDERSON. Johns Hopkins will have a sale on gallbladders this week.

REPRESENTATIVE STARK. What if you don't have one. Could you get a new one? Go ahead.

MR. ANDERSON. The health planners have the opposite position, closing hospitals will reduce the number of beds, which will mean less duplication of services. Finally, they argue that there is no evidence that competition, in fact, lowers costs. In fact, what we were talking about earlier, the whole issue of the supplier-induced demand for more beds implies more activities.

Unfortunately, there is no conclusive study that says that that is absolutely correct. But if you look, as you said earlier, at Minneapolis-St. Paul, and compare the costs of either per day or per discharge in Minneapolis to Baltimore, you see significantly lower costs in Baltimore than in Minneapolis. The competition that exists today is over services, not over price, in most cases.

The association, when we do our econometric studies, between beds per capita and utilization per capita is always positives, even if we control for demographics, more beds, more utilization.

If you look around the world, where is the most competition? It is in the United States. We have the highest cost and most competition.

The courts are being asked to answer right now these questions of whether or not they should encourage hospital mergers. How does that happen? A hospital wants to merge. The FTC or the Justice Department said, "No," you can't merge, and the court ends up deciding about a whole set of complex and technical issues.

REPRESENTATIVE STARK. Does Maryland get a waiver from this? I don't understand the legal system very well, but because Maryland sets rates on a statewide basis, do hospitals that want to merge in Maryland, still have to go through the same Justice Department, FTC reviews?

MR. ANDERSON. The Justice Department could be involved in this, yes. So far, they have not been involved in Maryland, and there have been a number of mergers. Johns Hopkins has acquired a number of hospitals and actually closed a number of them in Maryland, and they did it with no cost to the bondholders.

REPRESENTATIVE STARK. You get a bonus for that, don't you?

MR. ANDERSON. Absolutely. So, it was a good thing in that case, and the hospitals thought it was a good thing as well.

Judges, confronted with all these complex issues, have obviously resulted in different decisions. In Rockford, Illinois, two hospitals wanted to merge and the judge said no. As a result of that, after five years, both hospitals, which couldn't merge, are now in this medical arms race to have more and more equipment.

On the other hand, in Roanoke, Virginia, two hospitals wanted to merge. They would have gotten 73 percent market share. They were, in fact, able to merge, and according to a recent hospital magazine, they are saving $42 million by not entering this arms race.

And the courts are having this major impact beyond simply these individual decisions. If you are a hospital and you think you can merge with another hospital, you are not sure what the Justice Department is going to do, or what the FTC is going to do. So, the number of mergers that might occur diminishes because of a lack of policy.

We have 200,000 beds set up in staff that we don't expect to use on the busiest day of the year. We have 400,000 beds not used on the average day.

REPRESENTATIVE STARK. You have a million beds?

MR. ANDERSON. Yes. That is a big number.

REPRESENTATIVE STARK. The total number of beds is how much?

MR. ANDERSON. We have a million beds; 400,000 are not used on any given day.

REPRESENTATIVE STARK. That is staffed beds?

MR. ANDERSON. Yes. Yet, hospitals are trying to merge; they are trying to consolidate; they are all talking about this; and we have the Justice Department saying, "We are not sure."

We can continue to let the courts set the health policy as they are doing now, but it is my feeling that we will have a lot more inefficiency, and there is not going to be a strong concern over the long-run impact of this; we are just going to have more beds. The courts don't think about the long-run impact. Congress and the Administration can set a policy and say, "We want to have a certain number of beds. Be more proactive. Certificate-of-need is another way to do it."

Another way would be to set a capital cap and say that we want to have $3 billion or $6 billion spent on capital. That gets around the problems we had earlier with certificate-of-need, in the sense that we now have each state with a dollar amount that they can spend on capital however they want to do it.

Thank you very much.

[The prepared statement of Mr. Anderson, along with a paper, follows:]

PREPARED STATEMENT OF GERARD F. ANDERSON

Mr. Chairman, members of the Joint Economic Committee, I am pleased that you have invited me to discuss the future of the hospital industry. My name is Gerard Anderson, Ph.D., and I am Director of The Johns Hopkins Center for Hospital Finance and Management, Co-Director of The Johns Hopkins Program for Medical Technology and Practice Assessment, and an Associate Professor with the Johns Hopkins University, School of Hygiene and Public Health, Department of Health Policy and Management.

Some people do not "do windows" and I do not do forecasts. After watching macroeconomic forecasters, political pundits, and weathermen come and go, I decided there was not much of a future in doing long-term forecasts about the future of the hospital industry or anything else. Instead, I prefer to look for current trends which I believe will impact future behavior.

I was looking at the issues that you are discussing at this hearing and trying to find a common thread. After some thought I realized that Congressional uncertainty regarding these issues and the need to have these issues resolved has created a void which is being filled by the courts.

Today I would like to call your attention to the profound impact the courts are having on the hospital industry and whose influence I expect will continue to grow unless action by the Congress and the Executive branch is forthcoming. Since 1985, the courts have had an increasingly large impact on hospital mergers, the charitable mission of tax exempt hospitals, hospital payment rates, and the scope of services provided by hospitals--the very topics of this hearing.

My reason for focussing on the impact of the courts in a hearing of the Joint Economic Committee is that the court's decisions are having a significant effect of the allocative and technical efficiency of the hospital industry. In general they are reducing overall hospital efficiency.

It is likely that recent court decisions have already discouraged hospital mergers which could have reduced hospital costs in local areas.

Recent court decisions which specify the level of charity care a hospital must provide have an uncertain impact on the magnitude of charity care that is provided. They could encourage hospitals to provide additional charity care or have directly the opposite effect and encourage more hospitals to behave as profit maximizing firms and provide less charity care. Depending on how hospitals respond, the burden on public hospitals could be larger or smaller.

Recent court decisions have forced Medicaid programs to increase their payment rates to hospitals at a time when states are financially pressed to provide essential services. Recent court decisions have increased hospital payment rates by 15 percent in Pennsylvania and 10 percent in Washington.

Recent court decisions have encouraged hospitals to purchase expensive new equipment and use experimental procedures at a time when Congress, the Administration, clinicians, and health services researchers are searching for ways to encourage cost-effective medical care. Court decisions are requiring insurers to pay for "experimental" procedures and other services which public and private insurers believe that the care is still experimental and explicitly excluded in contract or regulations. Given these court decisions on coverage policy, it is not surprising that insurers deny only 1

or 2 percent of all claims at a time when many experts believe that much of the health care that is provided today is unnecessary or inappropriate.

This is not an indictment of the legal system or even specific court decisions. In fact, the courts are doing exactly what they are supposed to be doing, that is, resolving complaints between two parties. The problem is that the courts are not well equipped to resolve complex social and health policy issues. The courts have a number of institutional and procedural limitations which prevent them from considering all aspects of complex policy issues. These include:

- a focus on the concerns of the litigants and not on the broader policy context;
- a lack of technical expertise or experience in health policy;
- an inability of multiple, independent courts to generate a consistent policy position;
- a limited ability to recognize the long-term consequences of their decisions; and
- a procedure for discovering correcting the unintended consequences of the decisions.

These limitations can lead to court decisions which may be the best way to resolve the dispute between two parties, but ignore the long-term implications for the general public, hospitals, and other entities. As a result the courts may introduce technical and allocative inefficiency into the health care system.

Allow me to show how courts increase the level of allocative and technical efficiency in the four areas. Courts are being asked to decide between a policy which encourages hospital mergers to reduce duplication (the traditional HHS and health planning position) and a policy which tries to prevent mergers for antitrust reasons (the FTC and Justice positions). My reading of the literature suggests that hospital competition leads to a proliferation of services and not lower prices. Court decisions on this issue have been inconsistent, hospitals are uncertain as to what the policy is, and merger levels are lower due to this uncertainty.

Courts have tried to fashion a requirement that hospitals must meet in order to retain their tax exemption. I am less sure what the appropriate policy is regarding explicit requirements for tax exempt hospital status. I am sympathetic to the argument that profitable hospitals which provide very little uncompensated care are not deserving of the very valuable tax exemption. My reservation, however, comes from the fact that I do not know how hospitals will respond to an explicit charity care requirement—they could attempt to meet the standard by increasing their charity care or they could decide to behave like a profit maximizing firm and reduce their level of charity care. The courts have not addressed this issue. I know Congress has started to debate this issue, and believe a full debate in Congress is necessary before the courts have established a set of guidelines without careful consideration of the long-term implications of their decisions. This could have a profound impact on public hospitals.

The Congress was not precise when it passed the Boren Amendment in 1981 arguing that Medicaid programs must pay the costs of "economically and efficiently operated facilities". It did not define the term cost and did not give criteria for identifying an "economically and efficiently operated" facility. Subsequent HCFA regulations merely repeated Congressional language. As a result, the courts have become the final arbiter of this language with profound implications for state budgets and hospitals. Congress needs to decide if a payment system which allows Medicaid programs to pay 78 percent of Medicare rates on average is appropriate.

The courts are increasingly confronted with an individual with a life-threatening disease, a physician who believes an experimental procedure is the patient's only hope for survival, and a public or private insurer who has denied coverage for that procedure because the contract (regulation) states that experimental procedures are not covered. Given these circumstances, it is not surprising that courts will do everything possible to force the insurer to pay. While this is obviously in the best interest of the patient and represents a relatively small amount of money for a large insurer (typically less than $100,000), it has profound consequences for medical practice. It gives tremendous discretion to individual physicians at a time when numerous studies suggest that physician discretion explains much of the geographic variation in health care utilization and that many services are inappropriate or unnecessary. It encourages hospitals to expand their acquisition of high cost equipment.

In summary, my concern is that recent court decisions are having a profound effect on hospital behavior. In general, the decisions are lowering hospital productivity, requiring higher payments to hospitals, and encouraging the proliferation of untested new procedures. In addition, the courts could have the effect of concentrating the provision of charity care to a smaller set of hospitals. Congress must become more actively involved in these issues if hospital productivity is going to increase.

I am enclosing a longer paper which provides references for many of these statements.

THE COURTS AND HEALTH POLICY

Critics of judicial involvement in social policy issues such as school desegregation, environmental protection, and prison reform have suggested that the courts may have certain limitations when they become involved in reviewing and/or determining social policy (Horowitz, 1977; Melnick, 1983). This paper examines the growing role of the courts in four health policy areas: (1) review of coverage decisions made by public and private insurers, (2) analysis of the adequacy of Medicaid payment rates for hospitals and nursing homes, (3) assessment of the advantages and disadvantages of hospital mergers, and (4) development of criteria to assess the charitable mission of tax exempt hospitals. The purpose of this review is to determine if the criticisms of the courts with respect to social policy also apply to health policy and to suggest alternatives to judicial resolution of specific health issues.

The paper is organized as follows: first, a review of the concerns about court directed social policy; second, a brief synopsis of the four health policy issues and a review of how the court decisions are affecting the actions of payors, providers, and patients; third, a discussion of whatever the criticisms of the courts with respect to social policy also apply to health policy and finally, the development of specific alternatives to court directed health policy.

General Concerns About Court Involvement in Social Policy

Courts become involved in social policy issues once a complaint is filed. With few exceptions, the courts have not solicited cases in order to become involved in the policy making process. Nevertheless, the courts have become involved in some of the major social policy debates of the past thirty years.

Proponents of judicial involvement in social policy issues have suggested a number of positive outcomes of court decisions including: the promotion of minority rights, the promotion of more humane conditions in institutions such as prisons and mental institutions, certain restrictions on bureaucratic arbitrariness, and more generally, the promotion of positive social change (Kagan, 1991). Others have been more critical of judicial involvement in social policy. These critics are not suggesting that the courts should not have any role in the policy making process, instead, they are suggesting that the public and policymakers should recognize the limitations of the courts when the courts become involved in social policy issues.

One concern is that many judges do not have the appropriate educational background or experience to critically evaluate the technical information necessary to resolve complex social policy issues, especially in a court room setting where technical information may be difficult to present (Fuller, 1978; Moynihan, 1979). Unlike the legislative or executive branches where policymakers may have the opportunity to develop an expertise in a substantive area over a period of years, judges usually have to be educated at the beginning of each trial concerning the basic facts and the specific policies surrounding a particular issue. Critics of the judicial process have also noted that much of the information is filtered by the litigation process and that relevant information can be stifled by the adversarial system if one side is able to withhold or successfully prevent the introduction of relevant data (Horowitz, 1977). In addition, there is concern that courts are more likely to rely on theoretical arguments offered by

academic experts than by practitioners who are more likely to know the limitations of social science theory (Glazer, 1978).

The decentralized nature of the judicial system is a second source of concern since court autonomy not only hinders the formulation of coordinated policies, it also can lead to inconsistent treatment of similar cases. This can cause confusion among interested parties trying to determine what behavior the courts will accept, especially if apparently similar cases have been decided differently by independent courts. A related concern is that the court system is essentially a reactive system. Often, the first case involving a particular issue is an atypical case, or at a minimum, there is some randomness involving which case is decided first. However, the first case can play a significant role in the overall judicial policy making process, because of the court's reliance on precedent to justify decisions (Melnick, 1983).

A third area of concern is the narrow focus of the court's review. Typically, cases are initiated by one party, the scope of the issues under review is controlled by one or both of the litigants and the decision focuses on the specifics of the particular case (Chaynes, 1976). As a result, issues of concern to society generally, but not to specific litigants, may be given less weight.

It has been suggested that cases that involve "polycentric" issues are especially difficult for courts to resolve (Fuller, 1978). These disputes involve multifarious, interrelated issues that could lead to several different, but equally valid, solutions. The problem with judicial decisionmaking in these areas is that once the court establishes that a particular litigant has a right, it becomes difficult for the court to make tradeoffs (Liberman, 1981). However, many of these "polycentric" cases involve complex social policy issues where a compromise outcome may be preferable from society's perspective. However, since the courts must select winners and losers, it is unlikely that a compromise solution will likely evolve from a court decision. In addition, once a court has ruled it becomes more difficult for other branches of government to act since "winners and losers" are established by the courts.

Another concern is that judges, when confronted with two litigants in a specific case, do not have the responsibility, and may not have the ability, to determine the long-term consequences of their decisions (Horowitz, 1977; Fuller, 1978; Melnick, 1983; Easton, 1983). Court proceedings focus on retrospective conflict resolution' and not policies for the future. Also, the judicial process may isolate the judges from the broader public policy issues, limiting their ability to realize how their decisions will affect or be affected by the broader social milieu. Alternatively, the long run impact on the decision may not be relevant to the specific case. For example, without the requirement that judges or juries consider the budgetary implications of their decisions, the courts do not have to make the same financial tradeoffs that the legislative and executive branches must make in developing social policy (Fuller, 1978).

A final concern is that judges do not always have the tools to discover unintended consequences of their decisions and to modify their decisions. They do not, for example, have an established mechanism to monitor the long run effect of their decisions. Instead, they must rely on appeals or additional cases to make revisions to earlier decisions. In addition, they do not have access to the traditional "carrots and sticks" favored by economists to influence behavior--taxation, grants, or subsidies. Rulings that require additional government funding, such as school desegregation orders, have been

especially difficult for the courts to implement since they can require the expenditure of additional resources which could require the imposition of a tax increase (Schapiro, 1989).

Courts and Health Policy

It is not surprising to discover that many of the concerns expressed about the court's involvement in social policy seem to apply equally well to health policy. The purpose of this section is to illustrate how health policy is being made by the courts, the factors the courts appear to consider in reaching their decisions, and how specific constraints of the judicial process affect their decisions. The purpose of this review is not to criticize specific rulings or to suggest alternative policies, but instead, to illustrate the growing role of the court in health policy decisions.

Coverage Policy

The courts have been reviewing the coverage decisions of public and private insurers since the mid-1960s, however, the level of activity has accelerated in recent years as insurers have become more aggressive in denying claims for treatments which they believe are medically unnecessary, experimental, or are outside the scope of the covered services (Curran, Hall and Kaye, 1990). Initially, public and private insurers paid for all services that were ordered by a licensed physician. However, after a spate of cases in the 1960s where it was generally clear that there was no medical reason for hospitalization, public and private insurers revised their coverage policies by inserting an explicit requirement that services must be "medically necessary" in order to be reimbursed (Hall and Anderson, 1992). As public and private insurers started denying claims based on this criterion, the courts frequently disagreed with the insurer's interpretation of medical necessity.

Judges have typically viewed their role as the neutral arbitrator between the insurer who does not want to pay for a particular service, the provider who wants to be paid, and the patient who wants a particular service (Hall and Anderson, 1992). In order to render a decision, the judge must educate him or herself about the clinical aspects of a specific medical procedure in order to decide which set of clinical experts is correct. This is an example of where the judge may not have the technical background to completely understand the clinical information which is presented, and the adversarial nature of the court proceeding may stifle the educational process. In many cases involving the application of "medical necessity" provisions, the courts decided in favor of the physician who was treating the patient and against the public or private insurer who relied on government reports and scientific studies which challenge the value of a treatment (Hall and Anderson, 1992). For example, court's order an insurer to pay for laetrile delivered in a Bahamian clinic after the Food and Drug Administration made it illegal to ship laetrile across state lines (Shumake v Travelers, 1983). Other courts have ordered insurers to pay for "immuno-augmentative" cancer treatment provided by a Mexican facility in spite of the fact that the treatment had not been approved by the FDA and was generally discredited by the medical community at the time (Taulbee v Travelers, 1987; Dallis v Aetna, 1985; McLaughlin v Connecticut General, 1983).

In response to these and other rulings, private insurers revised the contractual language in their policies to expressly exclude coverage for experimental treatments, and specified in their contracts that the insurer is the final arbiter for coverage decisions. In spite of these contract modifications, insurers have continued to lose in some courts

(Anderson and Hall, 1992). The most recent well publicized litigation over coverage policy involves the use of autologous bone marrow transplantation to facilitate use of high dose chemotherapy for metatastic breast cancer. Many courts have ignored the fact that several institutional review boards and the National Institutes for Health (NIH) have found the evidence regarding this technique to be sufficiently tenuous to allow randomized clinical trials (Newcomer, 1990; Supple, 1990; Doza v Crum and Forster Insurance Company, 1989; Pirozzi v. Blue Cross and Blue Shield of Virginia, 1990; Cole v Blue Cross and Blue Shield of Mass, 1990). These courts have not accepted the technology assessments performed by Blue Cross and commercial insurers, and have ordered the insurer to pay for the service even though the contracts explicitly deny coverage for experimental procedures. In the most extreme case, a court ordered an insurer to pay for an autologous bone marrow transplant for an AIDS patient, even though the treating physician was the only physician in the country at the time using that therapy and the patient had signed a clinical investigation consent form that emphasized the research aspects of the procedure (Bradley v Empire Blue Cross and Blue Shield, 1990). Other courts, confronted with similar evidence, have ruled in favor of the insurer (Hall and Anderson, 1992). A careful reading of these cases suggests the courts have not given consistent guidance to insurers with respect to what constitutes "experimental" treatment.

These cases also illustrate the difficulties that courts have in making tradeoffs in reaching decisions. For example, it would be difficult for the court to decide in favor of the patient who wants experimental treatment, but then to decide to have the insurer pay only the cost of the conventional alternative. This, however, may be closer to the socially optimal solution since the individual would receive care and society would not have to pay the full cost for still unproven medical procedures.

The reasons given by the courts in reaching their judgments demonstrate their focus on the specifics of the case and not on what may benefit society in general. For example, some courts have been concerned that when the insurer employs retrospective utilization review, the patient already had relied on his or her physician's advice in undergoing the service and incurred a bill for that care. When insurers responded to this concern and developed pre-service certification programs, however, other courts become even more concerned. In one ruling, for example, the court argued that a "mistaken conclusion about medical necessity following retrospective review will result in the wrongful withholding of payment. An erroneous decision in a prospective review process, on the other hand, in practical consequences, results in the withholding of necessary care, potentially leading to a patient's permanent disability or death" (Wickline v State of California, 1987).

These types of cases demonstrate the court's focus on the individual case and not on the broader social or economic context. From the perspective of the individual patient with a serious, potentially life-threatening illness, the provision of any medical services that could potentially provide a benefit, no matter how small or at what cost, is worthwhile. However, from the perspective of generally healthy individuals who want to purchase an insurance policy, the perspective of do everything possible and ignore the expense may not represent their preferences when they purchase the insurance policy. There could be a market for policies which exclude specific types of treatments, for example, those treatments where the technology has not been

demonstrated to be safe and efficacious. Similarly, when Congress and the Administration make a coverage decision for the Medicare program based upon available clinical data and cost considerations, they supposedly are making the decision in the public's interest. In the present context, the relevant question is whether a cross section of generally healthy individuals would be willing to pay their share of the cost of particular treatments so that, in the unlikely event that one of them were to need that treatment, it would be a covered service. Instead, the courts' have frequently viewed the case from the perspective of the patient with an acute illness who has been denied coverage.

This perspective of the courts may be partially responsible for lack of aggressive behavior on the part of public and private insurers in reviewing medical practices. The actions of the courts may be a partial explanation for the fact that public and private insurers typically deny only 1 or 2 percent of all claims received (Pepper Commission, 1990) in spite of increased pressures by employers to control costs and published studies which suggest that a significant proportion of medical care is inappropriate (Park, et al 1989; Pepper Commission, 1990). Given that it is virtually impossible to demonstrate with certainty that a medical service will have no possible benefit and given the perspective of the court, the relatively few denials by insurers may be rational behavior from their perspective.

Medicaid Payment Policy

Courts have been asked to decide both policy-related procedural and technical issues in order to resolve recent litigation involving the adequacy of hospital and nursing home payment rates by the Medicaid program. In the early 1980s, Congress passed legislation allowing Medicaid programs the flexibility to stop using Medicare cost based reimbursement principles to pay nursing homes (in 1980) and hospitals (in 1981). The legislation, commonly known as the Boren Amendment, requires the Medicaid program to set rates for hospitals which are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to ... assure... reasonable access ... to inpatient services of adequate quality" (42 U.S.C. 1396A (a)(13)(A)). The statute also requires the Secretary of HHS to review the state's finding that the rates are adequate.

States responded quickly to the flexibility of the Boren Amendment and, by 1991, 47 states has instituted some form of prospective payment for Medicaid reimbursement to hospitals (ProPAC, 1991). Litigation over the meaning of the terms of the Boren Amendment and the adequacy of the Medicaid payment rates started almost as soon as the states instituted prospective payment systems which gave certain providers less than their full allowable costs (ProPAC, 1991, Anderson and Hall, 1992). As of July 1991, Medicaid programs in 12 states had been sued over the adequacy of hospital payment rates (ProPAC, 1991), and more suits are contemplated (Stout, 1991). Nursing homes have been involved in similar amounts of Medicaid reimbursement litigation.

In Wilder v Virginia Hospital Association, the Commonwealth of Virginia defended its hospital payment rates by arguing in front of the U.S. Supreme Court that Medicaid beneficiaries, and not hospitals, were the intended beneficiaries of the Medicaid program and, unless the Medicaid patients were actually harmed by the payment rate through reduced access or lower quality care, there was no cause of action.

A 5 to 4 majority of the Supreme Court disagreed, ruling that "there can be little doubt that health care providers are the intended beneficiaries of the Boren Amendment."

The Wilder v Virginia Hospital Association decision raised a second issue--how much discretion to afford a government agency in determining the adequacy of payment rates under the Boren Amendment. The Commonwealth of Virginia argued that the Boren Amendment gives a state flexibility to adopt any rates it finds are reasonable and adequate and are accepted by the Secretary of the Department of Health and Human Services. A 5 to 4 of the Supreme Court rejected this argument finding that while the states have considerable discretion, there is still a role for the courts to review the adequacy of the payment rates. In their dissent, however, four of the justices argued that the scope of judicial review should be narrow. Writing for the majority, Chief Justice Rehnquist noted that "providers ... will inevitably seek the substitution of a rate system preferred by the provider for a rate system chosen by the State" (Wilder v Virginia Hospital Association, 1990). When the court decides in favor of the provider, Chief Justice Rehnquist argued that states will be required "to adopt reimbursement rate systems different from those Congress expressly required them to adopt" (Wilder v. Virginia Hospital Association, 1990). Later in his dissent, Chief Justice Rehnquist argued that the major issues are whether the states can be trusted to determine if the rates meet the requirements of the Boren Amendment and whether the Secretary's review of the State's payment rates has any meaning without judicial oversight.

In this case, the Supreme Court also discussed the issue of the technical competence of the courts to decide complex rate setting issues. Justice Brennan, writing for the majority, believed that it is obvious when a State has set unreasonable rates and "Although some knowledge of the hospital industry might be required to evaluate a state's findings with respect to the reasonableness of its rates, such an inquiry is well within the competence of the judiciary" (Wilder v Virginia Hospital Association, 1990).

Reviews of recent Boren Amendment cases illustrate the complexity of the policy issues which the courts must decide in order to determine if the rates are adequate (ProPAC, 1991; Anderson and Hall, 1992; Harris, 1991). Some of the specific policy issues that have been litigated in Boren Amendment cases include:

- whether the need to balance the state's budget can be a factor in determining payment rates;
- what is an appropriate rate of increase in the payment rate and what factors need to be considered in establishing the update factor;
- what factors can be used to form hospital peer groups and how many peer groups are appropriate;
- whether or not Congress meant average or marginal costs when it required states to pay the costs which must be incurred;
- what percentage of hospitals are economically and efficiently operated in a state;
- whether or not the level of payment for capital, clinical education, and disproportionate share is a policy decisionthat the state can make.

As anyone familiar with the difficulty of setting payment rates can attest, these are extremely controversial issues and not easily resolved in the highly adversarial situation that exists in a courtroom by judges with limited familiarity with these policy issues. It is not surprising that when "the courts have scrutinized components of

Medicaid payment methodologies in detail [T)their final verdicts have been inconsistent (ProPAC, 1991)

Although early court decisions were generally in favor of the states as the courts deferred to the expertise of state agencies, increasingly providers have begun to prevail in more cases (Anderson and Hall, 1992). One of the primary reasons for the change was a U.S. Appeals Court ruling which created a standard which subsequent judges have used to determine if the payment rates are adequate. In AMISUB (PSL). Inc. v State of Colorado Department of Social Services, the court was not satisfied with Colorado's assurances that the rates were adequate and mandated that a "... Medicaid agency,' at a minimum [is] to make 'findings' which identify and determine (1) efficiently and economically operated facilities; (2) the costs that must be incurred by such hospitals; and (3) payment rates which are reasonable and adequate to meet the reasonable costs of the State's efficiently and economically operated hospitals" (ASISUB (PSL) Inc v State of Colorado Department of Social Services 1988. In effect, the court imposed new criteria which states must meet in order to be accepted by the courts even if findings that the rates are adequate have been made by the states and accepted by the Secretary of Health and Human Services. Subsequent courts have applied this standard in their review of Medicaid rates (Anderson and Hall, 1992).

Payment policy litigation has significant implications for Medicaid programs and providers. Both sides are affected by the cost of litigation (which can be several million dollars) as well as by restrictions placed on the policy making process during litigation when direct communication between the two parties is restricted. In cases where states have lost, the states have been ordered to alter their payment formulas and to make substantially higher payments to providers. For example, the court ordered hospital payment rates increased by 14.5 percent in Pennsylvania (ProPAC, 1991) and by 9 percent in Washington State (ASA News, 1991). Given the budgetary situation in most states, the court decisions ordering higher payment rates have forced governors and state legislatures to make difficult tradeoffs between eligibility and coverage reductions in the Medicaid program, reductions in other governmental programs, and new taxes.

Hospital Mergers

In 1975, the U.S. Supreme Court decided that learned professions were not exempt from antitrust law. Since that decision, the Federal Trade Commission and the Department of Justice have been investigating the anti-competitive actions of physicians, hospitals, and other health care providers (Havighurst, 1990). Much of the recent focus has involved review of hospital mergers. At the same time, working from a different policy perspective, the Department of Health and Human Services and many state health planning agencies have encouraged hospitals to merge in order to achieve economies of scale and to prevent the proliferation of new technologies. The debate has turned to the courts for resolutions.

Recently, two different courts have examined mergers of non-profit hospitals and have reached contradictory decisions in two cases with essentially the same facts (Anderson, 1991; Burke, 1990). In these two cases, the Department of Justice challenged the mergers of non-profit hospitals in Rockford, Illinois and Roanoke, Virginia. According to the Department of Justice, the mergers would have created a single institution which would have owned 73 percent of the licensed acute care beds in the

Roanoke Valley and 72 percent in Rockford (Holthaus, 1988). Following lengthy litigation, the courts permitted the merger of Roanoke hospitals but denied the Rockford merger. Since the court ruling, it has been reported that the hospitals in Roanoke have begun the merger process and are expected to save $42 million over a 5-year period while the hospitals in Rockford are continuing the "medical arms race" of purchasing duplicate equipment (Anderson, 1991).

During the court proceedings, a number of technical economic and policy issues were raised, (Kopit and McCann, 1988; Blackstone and Fuhr, 1989; Werden, 1989), including how to:

- Measure the hospital product - whether it is one service or a cluster of services.
- Define the geographic dimensions of a hospital market area.
- Measure hospital capacity - the possible measurement units include beds, discharges, patient days, patient days weighted by source of payment, and hospital revenue.
- Determine the effect of hospital mergers and market concentration on hospital prices.
- Evaluate the economics of scale and scope from consolidating clinical and administrative functions.

These are complex technical and policy issues that have not been resolved empirically. It is not surprising that the court decisions were inconsistent.

In court reviews of hospital mergers, the technical issues usually overshadow the fundamental policy issue of whether hospital mergers should be encouraged or prevented. This is related to the more fundamental debate over whether competition or regulation is the appropriate public policy. Health planners have generally encouraged hospital mergers as a means to eliminate duplicative services and to generate economics of scale and scope. Antitrust activities, on the other hand, are more concerned with the effect of market concentration on prices. In the absence of any consensus among policy makers on this issue; courts have become the arbitrator of this debate through their review of hospital mergers.

Charitable Obligations of Non-Profit Hospitals

From 1969, when the Internal Revenue Service established the "community benefits standard", to the mid 1980s, it was relatively easy for non-profit hospitals to maintain their tax exempt status. The community benefit standard, promulgated by the Internal Revenue Service, provides federal tax exempt status to organizations "operated for religious, charitable, scientific, testing for public safety, or educational purposes." Because the standard does not expressly mention hospitals, the presumption has been that hospitals qualify under the term charitable (Fox and Schaffer, 1991). In recent years, Congress has reviewed the IRS ruling and has conducted hearings on specific legislation to make the criteria for tax exempt hospitals more explicit without taking any action. In 1976, the U.S. Supreme Court decided that there could be no federal judicial review of the IRS ruling in response to a suit brought by members of the Eastern Kentucky Welfare Rights Organization who claimed that they were denied care by a tax exempt hospital and therefore the hospital was not meeting its charitable deduction (Fox and Schaffer, 1991).

The courts, however, are the primary actors in state and local debates over the charitable obligation of hospitals that claim exemption from state and local taxes. Recently, state and local officials have questioned whether the level of the societal

contributions made by non-profit hospitals fulfilled their charitable obligations and have attempted to levy state and local taxes on them. Hospitals have developed multiple arguments to defend their tax exempt status. As a result, the issue of what is the minimum level of service a non-profit hospital must provide in order to maintain its tax exempt status has ended up in state and local courts.

The Utah Supreme Court was the first court to attempt to establish a set of explicit criteria that non-profit hospitals must meet in order to maintain their tax exempt status (O'Donnell and Taylor, 1990). Subsequent court decisions in Tennessee, Vermont, and Pennsylvania also attempted to define the requirements for tax exemption. In Tennessee and Vermont, the courts have ruled that in order to retain their tax exempt status, hospitals must admit everyone regardless of their ability to pay (O'Donnell and Taylor, 1990). In Utah and Pennsylvania, the tests were more comprehensive. Utah hospitals, for example, are subject to a six-factor test of their non-profit status. The Utah test includes the requirement that care is available to all regardless of an ability to pay, but includes additional requirements that require comparisons of the value of the property tax exemption and the value of the charitable services provided. In Pennsylvania, the courts have been inconsistent, some courts have imposed the Vermont criteria, while other courts have imposed the Utah standard. As a result, hospitals do not know what specific standard will apply to them.

A key technical issue in specific cases where the value of charitable services must be quantified is the definition and measurement of charitable services. Definitions of charitable services generally include charity care; however, the inclusion of bad debt, payment less than costs for Medicaid patients, unsponsored research, unsponsored clinical education, the provision of health and non-health related services to the community, and many other factors is more debatable (Lewin and Eckles and __, 1988). Because the hospital and policy communities have not reached a consensus on which of these services are indeed charitable services, the courts are being forced to decide this issue in order to render a decision.

The long run response of hospitals to this requirement and therefore the impact on the provision of charitable services is unknown and generally not a part of the litigation. Non-profit hospitals could increase their level of charitable services to maintain their tax exempt status, remain not-profit but not tax-exempt, or they could become for-profit. As a result the aggregate level of charity care could increase, decrease, or remain the same. Even more difficult to anticipate is the long run impact on the overall system of hospital care which is based primarily on locally governed, community based institutions (O'Donnell and Taylor, 1990).

Role of the Courts

It is not surprising that many of the concerns expressed about court directed social policy are also applicable to health policy issues. Judges have needed to develop considerable technical expertise in order to render judgments on specific health policy issues. As noted earlier, judges have rendered judgments about the appropriateness of specific medical procedures and specifics about hospitals and nursing home payment formulas. They have needed to define hospital market areas, assess the impact of competition on health care prices, and define charitable services in order to render verdicts. It is unclear how successful the courts have been in processing the information which is presented or how well the information is presented in a court room setting.

The structure of the judicial system has made it difficult for the judicial system to develop a consistent health policy. For example, individual courts have rendered contradictory decisions in all four policy areas. Courts have decided for and against insurers involving the use of autologous bone marrow transplants for metastatic breast cancer (Doza v Crum and Forster Inc., 1989; Bradley v Empire Blue Cross and Blue Shield, 1990; Pirozzi v Blue Cross and Blue Shield of Virginia, 1990; Reiff v Blue Cross and Blue Shield of Oklahoma, 1991; Thomas v Blue Cross and Blue Shield of Massachusetts, 1990; Stewart v Hewlett Packard, 1990; Cole v Blue Cross and Blue Shield of Massachusetts, 1990; Adams v Blue Cross and Blue Shield of Maryland, 1991; Whittington v Blue Cross and Blue Shield of Maryland, 1991; Bucci v Blue Cross and Blue Shield of Connecticut, 1991), for and against states regarding specific provisions of the Medicaid payment system ProPAC, 1991; Anderson and Hall, 1992), for and against hospitals located in areas with similar market structures who were trying to merge (Holthous, 1988), and for and against hospitals with similar mission statements and levels of community service. This has made it difficult for providers, patients, and payors to anticipate the court's ruling in a particular case or to determine what behavior the courts will find acceptable.

A review of the courts involvement in these four areas suggests that primary purview of the courts involves the specific litigants. This focus, although appropriate for many judicial cases, may not be well suited to the development of policies involving complex health care issues where the long run implications of the court's decisions are difficult to anticipate. The coverage decisions are focussed on the situation of the individual patient, and not on the overall objective of paying for appropriate, cost effective, or cost beneficial medical care. The Medicaid payment issues have focussed on the needs of the specific providers and not on the opportunity costs associated with alternative uses of these dollars. The antitrust decisions have not examined the broader issue of whether society should be promoting or discouraging hospital mergers. The cases involving the responsibilities of tax exempt hospitals have not focussed on the long run responses of hospitals to an explicit standard or the implications of having fewer community based hospitals.

Before discussing alternative means of dispute resolution, it must be noted that courts have the ability to overcome some of the limitations. Judges can address their technical deficiencies by asking questions during hearings, appointing special masters and reviewing amicus briefs (Baum, 1986; Katzman, 1980). They can monitor and affect responses to their orders though structural injunctions, supplemental decrees, special masters, and lay committees (Katzman, 1980; Easton, 1983; Schapiro, 1989). In addition, unlike the political process or market place, the courts can rely on reasoning and not polls, majority votes, rule of expediency, or claims of right in reaching their decisions (Calabresi, 1982).

Alternatives to Court Directed Policy

Students of conflict resolution have proposed several alternatives to litigation for social policy resolution (Resnick, 1982; Sander, 1985; Kagan, 1991). The alternatives include negotiation, binding arbitration, legislative action, reliance on expert judgment, informal discussions, administrative courts, contract revision, and more generally, a restructuring of the decision making process. It is not surprising that the

selection of a specific alternative to resolve a particular dispute will depend on the specific policy issue.

Contract revision and restructuring of the decision making process could help resolve coverage disputes. One proposal is for public and private insurers to explicitly state what treatments they wish to cover, develop standards to determine under what circumstances other treatments would be covered, establish one or more entities to make prospective and case specific judgments about whether the standards are being met, and include a provision that mandates that the process is binding on all parties (Hall and Anderson, 1992). This process would remove some of the ambiguity in the current coverage process and it is possible that more specificity would constrain the scope of the court's inquiry.

Reducing litigation over the appropriate Medicaid payment rate to hospitals may require legislative or regulatory clarification of the language in the Boren Amendment or possibly a complete revision of the legislation (Anderson and Hall, 1992). For example, Congress may explore the option of mandating an all-payor system or a single-rate system for all public programs. Alternatively, Congress could consider whether actual costs should be a standard for determining appropriate payment rates. It has been suggested that the regulation be revised to include more specificity (ProPAC, 1991).

Policies regarding hospital mergers and the charitable responsibilities of tax exempt hospitals may require legislative or executive branch action. More research and policy discussion regarding the benefits and liabilities of hospital mergers is probably necessary. There is Congressional activity on the non- profit status of hospitals. This legislation, if passed, would provide an explicit standard for determining tax exemption and could establish a standard that states and local municipalities could use.

Conclusion

Because of the difficulty in making decisions about certain health policy issues, resolving many of these issues has become the responsibility of the courts. This paper has described some of the inadequacies of this solution and has suggested that it may be necessary to consider alternative means to resolve these policy issues over the long term. It is important for executive and legislative branches of government to act quickly since allowing the courts to direct health policy will make it more difficult to intervene if the court already has established winners and losers. In the four examples cited, it is possible for the executive and legislative branches to reverse or modify the court rulings by changing statues or regulations if they do not agree with the court's decision. However, once society has become accustomed to the decision, it becomes more difficult to take action. Finally, "excessive reliance on the courts instead of self government through democratic process may deaden a people's sense of moral and political responsibility for their own future" (Cox, 1976).

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REPRESENTATIVE STARK. We will come back to this.
Mr. Scott, please proceed.

STATEMENT OF JAMES L. SCOTT, PRESIDENT AMERICAN HEALTH CARE SYSTEMS' INSTITUTE

MR. SCOTT. Thank you, Mr. Chairman.

In my oral remarks, I want to devote attention to three of the very specific questions that you outlined in your letter of invitation. In the first one you asked, should there be more coordination between regional centers and rural hospitals? There is no doubt that we need to develop this kind of coordination.

In May of 1971, when I started my first job in this industry as a hospital administrator, I worked for a company that operated 20 small rural hospitals with four or five circuit riding administrators. This was in far Northwest Kansas. At that time, we had a very aggressive program for sharing services between our hospitals and, what to us, were the large regional hospitals in the state.

Now, compared to what you will hear from the second panel, these were still very small hospitals, but the bottom line is that this was 20-some years ago. We had very aggressive programs of coordination at that time.

Some of that was due to the kind of unusual leadership that we had in Curt Erickson, the executive director of Great Plains Lutheran Hospitals. But, in reality, we weren't that much different from many of the rural hospitals in Kansas and Nebraska and Colorado.

The range of health services has increased dramatically in the last two decades. For example, in Des Moines right now there are over 50 distinct outreach programs offered to 120 rural communities. One of the most interesting of those is their remote fetal heart telemetry program. In 21 rural hospitals, expectant mothers are hooked up to machines and their babies' heart rates are read in Des Moines. This is a program that has enabled both the urban and rural hospitals to address one of the most significant barriers to cooperation, and that is the fear of the rural communities that they are going to lose the patients.

At the beginning of the program, many——

REPRESENTATIVE STARK. You mean lose them to another hospital?

MR. SCOTT. Transferred, yes.

REPRESENTATIVE STARK. Not croak.

MR. SCOTT. Yes, not croak, that the patients would be transferred too early.

This was a concern that the hospital administrators in rural Iowa had, but the reality is that just exactly the opposite has happened. The improved fetal monitoring has enabled more mothers to stay and deliver in rural communities than what they had expected.

Does this mean that we have achieved an optimum level of cooperation? Of course not. But it is clear to me that significant progress is being made on this very important question in local settings across the country.

I think we need to recast the question and ask another question, and that is, in the future, what role will the hospital play in integrated health-care delivery organizations?

Now, some believe that the actual delivery of care in the sometime not-too-distant future is going to be coordinated by these organizations, that there is much less agreement among the people talking about it as to what these things would be called or what the structure of it might be. I myself don't know. But I do know that as we move more in this coordinated care direction that we are going to see some dramatic departures from existing delivery approaches. Hospital executives, physicians, and other members of the health-care team are going to have to learn new roles and adjust to new responsibilities and relationships.

The honest answer to your second question regarding the future mix of inpatient-outpatient care, it depends. The primary determinant in my mind would be new technological developments.

The tremendous increase in outpatients services has not just been driven by incentives from payment reform. Specific new technologies have arisen that allow services previously provided on an inpatient basis to be delivered on an outpatient basis, such as DRG-6—the carpal tunnel release—which had drops of inpatient numbers of 89 to 90 percent. I think we are far from reaching the end of such developments.

The technological advances will continue the movement toward shorter length of stays, and by 1995, endoscopic surgery could account for a significant portion of high volume surgeries, including 90 percent of the gallbladder operations.

A friend of mine, who is a hospital administrator and needs open heart surgery, says he is putting it off, waiting for the day when they can do it on an outpatient basis. Now, I think he is kidding, but I am not sure how many years in the future it is going to be before that might be the case.

A Hamilton KSA survey, conducted earlier this year, predicted that by the year 2000 that 49 percent of their revenues will come from outpatient services. The bottom line is, I think the proportion of care delivered on an outpatient basis will continue to grow, and the limitation is primarily a technological one.

The third question you asked, and I think the most important one, is, how many hospital beds will we need. I don't think one can calculate or predict with any degree of confidence the future acute care needed capacity.

We did a chart that is in the testimony that shows that if the growth of inpatient days had continued from 1980 through 1989, at the same rate of the previous eight years, hospitals would have had 310 million patient

days of care in 1989 instead of the less than 230 million that were actually delivered.

What is interesting about this dramatic decrease in volume measures is that it was unexpected. In fact, at the time we were implementing PPS, many policymakers were predicting an increase in patient days rather than a decrease.

From the experience of the 1980s, I think we can draw a couple of conclusions. The first is that predictions on future health-care trends which are based on demographics and technology are often unreliable. America is greying, but I don't think many people understand just how gray our future society is going to be.

In about 20 years from now—the year 2010—this is some information provided to us by Neal Howe, a well-known author—the age composition of the United States will resemble that of South Florida today, and by the year 2040, our population over age 65 will be 170 percent larger than it is today, while our working age population will be only 5 percent larger.

If no other factors were to be considered to determine our future need for hospital beds, I think it would be safe to assume that we would need more, not fewer, beds. But I think there is another more potentially powerful factor that exists, and that is medical technology. We cannot predict what technological developments are on the horizon.

Just a couple of comments on some of these. We had a recent speaker at one of our meetings who led the research team that developed Tylenol. Dr. McConnell talked to us a great deal about things I don't understand at all and what they can do in cancer treatment. Somebody in the audience asked him a question about the use of monoclonal antibodies in cancer treatment, and he responded that if some of the potential technologies were as effective as he thought they would be that they could render unnecessary almost all of the existing hospital cancer treatment facilities we have today.

Dr. McConnell predicted that we can expect as much progress in the next two decades as we saw in the past when we conquered polio and TB in the diagnosis and treatment of allergies, arthritis, cancer, cardiovascular and congenital disease.

Now, it is not possible for us at this time to predict which of these two forces—demographics or technology—is going to be the most important, but my guess—and I use that word advisedly—is that we will find that technology is clearly going to be the driving force.

Therefore, we would probably need fewer beds in the future, and this is related to the important part of your third question, how do we get there.

Should hospitals merge, close, or share facilities? The simple answer is yes. Indeed, if the demand for inpatient capacity continues to shrink, then some hospitals will be compelled to close, many will merge and almost all will share services.

The salient public policy services questions are, number one, the rate of shrinkage. We do not want to move too quickly and then find hospitals lack the capacity needed for future community needs.

Number two, the one that you are most interested in is the role of the government. Should government drive the process, facilitate change, or simply monitor private efforts.

REPRESENTATIVE STARK. You didn't mention pay the bills.

MR. SCOTT. Just a little insignificant thing.

The third is the usage of existing health-care facilities that are no longer needed for that purpose. One of the biggest unknowns in planning for the future capacity needs is the impact of the AIDS crisis. At the very least, we should consider the conversion of some existing acute care capacity to meet the long-term needs of our AIDS patients.

In summary, Mr. Chairman, I cannot confidently predict what I think the structure of the industry will be in the future, but do I know what I hope it will be. I would like to see acute care hospitals as important elements, along with physicians, allied with health care professionals in vertically integrated health care delivery organizations.

Given the potential of new medical technologies, I hope we will be able to meet the needs of our communities with significantly fewer hospital beds by relying still more on outpatient care and disease prevention.

Thank you.

[The prepared statement of Mr. Scott follows:]

PREPARED STATEMENT OF JAMES L. SCOTT

Good morning Mr. Chairman. I am James L. Scott, President of the AmHS Institute.

The AmHS Institute is the public policy center for American Healthcare Systems, which represents health care facilities located in 47 states. It is the largest national alliance of not-for-profit multihospital systems, with 40 multihospital systems representing 1,100 facilities. AmHS shareholder-owned, leased, managed, and affiliated hospitals comprise nearly 15 percent of all community hospital beds in the United States.

While American Healthcare Systems has developed a comprehensive plan for health care system reform - known as **"PATIENTS FIRST"** - and policy positions on many of the pertinent health care financing and delivery issues of the day, we have not gone so far as to predict what hospitals should or might be in the 21st Century. Therefore, some of what I will say here today reflects my own personal views of what the future might hold.

The title of this hearing, **THE STRUCTURE OF THE HOSPITAL INDUSTRY IN THE 21ST CENTURY,** and your letter of invitation suggest that action can, and should be taken to ensure that the structure of the hospital community is consistent with the overall direction of the health care system in the next century. If history repeats itself, there is no doubt that natural forces will cause this to happen.

As needed reforms are made in our current mechanisms for financing and delivering health care services, hospitals will accommodate to those changes.

The record of hospital response to externally developed incentives is well documented. From the passage of Medicare through the development of Medicare's prospective payment system (PPS) we have seen the hospital community adapt to a constantly changing environment.

In your letter of invitation you asked us to respond to certain questions. Mr. Chairman, I must respectfully note that some of those were more appropriate at the beginning of the 1980s than they are today. Some of them are questions we either know the answers to, or know that we are never going to be able to answer.

The first question is: **SHOULD WE HAVE MORE COORDINATION BETWEEN REGIONAL CENTERS AND RURAL HOSPITALS?** There is no doubt that we need to continue to develop coordination between regional centers and rural hospitals. In May of 1971, when I started my first job as a hospital administrator, my organization, Great Plains Lutheran Hospitals in Phillipsburg, Kansas, served 20 rural hospitals with five circuit-riding administrators. These individuals traveled many thousands of miles annually, as did circuit-riding preachers of the last century.

At that time we had a very aggressive program for sharing services between our hospitals and large regional hospitals in the state. Those services ranged from such mundane activities as data processing to shared mobile nuclear medicine scanners. While some of our successes were the result of innovative leadership, we were not that different from many other health care providers in rural areas.

The complexity and range of coordination of health services has increased tremendously in the past two decades. For example, today at the Iowa Methodist Health

System in Des Moines there are over 50 distinct outreach services offered to 120 communities. Each of these is an example of successful coordination.

One of the most interesting services is the system's remote fetal heart telemetry program. In 21 rural hospitals expectant mothers are "hooked-up" to machines and their babies' heart beats are read at Iowa Methodist. This program is especially valuable because of what it teaches us about one of the most significant barriers to coordination between rural hospitals and urban medical centers. Many rural hospitals fear that close ties with regional centers will result in a loss of patients. This concern was expressed in Iowa by rural hospital administrators who at first were worried that the program would mean an early transfer of maternity cases to the regional center. But the opposite has happened. Improved fetal monitoring has enabled more mothers to deliver in their home communities.

Does this mean that we have achieved an optional level of cooperation? It does not. More can be done, but it is clear that significant progress is being made in local settings all across America.

A question we need to ask is: **WHAT ROLE WILL THE HOSPITAL PLAY IN THE INTEGRATED HEALTH CARE DELIVERY ORGANIZATIONS OF THE FUTURE?**

We are far beyond questions of coordination between rural hospitals and near-by medical centers. What we need to do is to focus our attention on examining ways to make sure that the totality of the health care delivery system is responsive to local health needs. There is great promise for improved continuity of care and operational efficiencies through the integration of the roles and financial incentives of hospitals, physicians, and payers.

There seems to be a growing consensus that the actual delivery of care should be coordinated by new organizations in the future, but much less agreement on the structure of an integrated delivery organization. Will physicians be owners, partners, or employees of these organizations? This is just one of the myriad structural questions that must be answered as these new organizations are developed. Other questions involve issues of common or separate ownership of facilities, governance, financial risk sharing, antitrust, and how traditional insurance functions will be handled.

Integrated delivery organizations will depart dramatically from existing delivery approaches. Hospital executives, physicians, and other members of the health care team will have to learn new roles and adjust to new relationships.

Given the importance of health care services to our communities, and the great uncertainty that exists in how new delivery structures might work, we feel it is important to test, through comprehensive demonstrations, various new methodologies prior to any national implementation.

The honest answer to your second question regarding the **FUTURE MIX ON INPATIENT AND OUTPATIENT CARE** is: It depends. The primary determinants will be new technological developments. The tremendous increase in outpatient services has not been driven solely by new incentives arising from payment reforms. Specific new medical technologies that permit services previously provided on an inpatient basis to be delivered in an outpatient setting have also contributed substantially. A particularly significant example is cataract surgery. In the Medicare program the number of inpatient cataract lens procedures in DRG 39 (in-hospital surgery)

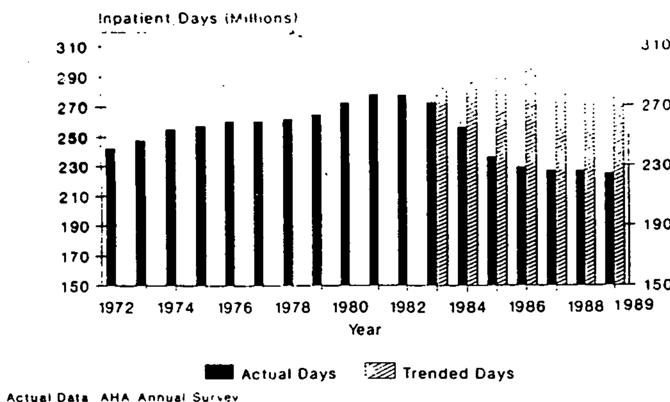
decreased by 93.9 percent between 1983 and 1988. DRG 6, carpal tunnel release, dropped 88.6 percent in the same period as these procedures were shifted from an inpatient to an outpatient basis.

The total growth of outpatient surgery was strong during the decade of the 80s. From 1980 to 1987 the number of outpatient surgery cases grew at a 10 percent annual rate. The last three years of the decade saw the growth rate fall, but remain a still strong 7 percent.

We are far from having reached the end of such developments. A recent Hospitals magazine article predicted that technological advances will continue the movement toward shorter lengths of stay. By 1995, for example, endoscopic surgery could account for a significant proportion of many high-volume surgeries including: 90 percent of cholecystectomies and prostate cancer stagings; and 70 percent of appendectomies, hysterectomies, and hernia repairs. It is just a further short step to doing some of these procedures on an outpatient basis.

In a Hamilton/KSA survey conducted earlier this year, hospital CEOs predicted that by the year 2000, 49 percent of hospital revenues will come from outpatient services. The bottom line is that the proportion of care delivered on an outpatient basis will continue to grow. Its expansion will be limited, in the long run, only by the rate of technological change.

Your third question is: **HOW MANY HOSPITAL BEDS WILL WE NEED?** One cannot calculate, or predict with any degree of confidence, future needed acute care bed capacity. Much of the new hospital capacity that was committed in the late 1970s was not needed by the time the lengthy planning and construction was completed. Figure 1A illustrates this point.



If the growth of inpatient days had continued from 1980 through 1989 at the same rate of the previous eight years, hospitals would have provided almost 310 million patient days of care in 1989 instead of the less than 230 million that were actually delivered. The figures are even more startling when viewed on a per-capita basis. In 1981, after 24 years of uninterrupted growth, the nation's community hospital admission rate declined. In 1980, which marks the high point, there were 154 admissions per 1,000

population. By 1990, only 10 years after the high point, admission rates had fallen to 125.2 per 1,000, a level not seen since 1957.

During this period, total admissions fell 13.7 percent despite a 10 percent increase in the U.S. population. The average length of stay dropped 4.1 percent, inpatient days were down 17.3 percent, and average daily census fell 17.1 percent.

The dramatic decrease in these volume measures was unexpected. In fact, many policymakers predicted more days of care because of the increased aging of the population. You may recall that during the development of Medicare's first PPS regulation there was considerable discussion between the Department of Health and Human Services and the Office of Management and Budget over the need for a volume adjustor to the PPS payment rates to account for the increase in admissions some anticipated as a result of the admission-based reimbursement system.

From the experience of the 1980s we can draw several conclusions. First, predictions on future health care trends are often unreliable. Second, the variables that will most likely determine future capacity needs are external to the public policy financing debate.

The two variables that will most directly affect the number of hospital beds needed in the future are demographics and technology. In addition, the continued growth of managed care and payment incentives will also influence the future need for hospital beds.

America is graying, a fact about which there can be no doubt. What most do not understand, however, is how really gray our future will be. Neil Howe, coauthor of "On Borrowed Time" and "Generations: The History of America's Future, 1584-2069," spoke to an AmHS audience in the winter of 1990 and provided us with some sobering statistics. Let me recount just a few:

* About 20 years from now, (in 2010) the age composition of the United States will resemble that of Florida today.
* By the year 2040, our population over age 65 will be 170 percent larger than it is today, while our working-age population will be only 5 percent larger.
* By the year 2060, our total population will be the same as it is today, but its composition will be drastically altered. Howe asked us to imagine, if we could, an America in which the population west of the Mississippi would be comprised entirely of persons over the age of 65, and a New England full of Americans age 20 to 65.

In a "DATA WATCH" article in the Winter 1992 issue of Health Affairs, several analysts from HCFA's Office of the Actuary reminded us that persons eligible for Medicare consume health care resources at a rate four times that of the younger population. Solely as a result of the aging of our population, they predicted that health care spending would be 27 percent higher in the year 2030 than it is currently.

However, the Prospective Payment Assessment Commission reported this spring that ..."the volume of admissions for persons 65 or older remained about 15 percent higher in 1990 than in 1979. Thus, changes in the volume of inpatient admissions have been much greater among the population under 65 than among the elderly.

If there were no other factors determining our future need for hospital beds, it would be safe to assume that we would need to increase our current supply dramatically. But another, and potentially more powerful factor does exist--and that is medical

technology. The difficulty is we cannot predict what new technological developments are just beyond the horizon.

Technological change today is occurring at an accelerating pace. Jack McConnell, M.D., a nationally recognized research scientist for Johnson and Johnson who headed the research program which developed TYLENOL and an expert on the broad range of emerging medical technologies, has this to say about just one new technology when he addressed an AmHS conference:

"A plethora of technical opportunities have emerged out of molecular biology technology and have provided a stream of new options and opportunities to interact with the disease process. For example, monoclonal antibodies, proteins that act with a high degree of specificity, can be delivered to the diseased tissue for early diagnosis and treatment. Its application to cancer and cardiovascular disease, the two leading causes of death in hospitalized patients, are in the forefront of current research and development. The applications for both diagnosis and treatment are virtually limitless."

In a response to questions from the audience, Dr. McConnell noted that if some of the promising new cancer treatment therapies prove to be as effective as hoped they could render unnecessary almost all existing cancer treatment facilities.

Dr. McConnell predicted that, "We can expect as much progress in the next two decades in the diagnosis and treatment of allergies, arthritis, cancer, diabetes, cardiovascular and congenital diseases as we saw in the recent past when we eliminated smallpox, controlled TB, learned to manage many of the mental illnesses, conquered polio, and developed new techniques and materials for eye problems and cardiovascular diseases."

At AmHS we have the opportunity to see at close range much medical research that is underway in biotechnology. Many of the dreams of the scientists and entrepreneurs will not be realized, but some will, and there is good reason to be excited about what our technological future holds.

Another factor that will help determine future inpatient capacity needs will be the growth of managed care. Although HMO membership has stabilized at around 35 million Americans, or 15 percent of the population, some experts continue to believe it will increase to at least 25 percent by the year 2000. The 1990 average HMO hospital admission rate was 74.6 per 1,000 population, compared to an overall rate of 125.2, and their length of stay was 4.7 days compared to a 7.2 day average for community hospitals. If future HMO growth is as predicted, fewer hospital beds will be needed.

It is not possible to predict, with any confidence, the impact of potential new medical technologies and managed care growth on inpatient hospital usage. I do have some personal opinions. My guess (and that word was chosen carefully because I have no crystal ball) is that new medical technologies, rather than demographic or delivery changes, will be the driving force that shapes our future demand for hospital capacity.

We will probably need far fewer hospital beds in the future, and this is related to the important part of your third question: **HOW DO WE GET THERE? SHOULD HOSPITALS MERGE, CLOSE, OR SHARE FACILITIES?** The simple answer is yes. If indeed the demand for inpatient capacity continues to shrink as I believe it will, then some hospitals will be compelled to close, many will merge, and almost all will share services.

Gerard Anderson, Ph.D., Director, The Center for Hospital Finance and Management, The Johns Hopkins Medical Institutions, conducted a study of the number and costs of excess hospital beds for the AmHS Institute. In January of 1990, we concluded that there were 194,000 excess hospital beds. The total annual capital costs associated with these beds was then $3.1 billion. Simply closing them, however, would not save an equivalent amount unless a mechanism was established to excuse the principal and interest expense already obligated by these hospitals.

The salient public policy questions relating to the shrinkage of inpatient capacity are:

- The rate of shrinkage (because predictions in this area are imprecise, we do not want to move too quickly and then find that hospitals lack the capacity needed to meet future community health care needs);
- The role of government (should government drive the process, facilitate change, or simply monitor private sector efforts?); and
- The usage of existing acute care facilities that are no longer needed.

One of the biggest unknowns in planning for future capacity needs is the impact of the AIDS crisis. At the very least we should consider the conversion of some existing acute care capacity to meet the long-term care needs of our AIDS patients. The health policy establishment will debate all such questions for much of the next two decades.

My personal hope is that as integrated health care delivery organizations continue to develop their levels of integration they will be the most appropriate vehicle for managing the downsizing process.

In summary Mr. Chairman, I cannot confidently predict what the structure of the hospital industry will be in the next century. But I do know what I hope it will be. In the 21st Century I would like to see acute care hospitals as important elements, along with physicians, in comprehensive, vertically integrated health care delivery organizations. Given the potential impact of new medical technologies, I hope that we will be able to meet the needs of our communities with significantly fewer inpatient beds by relying still more on outpatient care and disease prevention. The hospital beds that will remain will be filled by patients who are the most seriously ill, as less serious cases will be handled on an ambulatory basis.

I would be pleased to answer any questions you or other members of the Subcommittee might have.

REPRESENTATIVE STARK. When you say vertically integrated, I can deal with you in making cars, vertical and horizontal, but define that for me. What is an HMO? That is vertical?

MR. SCOTT. Yes.

REPRESENTATIVE STARK. What is horizontal? Fee-for-service?

MR. SCOTT. I think what we have in mind, Congressman, are organizations where you have in one kind of a corporate umbrella the hospital facilities, the physicians, the home health agencies, the——

REPRESENTATIVE STARK. That is vertical, and horizontal is, you are on the market?

MR. SCOTT. Yes. We think that has great promise.

REPRESENTATIVE STARK. Dr. Kimmey, please proceed.

STATEMENT OF JAMES R. KIMMEY, PROFESSOR OF COMMUNITY HEALTH AND DEAN, SCHOOL OF PUBLIC HEALTH, ST. LOUIS UNIVERSITY

DR. KIMMEY. Thank you, Mr. Chairman.

In 1975, when Congress enacted the National Health Planning and Resources Development Act, the report to the Interstate and Foreign Commerce Committee said, "We are enacting this legislation in order to prepare for a national financing program which we anticipate within five years."

In the event there was no national financing program in five years which could attract a political consensus, and the planning structure that was put in place without the resources to manage and ultimately drafted into a regulatory strategy the attempt to control federal costs under Medicare, lost a great deal of support, both here in Congress and at the community and state levels.

By 1985, the federal financial support for planning had faded from the scene. The watch word of the day was competition in the health industry. With a few exceptions, states and communities were unable to sustain their planning structures, mainly because they couldn't sustain financial support for the activity. Planning did not then, nor does it now, have much of a constituency when it is compared to those for whom the planning was undertaken.

State regulatory activities in health care, which peaked in the late 1970s, have also faded except in a few states which that feel their cost problems are such that they must maintain some control over capital investment decisions.

REPRESENTATIVE STARK. Did they do better than the other states in the last decade?

DR. KIMMEY. There are really no studies that will demonstrate that one way or the other, that I am aware of. They think they did better. And maybe a lot of this is perception of how one is doing.

Now, as the debate concerning organization and financing heats up again, and we hear that we are going to have national financing within

five years, one hears very little of the either the "P" word, planning, or the "R" word, regulation. And, indeed, planners spend a great deal of time trying to think of another name for what they do because they got so burned on the planning name of 10 years ago.

Cost controls are part of some of the proposals for reform, but neither planning nor cost controls are receiving a great deal of attention, in my view. The Medicare lesson that infusions of large amounts of money into the system to care for undeserved members of society without concomitant controls in the system breeds inflation, if that hasn't been brought into the "corporate culture" in Washington, then the coming solutions will cause worse problems in the Nation then we are experiencing right now.

One aspect of the current debate holds that there are sufficient resources—dollars, personnel, facilities—already devoted to health care to meet the needs of the 37 to 50 million uninsured only if they were organized differently. If that is true or even close to true, then the problem is not financing but planning and resource allocation, or reallocation to meet the needs of the population as a whole. If the money is there and we are not doing it right the solution does not lie in changing the financing system alone; we must look to planning, we must look to reallocation.

It is the facilities question—the topic of this hearing—that is going to be most difficult to deal with in reorganizing and restructuring the health care structure. Facilities, hospitals, clinics, emergency rooms, docs in a box, and so forth, include any fixed location at which health care at any level is offered.

The key word is fixed. Facilities represent large investment, take time to construct and activate, and are difficult to move. To the extent that they are in the wrong place relative to communities' needs or that additional facilities are needed to provide services to additional people under a better access plan, then more than dollars or personnel determine the rate of real change in a reformed health care system.

The hospitals of the 21st century are already with us. With a few exceptions, their locations are set. The facilities are in planning or in construction. The technologies are in testing, or being adopted already. That is the problem with facilities. They have lead time. They are immobile. And if they aren't planned with attention to future community needs, they are going to be problems, not solutions.

If the system continues as it is, the situation in the 21st century will not improve significantly, and could be much worse. If, indeed, we were to put new financing mechanisms in place and change nothing, I would expect that we will see continued excess capacity in beds and expensive diagnostic equipment in urban and suburban areas. I think we will see a continued shift from inpatient to outpatient services, something the rest of the panel has talked about. However, those new initiatives will offer secondary and tertiary services, not provide primary care, which is the major need for the uninsured population in this country.

Urban problem hospitals, those that provide the most service to those with the least access, will continue to deteriorate in terms of physical plant and basic diagnostic and therapeutic equipment.

Inter-hospital cooperation in sharing and coordination of services will remain the exception, in large part, because of interference from the Department of Justice and Federal Trade Commission, who have intervened in a number of attempts to get more efficient services.

Rural areas will continue to be disadvantaged with either inadequate or inappropriate services available for their residents.

Changing the financing system to improve financial access to services would have minimal impact by itself on these trends in the system. They reflect the inadequacies of totally independent, market-driven institutional planning as the sole means for structuring the system that does not respond well to market force.

Whether or not this is the decade in which we will see fundamental reform in health care financing, this is the time to revisit the issue of health planning as a responsibility of every community.

The current approach to allocating resources is not working effectively from the community's perspective. Many communities across the country have recognized this need to bring some sense of direction to the development of their health care systems, particularly if these systems are to meet the needs of the medically disadvantaged, the homeless, the growing number of people with AIDS, among other problems.

But the number of communities which have evolved the leadership and identified resources for planning efforts is small. It is an important start, however. And it should alert thoughtful designers of reform legislation that there is a perception of need for planning, but not for launching expanded entitlements to health services.

Without some broad-based consideration of the direction of development in the system at the community level, the system will change, but in the direction which maximizes the chances that current institutions and delivery systems will survive rather than in the direction that will assure the population that their needs will be met.

Thank you.

[The prepared statement of Dr. Kimmey follows:]

PREPARED STATEMENT OF JAMES R. KIMMEY

Mr. Chairman and Members of the Committee:

I am Dr. James R. Kimmey, Professor of Community Health and Dean, School of Public Health, at Saint Louis University. I am here today in my capacity as an analyst and teacher in the area of health policy to present some ideas concerning the relationship of today's resource allocation decisions to the subject of these hearings, the Structure of the Hospital Industry in the 21st Century. My views in these matters have been shaped over a twenty-five year career as a Federal and state health official, health planning consultant, and academic.

In 1975, the Congress enacted the National Health Planning and Resources Devel-op ment Act (P.L. 93-641) which had as a central goal the preparation of the nation's health care system for the advent of a national financing program. In the event, there was no national financing program which could attract a political consensus at that time, and the planning structure put in place--without resources to manage and ultimately trapped in a flawed regulatory strategy--was deemed ineffective. By 1985, Federal financial support for state and community health planning had faded from the scene. The watchword of the day was competition in health care. With a few exceptions, states and communities were unable to sustain financial support for planning activities without Federal assistance. State regulatory activities in health care, which peaked in the late seventies, also faded except in a few states which felt that their cost problems were such that some controls on capital investment decisions, even in a more competitive system, were essential public policy.

Now, as the debate concerning organization and financing of health care heats up again, one hears little of planning. Cost controls are a part of some of the proposals for reform, but neither planning nor cost controls are the focus of great attention. If the Medicare lesson--that infusions of large amounts of money into the system to care for underserved members of society without concomitant controls on the system breeds inflation--has not been internalized in Washington's "corporate culture", then the solutions to the access problem may indeed cause worse problems for the nation than we are experiencing today.

One aspect of the current debate holds that there are sufficient resources--dollars, personnel, and facilities--already devoted to health care to meet the needs of the 37 million uninsured if only they were organized differently. If that is accurate, or even close, then the fundamental question is not financing, but rather planning and resource allocation (or reallocation) to meet the needs of the population as a whole. To the question of whether there are sufficient dollar resources, the answer has to be yes, there are enough in the system to meet much of the need if they were reallocated; after all, we know that we spend proportionately more than other developed countries but receive less for our investment. In the case of personnel resources, the answer is a qualified yes; we have more of most types of personnel per capita than nations which are doing better at meeting health needs of their citizens; but these personnel are maldistributed geographically and by specialty and by work setting. In the case of facilities, the answer is no. If we were to take seriously the challenge of providing health care to all, we would quickly find that we have the wrong types of facilities in the wrong places managed the wrong way.

In a sense, it is the facilities question which will be most difficult to deal with in reorganizing and reorienting the health care structure. Facilities--hospitals, clinics, emergency centers. ambulatory surgery centers, dialysis centers, public health centers, nursing homes, physician office buildings, and so forth--include any fixed location at which health care at any level is offered. The key word is "fixed"--facilities represent a large investment, take time to construct and activate, and are difficult to move. To the extent they are in the wrong place relative to a community's needs or that additional facilities are needed to provide services to additional people under a universal access plan, they, more than dollars or personnel, will determine the rate of real change in the reformed system.

This was recognized in the 70s. The intent of the health planning initiatives in that era was to develop a coherent description of the optimum mix and distribution of services and facilities based on the characteristics of the populations which comprised medical market areas. The planning was population based--flowing from the location and needs of people in an area--rather than resource based--flowing from the location and needs of providers in an area. Planning as conceived and carried out in most communities was participative and technically sound. It was successful in developing the data necessary for good decision making; analyzing that data; setting overall goals for development of resources; and suggesting alternative ways of reaching those goals. Planning did not fail in the 70s--implementation failed.

Although there was a commitment to health planning in the Congress, the Administration, in state and local governments, and in the industry itself in that era, there was little commitment to real change in the system. The actions necessary to bring about the changes in the distribution and types of health services which planning identified as essential for a more effective health care system were often unpopular. Where there were attempts to move the system in directions indicated by the community-based planning process, they were regulatory and not developmental. Congress mandated state certificate of need programs in which regulatory decisions were based on needs identified by planning. At the same time it declined to fund one of the most powerful tools for change, the Area Health Services Development Fund which was to provide planning-related seed money grants. Federal administrative agencies fought hard to keep their particular projects from being reviewed for consistency with community plans under the Review of Uses of Federal Funds portion of the planning agency responsibility. When planning agencies worked with hospitals to voluntarily secure more rational distribution of services, the Department of Justice raised the threat of anti-trust litigation. When planning agencies attempted to negotiate expansion of services needed by the community as a condition of approving services desired by institutions, the Congress, under intense industry pressure, amended the basic legislation to prohibit the practice. This list of examples of inconsistent support could continue, and be expanded by examples from states and communities, but the point is made. Society was willing to support planning efforts, but felt little pressure to support the indicated changes in the organization of services.

With the lack of serious commitment to implementing plans on the part of those with the capacity to do so, it is not surprising that the health planning structure was received as ineffective in many quarters. This perception was magnified when, in the late 70s, the health planning structure--designed to rationalize the system--was tasked with

controlling health care costs through certificate of need. This was a task which the agencies were poorly equipped to perform, and their limited abilities contributed to predictable failure. Coupled with a growing disenchantment in the society with regulation in general, and an interest in competitive forces as an alternative approach for health care, interest and support for planning waned.

Beginning in 1980, national policy moved toward promoting a more competitive approach to organization and financing of health services. Any planning was seen as interfering with such an approach, and the planning structure built up over six years was gradually starved for resources. Federal support was ultimately discontinued, and some states abandoned both planning and regulatory programs. The health system was freed to respond to market forces, and the focus shifted from resource allocation based on planning to resource allocation based on those forces. Prudent purchasing, prepayment, and fixed per admission reimbursement shaped the system as it is today, not planning.

The record for the decade of competition is not comforting. The promise seen in increased competition by some has not materialized. Cost inflation has continued virtually unabated. The number of Americans lacking financial access to needed services has exploded. Duplication of services, equipment, and facilities remains a major problem, especially in urban areas. Consumer-driven competition has not become a reality, and hospitals continue to compete not for consumers but for physicians, and have added HMOs, PPOs, and business clients to the list. Decisions concerning programs, services, equipment acquisitions, and facility expansions are made with appropriate attention to individual institutional survival. They are based on institutional and provider, not necessarily community, needs and desires.

As it has in the past, this approach subverts community interests to the interests of the provider in that community. For the past ten years, for example, capital investment decisions have been made independent of any considerations beyond the institution and its perception of community need. A more competitive situation in the health care market has had an effect on these decisions--it has tilted them toward investments with high prestige value which attract physicians to a hospital staff, or investments which improve the bottom line for the hospital. This period of *unplanned* investment has also been one of relatively uncontrolled investment. For example, capital costs as they relate to Medicare recipients were reimbursed outside the DRG system. The recent decision to incorporate capital payment into the DRG system will do little to affect this situation. There is still no provision for planning to meet community needs using these federal funds.

Resource allocation in the health system has returned to the model of the 30s and 40s, one rejected in the 60s and 70s. Assessment of community need for expensive facilities and equipment has be defaulted to the hospital industry, and resource allocation decisions are made from an institutional rather than a community perspective. This is not to say that those decisions are not without merit, but rather that they are made from the perspective o the institution's best interests which are often very different from the community's interest. Further, they are committing the community to a certain pattern of facilities and services in the intermediate future.

The hospitals of the 21st century are already with us. With a few exceptions, the locations are set, the facilities in place or in planning, the technologies in testing. That's the problem with facilities--they have lead time, they are immobile, and if they aren't planned with attention to future community needs they are going to be problems, not

solutions. If the system continues as it is, the situation in the 21st century will not improve significantly, and could be much worse if a new approach to financing is enacted without attention to planning and cost controls. In that case, one can expect:

Continued excess capacity in beds and expensive diagnostic equipment in urban and suburban areas.

Continued shift from inpatient to outpatient services, but to offer secondary and even tertiary services, not to expand primary care availability.

Urban problem hospitals--those providing most service to those with the least access--will continue to deteriorate in terms of physical plant and in basic diagnostic and therapeutic equipment.

Inter-hospital cooperation in sharing and coordination of services will remain the exception.

. Rural areas will continue to be disadvantaged with either inadequate or inappropriate services available for their residents.

Changing the financing system to improve financial access to services would have minimal impact on these trends in the system. They reflect the inadequacies of totally independent market driven institutional lanning as the sole means for structuring a system that does not respond well to market forces.

Whether or not this is the decade in which the nation will achieve fundamental reform in health care financing, this is the time to revisit the issue of health planning as a responsibility of every community. The current approach to allocating resources is not working effectively from the community perspective.

Many communities across the country have recognized this need to bring some sense of direction to the development of their health care systems, particularly if these systems are to begin to meet the needs of the medically-disadvantaged, the homeless, and the crowing number of people with AIDS, among other problems. In St. Louis, such an effort was launched last July by Mayor Vincent C. Schoemehl, Jr. and County Executive George R. Westfall. They convened a broadly-based community wide task force to examine the current health system, identify its strengths and weaknesses, and recommend changes which can be pursued by joint efforts involving providers, consumers, business, and government working together. The range of issues the group has examined over the past year include economics of health care in the community, health care cost containment, access to care for community residents, and educational needs and opportunities. In addition, the task force has explored the need for a permanent planning structure for the St. Louis community. A preliminary recommendation for establishment of a planning body with broad responsibility for defining a more effective approach to organizing and financing services locally is under consideration.

St. Louis is not alone in identifying the need for re-establishing health planning. But the number of communities which have evolved the leadership and identified resources for these efforts is small. It is an important start, however, and should alert thoughtful designers of reform legislation that there is a perception of need for planning before launching an expanded entitlement for health services. Without some broad-based careful consideration of the direction of development in the system in communities, the system will change, but in directions which maximize the chances that current institutions and delivery systems will survive rather than in those which assure that the population's needs will be met.

The hospital in 1992 is central to technically complex medical care but tangential to community health. Left to the workings of the market, and without organized community planning efforts, that cannot be expected to change significantly as we move to the 21st century. The largest component of increased demand from the underserved population will be for primary care, and for services which are accessible temporally and geographically as well as financially. These are not the strong points of an institution-focused system.

REPRESENTATIVE STARK. Thank you.

Let me make a statement or two, and then you can tear it apart. We are really focusing, I guess, on building a record, or some evidence, that would help us sort out the box that we are in of having to deal with antitrust legislation and fair trade things, which were designed, it is my contention, for something else.

So, my first hypothesis is that, compared to the market, for soybeans, automobiles, sneakers, imported T shirts, there is generally no market relationship between the consumer—patient—and the seller of the service—hospital, doctor, etc. I mean, the patient doesn't pick the hospital, generally. They may be forced into a hospital because it is the only one in town, but basically the doctor makes the decision. Often the patient hasn't even picked the doctor; he or she has been referred.

And the two people involved, the hospital and the patient, deal with some other person who nobody knows; the hospital may not know them—whoever pays the bills and decides what is going to be paid. So, you have a whole bunch of people who are unaware of what the costs are or of what the options would be.

It is hard for me to see a market—as I learned about that from Professor Samuelson a thousand years ago—I can't find it in there. If there isn't that market, you either have a situation then that is an anarchy—everybody for themselves, and the devil take the hindmost—or you have to regulate it somehow. You have to figure out how you are going to pay for the services.

I don't understand how our standard concept of antitrust of A&P controlling all the prices of eggs because it owns the chicken farms applies here. I can follow that for a grocers chain, but I can't follow the logic of why two hospitals in San Francisco should merge or should not merge.

I can see the issue of, should you just leave it to chance, because it is conceivable that in nonprofit institutions there is greed, competition on the basis of pride, institutional jealousy, and they could gang up on somebody in town and decide, "We are going to put hospital X out of business because we don't like them, or they haven't joined the club."

There is probably no evidence that says we ought to put the fox in the chicken coop. We ought to let the hospitals divvy up the market without any consideration for the public interest because, arguably, they would all end up in the suburbs and leave behind the public hospital to deal with the problems of the inner city.

It may be an unfair characterization of the industry, but the evidence shows that that is pretty much what has happened.

Is that a fair characterization of what we are facing, relative to dealing with the antitrust issue saying: "We have to do something to get this kind of system, this antitrust procedure, off the backs of hospitals, but we have got to replace it with something."

DR. KIMMEY. I will start with a response because mine will be predictable, and that is that a planning system that has set up and laid out how

the community system ought to be structured would provide a test against which mergers and other kinds of activities could be viewed.

REPRESENTATIVE STARK. I could understand that test.

DR. KIMMEY. Yes. If the community has undertaken a planning process and says it is more advantageous for this community to have one obstetrical hospital and have another hospital provide community emergency service, and hospitals are willing to do it——

REPRESENTATIVE STARK. If the good burghers of that town are willing to vote for the bond issue.

DR. KIMMEY. But if they are willing to do it, they should be able to go ahead and do this if it is consistent with planning.

Look at what happened several years ago in the first antitrust cases in Virginia where just this suggestion was made. The Department of Justice sent a letter to the planning agency and to the hospitals involved, and said, "We think we might consider this a violation." Bang, end of talk of distributing service, end of merger, end of planning agency's effectiveness.

MR. ALTMAN. On the other side, having watched the 1970s and having been a participant in trying to get the 1974 legislation passed, I am not unsympathetic to the scenario that you played out.

But let me give you my sense of what actually happened. That is, it didn't work out the way you said. What happened was that the existing power structure protected itself. It prevented others from coming in. Organized medicine often prevented doctors who wanted to practice alternative ways from getting into their hospitals.

Yes, it may have preserved some hospitals in the inner city, sometimes for the good. It is not clear to me, however, that all people from the suburbs should come into the inner city. Some of the protected inner-city hospitals may have been pretty weak hospitals.

Second is what I said previously, when the planners fought against the power structure, guess who won. If we had been able to keep the pressure on the government level and on the private side—I think the system might have won. But we didn't. I think we did a better job using tough reimbursement.

So, that is why I put my stock increasingly on the reimbursement side. Not that I am opposed to planning; I think good reimbursement policy needs to have planning in it. Why? Because I don't think you should just pay the bills.

I think that what we are doing in PPS makes sense. We may need to pay certain hospitals more and certain hospitals less. We can torque the reimbursement system to reach out and create a structure that we like. It is not like reimbursement means market, planning means CON. I don't view it that way. I think a good system needs a combination of both. I just fear relying on constraints of capital while we allow the reimbursement system to run its willy-nilly way.

Finally, I would say that the scenario you play out could happen, and it does happen, but the alternative happens as well, and that is a sloppy, inefficient, controlled power structures which uses the CON process for their own benefit. And we have seen that too often take place.

REPRESENTATIVE STARK. Mr. Anderson, then Mr. Scott.

MR. ANDERSON. I agree that we don't have a market in health, and I think most people who have looked at this industry would agree with that.

REPRESENTATIVE STARK. Including Professor Enthoven?

MR. ANDERSON. He would like to create a market in health care.

REPRESENTATIVE STARK. If he came to a little lower altitude, maybe, where there was more oxygen. Jackson Hole is pretty high.

MR. ANDERSON. My concern is similar, but a little different from Stuart's. Certificate-of-need had really two objectives. One objective was to control capital and expenditures, and I am not sure it was very successful in that, but what I am more troubled by was the fact that it was basically ineffective in redistributing dollars from the suburban areas where the dollars were going into inner cities or rural areas. I don't see much evidence that it was able to do that. And, if that is the public policy goal, which I think it should be, then we have got to look for an alternative mechanism.

REPRESENTATIVE STARK. That is just paying the bills for the poor. I mean, that will take care of redistributing the dollars.

MR. ANDERSON. That will certainly help. Then, you might create a market for hospitals in the inner cities.

But the other thing to do, in a more proactive way, is to look to other countries and to look to how they have allocated capital. They effectively have the government with a stronger role in allocating capital.

You can do it in one of two ways. You can give out the dollars or set targets that each country, each region, each area, can have that is based upon a set of——

REPRESENTATIVE STARK. You and I could go on with this all day, but as you understand, this raises the specter of socialism. You can see all these socialists rowing across Lake Erie from Canada to take over our system. With some of them, we have to do it in-house. As we look across the border for solutions—it's like buying a Japanese automobile today—it might be better, more fuel efficient, safer and more fun to drive, but don't buy one.

MR. ANDERSON. The third thing is what is going on in Maryland. They have tied the reimbursement system to the planning program. And you don't get additional dollars for reimbursement until the planning program has approved it, and the regulatory people for rate setting have to approve it as well. So, you have to have both of them making that decision, to close hospitals and to add hospitals.

REPRESENTATIVE STARK. Maryland likes the system.

MR. ANDERSON. Right. And the hospitals in Maryland like the system.

REPRESENTATIVE STARK. Somebody suggested that there was no evidence that we were saving any money with these programs, who said in the states, with more planning——

DR. KIMMEY. Certificate-of-need states.

REPRESENTATIVE STARK. Okay. What I am led to believe is that New York, for instance, which I think for the sake of argument we could call a highly regulated state——

DR. KIMMEY. But that is the key thing, it is certificate and rate review. States that have both——

REPRESENTATIVE STARK. But then states like California, which has neither, probably doubled the cost of a room over New York.

Now, we have an excess of beds. In New York, there is a shortage of beds. So, New York, maybe, constrained themselves too much and they have an occupancy problem where there are not enough beds, arguably. California's problem is twice as many beds as it needs. But Maryland seems to come in—I think they brag on it a little more than the actual results—but they come in, at least, at the Medicare average, which isn't bad.

MR. ANDERSON. And they do it at 80 percent occupancy.

REPRESENTATIVE STARK. They are not happy about it.

MR. ALTMAN. As we pointed out in the report that we sent to you, if you look at those states that are doing the best under Medicare, have kept their cost shifting the lowest, and have a much better payment to cost by Medicaid, all of them are rate-setting states.

REPRESENTATIVE STARK. And then the other approach is in those states or areas that have HMOs or delivery systems. My own county has—I will just refresh your memory—1,200,000 people. Half of them go to Kaiser, arguably, if you take out the poverty folks and the military folks and so forth. Kaiser delivers the care to my county. I don't know about its overall cost structure, but with a third the number of hospital beds and a quarter of the number of docs.

You can argue whether it is good or bad, but it has been there for 50 years, and they tell me that they will lower the rates next year; that is, after some increases, but that is a different system completely. They are outside the certificate-of-need system. But we haven't been able to duplicate that.

As much as the Administration would like me to make that a cookie cutter and stamp them out in every state, all we have managed to do is generate felons in Florida and bad business people in Los Angeles. It is not easy to do.

What do you think we should do?

MR. SCOTT. First of all, I agree with what Stuart has said, that the more powerful approach to this is through the reimbursement system as opposed to some kind of planning mechanism. But I think it needs to go beyond just being tough on reimbursement, and I think we have to do more of what the folks have done at Kaiser. We have to find increasingly

better ways to bundle the payments, so we don't have a stream of revenues coming to the hospitals for outpatient surgery, and they are competing with a freestanding surgical center.

We have to find a way so that whoever is making the decision about where is the best place for a person to have surgery, if the most cost-effective place is the outpatient surgery center, the patient ought to be directed that way.

But in addition to what Stuart said about being tough on reimbursement, we need to be tough on a much broader scale. We need to bundle.

REPRESENTATIVE STARK. Are you comfortable with——

MR. ALTMAN. I support that.

REPRESENTATIVE STARK. Let me ask the next question. Are you comfortable with just expanding what we do now under Medicare reimbursement policies, and just dealing and trying to refine the DRG system, and expanding that as a payment system with appropriate opt-outs for states like Maryland who want to do it on their own, without Stuart's heavy hand on the tiller, or mine?

I mean, I am, of course, leading into it. That is one of the suggestions that is before the Congress now. It is America, for better or for worse.

How would that work?

MR. SCOTT. I don't think that that gets us to the place we need to go. That just perpetuates the problems that we have with hospital payments coming in this direction, physician payments coming in a different direction. The incentives for the hospitals under the PPS system are very different than the incentives under RBRVS.

Rather than worrying about applying those kinds of rates to other payers or other parties, I think we need to find ways to bundle those payments into much larger units, then we can let the physicians, the hospitals, the nursing homes——

REPRESENTATIVE STARK. You mean like a preferred provider or capitated plan?

MR. SCOTT. Ultimately, we have to move forward to a capitated system, that is my belief.

REPRESENTATIVE STARK. Anybody making a rational decision in my county would join Kaiser. In the previous Administration—Bill Roper's idea—was to have a complete capitation plan; it is the only way we can save money. And I agree with that.

MR. ALTMAN. They said that, and then they did all the wrong things.

REPRESENTATIVE STARK. They couldn't get any support.

MR. ALTMAN. No, you listen to the rhetoric of the previous two administrations on supporting capitation, and then you look at how they pay HMOs. You can't survive under the existing AA PPC systems in areas that are not oversubscribed in terms of resources. So, they talk with one set of tongues and they do something totally different.

I am not a super advocate for all aspects of managed care. I think you and I share the concerns about all the quick buck artists that are making money by setting up these systems.

REPRESENTATIVE STARK. The Administration?

MR. ALTMAN. Yes.

REPRESENTATIVE STARK. That goes without saying. But what I am suggesting is that there was a thought that capitation would be a solution. And I am just suggesting that the populous aren't going to sign up. My bellwether person in my intensive research is my mother. I have my doctor, I am not going to join Kaiser. And there are a lot of folks who have this attachment to the current medical delivery system. Generally, in whatever way they came into it, that is where they want to stay because they are comfortable and familiar with it.

I think that over time more and more people will find this system useful. But in the meantime, coming back to Mr. Scott, if we apply the DRG system to all hospitals, plus they got the fee, there is no more uncompensated care, and allowed those who wanted to go off and meet the federal standards for HMOs or managed care exempt them, what is wrong with that system?

MR. SCOTT. There is a lot wrong with that system. One is the level of Medicare payments.

REPRESENTATIVE STARK. I am saying the system, not the level of payments.

MR. SCOTT. It is a little hard to make the distinction.

REPRESENTATIVE STARK. Let's assume that we gave the hospitals their current costs, or 130 percent of the Medicare payment. Pretty generous, right?

MR. SCOTT. Sounds generous.

REPRESENTATIVE STARK. You get a 10 percent increase next year, not bad. But we rachet that down, so it goes 10 percent, 9 percent, 8 percent, 7 percent, 6 percent. In the out years, no more than Gross Domestic Product. A good hospital administrator ought to put jillions of surplus dollars in his or her pocket, with all Medicaid patients now reimbursed at the Medicare level. How much more can we give them?

MR. SCOTT. The bottom line is that applying the Medicare payment rates to all payers takes away——

REPRESENTATIVE STARK. Not rates. We didn't say rates. System.

MR. SCOTT. System to all payers takes away a great deal of flexibility that hospitals currently have; flexibility we very much want to keep.

REPRESENTATIVE STARK. To shift costs?

MR. SCOTT. That is right.

REPRESENTATIVE STARK. I mean, my poor people shift all the costs onto the taxpayers in my district.

MR. SCOTT. Cost shifting, for all the negatives about it, it does enable us to continue to provide services that we could not provide if we didn't have the ability to shift those costs.

Congressman Stark, the hospital industry doesn't trust the government.

REPRESENTATIVE STARK. We don't trust the hospitals. They have been lying to us.

Let me talk to you about the hospital association. If I could paraphrase their testimony, every hospital in the country—I am sure Stuart has heard this—is going to go broke. I mean, go broke. How many hospitals? Your testimony said 500 over 10 years. Fifty a year out of 6,000? I mean, I have more saloons in the town I grew up in go broke every year than that, and another one steps right in to take their place.

I mean, arguably a thousand a year should go out of business if we were going to take care of the excess capacity.

So, the hospital industry keeps strumming in tune to us that we are breaking them, and they know that is not true. They can't support it with numbers.

MR. SCOTT. In my statement, I made the point that in the future we are going to have to close hospitals, we are going to have to merge hospitals, and hospitals are going to have to share services. I don't think there is any doubt that that is the reality we are facing.

The decrease in inpatient days that we have seen as a result of technology and payment incentives is very real. I don't anticipate that it is going to change, and we are going to find ways to reduce the size of inpatient capacity.

REPRESENTATIVE STARK. How are we going to find ways to cut down the costs? Who is going to do that?

MR. SCOTT. Right now, even though the numbers continue to go up, the thing I know from working with the hospitals that I work for is that they are very diligent in their efforts to control cost.

REPRESENTATIVE STARK. But they aren't controlled.

MR. SCOTT. They are working very hard.

REPRESENTATIVE STARK. But they are doing a lousy job. Their costs are increasing 10, 12 percent a year, and there is no business in this country that won't go broke at that, and they come back to us and ask us to bail them out.

But then they say what you just said, "Don't control the costs." I say, wait a minute. How about if we don't pay the bills either? If you want us to pick up 40 percent of your revenue and take it out of the taxpayers' pocket, we have a duty, somehow, to see what you guys are doing with that money.

MR. SCOTT. Absolutely. I don't doubt that.

REPRESENTATIVE STARK. Isn't that regulation?

MR. SCOTT. This is an industry that is not going to be able to avoid regulation. There is a substantial amount of regulation already inherent in the industry. There is always going to be regulation in the industry.

I think, in my mind, the question for the future is, what is the right mix of regulation and market incentives?

REPRESENTATIVE STARK. How about what they do in Maryland? Let's just do the Maryland plan.

MR. SCOTT. There are a lot of people in Maryland who like the Maryland plan.

REPRESENTATIVE STARK. Who do you know that doesn't?

MR. SCOTT. Who thinks it works in Maryland.

REPRESENTATIVE STARK. Who do you know in Maryland doesn't like it?

MR. SCOTT. I don't know of any.

REPRESENTATIVE STARK. Why don't we do the Maryland system, then?

MR. SCOTT. Like Dick Davidson says, just because it works in Maryland doesn't mean it is going to work in southern California.

REPRESENTATIVE STARK. That isn't what he said in Maryland. That is just because he went into a new job.

MR. ANDERSON. One of the big issues about cost shifting is, who can cost shift? If you have a lot of Blue Cross patients, you can cost shift. If you are an inner-city hospital, you don't have much of an ability to cost shift.

MR. ALTMAN. As you know, I basically support what you are saying. I would make two modifications in it to allow some degree of managed care and competition to play into it.

One, to the extent that a managed care plan can demonstrate that it is using resources more efficiently by having their patients stay shorter lengths of stay by using less tests and procedures, they should be able to negotiate a discount below these fixed charges.

Second, to the extent that they can set up a system with a different set of providers, they should be able to negotiate a lower price.

So, yes, we can have an all-payer structure without every payer paying exactly the same rate. But, as you know, I support the idea that we have to bring everybody to the table.

REPRESENTATIVE STARK. Mr. Scott, you don't like that system?

MR. ALTMAN. To do what Jim says we need to do, we need to bundle and provide a decent payment.

What the Chairman says is, you bring government payments, both Medicare and Medicaid, up to decent levels, but what you do is to establish a structure that prevents this kind of fee where the last person in the door pays the check. What we are finding is that the people who are paying the check are the least able to afford it.

Even within managed competition, you wind up with the small businesses and the ones the least well insured have the least clout, and they are paying 200 percent of costs while our big corporations are only paying 150 percent.

REPRESENTATIVE STARK. What is wrong with what he says?

MR. SCOTT. If it were to work in real life as it is described, probably very little. Our experience with the Federal programs has taught us that things don't work out as they are predicted at the beginning. Sometimes,

as Stuart said, in the first few years of PPS, that worked to our advantage. In the most recent years, it has not.

Congressman Stark, it comes back to a basic level of trust. You don't trust us, and we don't trust you.

MR. ALTMAN. Can't we come together?

REPRESENTATIVE STARK. We both trust Stuart!

MR. ALTMAN. I am a very trusting person. I think I can do a good job.

REPRESENTATIVE STARK. That is why he is there.

MR. ANDERSON. In Maryland, I want you to know that we have as many people enrolled in HMOs, or the same percentage, which is slightly higher than the national average, in fact. So, rate setting and managed care are not incompatible.

REPRESENTATIVE STARK. I agree. But my guess is that in any of these programs that have been suggested, the hospitals, the doctors, the pharmaceutical manufacturers, and the insurance companies will oppose them as a complete destruction of the system. That doesn't surprise me because, in each instance, there is some financial reward by staying with the present inefficient system. And there is some resistance to change.

I despair that there will ever be a program that will, somehow, establish a budget. If we are going to control cost, it seems to me, we have to—I know that is a contentious position, but I just don't know how you control costs, unless you are Lockheed and manufacturing for the Government—but other than that, I know of no one outside of the medical industry who gets every bill paid that they submit.

Somehow, if you are going to control those costs, you have to have a budget. And, if you have a budget, somebody has to divvy it up. It is a matter of indifference to me who divvies it up.

Maryland, I think, does a good job, and their politicians like the fight, and the good burghers of Maryland like the way it is providing services, and the Federal Government leaves it pretty much alone. So, the hospitals there don't have to trust me. They have to trust somebody in Baltimore who I don't know, and they do.

I have no quarrel if they want to do that in Massachusetts or anyplace else. I don't know why we shouldn't let them.

But Maryland does say, "This is all we are going to spend, period." That is all we have to get to. It is a matter of indifference to me how you want to get there. But I don't see you doing it without regulation. Whether it is county, city, state, federal, makes no difference to me. But I don't think the hospital association will buy any of those. Am I correct?

MR. SCOTT. You are correct.

REPRESENTATIVE STARK. They want no regulation. Just pay the bills. That is a tough spot for the taxpayers, who are going to catch on to that.

DR. KIMMEY. When I started out, I said the planners are looking for another word for what they do. I talked about planning as a place to look at, in terms of mergers and so forth, and it was immediately assumed that I meant certificate-of-need. They are not the same thing.

I think that we can get along without a blanket certificate-of-need structure, although I think there are some areas where that may be needed, but I don't think we can get along without planning.

It is no more appropriate, in my mind, to say that reimbursement can plan for the way the system ought to look than it was 20 years ago to say that planning can handle how reimbursement looks. You need both. We have abandoned one totally, and we are getting a system that increasingly has no relationship to the community's need.

MR. ALTMAN. One final thing. I know Jim and respect what he is doing, but I am not sure all the hospitals would agree with what he said.

I talk to a lot of hospital administrators who are increasingly uncomfortable with the shifting sands of the current reimbursement system. But I share his concern that government enters into a deal and then doesn't follow through—that is what I think he is really saying, and I guess there is evidence to support him.

MR. SCOTT. Good evidence.

MR. ALTMAN. I think that if everyone was at that table, including the private sector, and they knew that the day that the government paid a dollar less they would have to pay a dollar more, they would line up full square on side of the hospitals to make sure that the government paid their bills.

REPRESENTATIVE STARK. I agree with you.

MR. ALTMAN. And that is what happens in Maryland.

REPRESENTATIVE STARK. The problem with organized advocacy—let's take the AARP. If one group of seniors objects to a program, the AARP will not support it, even though 80 percent of the seniors might. In other words, you have a situation where you are trying to keep your membership. You dare not, if you are running the American whatever it is, offend your rural members, say. They almost have a veto.

So you begin to water this down to the lowest common denominator for any change, which gets to be no change. Similarly, you cannot get a majority of the members of Congress to agree to significant change. You are not going to get 100 percent of the members of the American Hospital Association or the American Medical Association, or the Pharmaceutical Manufacturers Association to agree to one program. And their position pretty much is like the labor unions. If you hurt us one, you have hurt us all. That is the box we are in.

At some point, it falls to us, unfortunately, to vote. That means that we are going to offend someone and make the other person happy. And thus far, Congress keeps looking for the solution that will make everybody happy, and I don't think it is there.

I mean, I think it is close in some area, but certainly we are not going to get this through by unanimous consent.

But, again, the principal purpose here, with whatever program we end up with, is to see if we can come to grips with the Justice Department and the FTC, which I think has frustrated well-intended efforts of the

industry, and that is the purpose that I would like to help them. I know they don't believe that, but that is the purpose of the hearing, to suggest how we can simplify their lives and get a more rational way for them to do some planning under whatever process they agree to.

I thank the panel for their participation.

We will recess for five minutes, and we will then have our second panel.

[Recess.]

REPRESENTATIVE STARK. We will proceed. I apologize for the interruption.

We have our second panel now, which consists of experts in the public hospital community, including Larry Gage, who is president of the National Association of Public Hospitals.

I am pleased to see Ms. Ophelia Long, who is the Chief Executive Officer of my favorite hospital, Highland General in Oakland, California.

Edward J. Renford, Administrator from King/Drew Medical Center, which, with some cooperation, could become my second most favorite hospital.

Donna D. Fraiche, the Chairman of the Medical Task Force in the Downtown Development District in New Orleans, Louisiana, and the home of the second best group of restaurants in the United States.

Finally, Michael A. Morrisey, a professor at the Lister Hill Center for Health Policy and School of Public Health, University of Alabama, Birmingham, Alabama.

We welcome you all and will ask you, if you can, to limit your explanation of your written testimony to about 5 minutes. Then, we will get into a less formal discussion. We will proceed in the order that I introduced you, starting with Larry.

STATEMENT OF LARRY GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

MR. GAGE. Thank you very much, Mr. Chairman.

I am Larry Gage, President of the National Association of Public Hospitals. As we have told you many times in the Ways and Means Committee, NAPH'S members include over 100 of America's metropolitan area safety net hospitals. Most of our members are public, although some are private. These institutions, taken together, comprise America's most important health and hospital system. They have combined revenues of over $10 billion, and they provide over half of their services to Medicaid and low-income, uninsured and underinsured patients.

I am pleased to have this opportunity to testify on the situation of safety net hospitals in America, both today and in the 21st century. My prepared testimony will be submitted for the record. It covers four broad areas.

First, I have described the current situation of America's safety net hospitals in some detail, including the tremendous volume of services that they provide to uninsured patients. Second, I have focused, in particular, on the increasingly acute capital financing crisis confronting these hospitals. In this regard, I am announcing today the results of a new NAPH survey of the capital needs of urban public hospitals; that survey is attached to my testimony.

Third, I have briefly summarized the need for the important new health safety-net infrastructure legislation, which you have introduced, that will help to address this capital crisis. We will be pleased to work with you to streamline the title of that legislation, by the way.

Fourth, I have provided you with NAPH'S principles for achieving national health system reform, against which we believe the specific reform bills that are pending before Congress should be considered.

Despite the critical role that these hospitals play within their communities, the combination of increased demand for their services and pressures to reduce local funding have created a potential crisis today of unprecedented proportions. The continued viability of these hospitals cannot be taken for granted. After decades of underfunding and years of recessionary pressures in many areas, the safety-net infrastructure is beginning to crumble around us. The buildings and equipment on which these hospitals rely have been allowed to deteriorate to the point that delivery of care to major portions of the population is now in jeopardy. A new survey conducted by NAPH gives some indication of the scope of this need.

The average age of the physical plant of urban public hospitals is nearly 26 years, as compared to a national average of only seven years for private hospitals. Many safety-net hospitals are far older than that. For example, public hospitals in Los Angeles, New York, New Orleans and Chicago are over 50 years old, built by the WPA and not the Hill-Burton program. The 51 hospitals responding to our survey indicated 10-year capital needs totaling $10.4 billion.

We also found, not surprisingly, that capital spending by safety-net hospitals is far below that of private facilities. The average capital expenditure for an urban public hospital is $12,600 per bed as compared to an average expenditure for all hospitals of $23,500. In other words, it is half.

In New York City, public hospital capital spending per bed is 59 percent of the industry average. Public hospital capital spending per bed in Louisiana, which you will hear about in a moment, is less than 15 percent of private hospital spending. In California, private hospitals spend five times as large a proportion of their budgets on capital expenditures as do public hospitals. Examples of underinvestment in safety-net facilities can be recounted in communities all across the Nation.

Clearly, with needs such as these, the time for rebuilding and reinvesting in this infrastructure is long overdue. We think the desperate need for

capital and health-care services is itself sufficient reason for making new investment in their futures. We are pleased that this hearing is in the Joint Economic Committee, because we also believe that the benefits from such spending would extend far beyond the immediate ability of these hospitals to deliver health services.

Investment will be a shot in the arm for local economies, no less than any other kind of public works project. Individual public hospital replacement and renovation projects in major cities often exceed $250 million, and a few approach or exceed $1 billion. In fact, as you will hear from my colleagues, needed safety-net hospital projects in Atlanta, Boston, Los Angeles, Chicago, New Orleans and New York are among the largest public works projects ever to be undertaken in those cities.

Unfortunately, many of these hospitals will be unable to secure sufficient financing without federal assistance. A number of obstacles bar these hospitals' access to adequate funding sources, including state and local fiscal crises, the lack of availability of general obligation bond financing in many cities and counties, revenue margins too low to support revenue bonds, and the instability with which the bond markets typically view hospitals that need to rely on local subsidies.

In summary, to follow up on the discussion that you had earlier about the competitive versus the reimbursement and regulatory system, we strongly believe that the marketplace alone cannot and will not be able to decide whether these hospitals get rebuilt or whether they are needed. As Stuart Altman said, you will need to tweak the system in order to generate the spending needed to rebuild these facilities.

In conclusion, Mr. Chairman, the time has come for the Federal Government to step in again and form limited, carefully targeted partnerships with states and local governments and safety-net hospitals to stem this tide of deterioration and to rebuild our health infrastructure. It is important to point out that we are not talking about a broad new Hill-Burton-type program. Rather, we believe that a relatively small amount of targeted, highly leveraged federal funds could make all the difference in uncorking the flow of capital to these institutions. The legislation that you have introduced accomplishes that, using relatively small numbers of federal dollars to leverage many times that amount in the bond market and from other capital sources.

We are grateful for your leadership in introducing this legislation. We are also pleased to let you know that Senators Tom Daschle and John Breaux, who are both members of the Senate Finance Committee, are drafting a companion bill to be introduced in the Senate.

Finally, we have asked that the House and Senate leadership incorporate at least some elements of these proposals in the urban initiative currently being developed in both Houses, and you and your staff have been helpful in that regard as well. In closing, let me urge that we not lose sight of the important and ongoing need for an institutional safety-net in our preoccupation with achieving system-wide health care reform. These

hospitals are here today serving millions of uninsured and underinsured, as well as providing many community-wide services. For a variety of reasons, they will continue to be needed in the 21st century, as well, whatever we do about health insurance reform. It is essential that we take steps today to insure their long-term viability.

I would be happy to answer any questions at the conclusion of all presentations.

REPRESENTATIVE STARK. Thanks very much.

[The prepared statement of Mr. Gage, together with tables and data, follows:]

PREPARED STATEMENT OF LARRY GAGE

Mr. Chairman, members of the Committee, I am Larry Gage, President of the National Association of Public Hospitals (NAPH). NAPH's members include over 100 of America's metropolitan area safety net hospitals. These institutions (taken together) comprise America's most important health and hospital system. With combined revenues of over $10 billion, these hospitals provide over 50 percent of their services to Medicaid and low income uninsured and underinsured patients. As you debate the structure of the hospital industry in the 21st century, it is imperative that you understand the critical role that this handful of institutions plays and will continue to play in holding together the threadbare fabric of the health care delivery system in most of our nation's urban areas.

I am pleased to have this opportunity to testify on the situation of safety net hospitals in America both today and in the future. My testimony will cover four broad areas:

- First, to provide the appropriate background, I would like to describe the current situation of America's safety net hospitals in some detail, including the fragile sources of financing of such hospitals and the increasing demand for their services by uninsured patients.
- Second, I will focus in particular on the increasingly acute capital financing crisis confronting America's urban health safety net institutions, and on the need to include health care institutions in any national policy discussions on rebuilding the infrastructure; in particular, in this regard, I am announcing today the results of a new survey of the capital needs of urban public hospitals.
- Third, I will briefly summarize the important step that can be taken in meeting these capital needs by enactment of the National Health Safety Net Infrastructure Act of 1992, which has been introduced in the House as H.R. 4521 by House Ways & Means Health Subcommittee Chairman (and Joint Economic Committee Member) Pete Stark. Senate Finance Committee Members Tom Daschle and John Breaux are drafting legislation for introduction of a companion bill in the Senate.
- Fourth, I will provide you with NAPH's principles for achieving national health system reform, against which we believe the specific reform bills before Congress should be considered, and also make some observations about the importance of continuing to address the other immediate needs of our nation's health safety net hospitals and the patients they serve.

AMERICA'S SAFETY NET HOSPITALS

With the nation still mired in the depths of a prolonged and painful recession, a new and growing population of uninsured Americans has been forced to rely for health care on the already overburdened safety net hospital system. This small and extremely fragile safety net is comprised of no more than two to three hundred public and non-profit teaching hospitals, mostly in metropolitan areas, and by sole community hospitals in many isolated rural areas.

America's urban safety net hospitals provide an extraordinarily high volume of primary and outpatient care, serving as family doctor and emergency department for both insured and uninsured low-income patients. Without these safety net hospitals, access to health care would simply not exist for many of these people. In addition, safety net

hospitals provide essential, specialized health services to all residents of their communities, regardless of economic status, including trauma care, burn centers, high-risk pregnancy services and neonatal intensive care.

Despite the critical role many such hospitals play within their communities, the combination of increased demand for their services and pressures to reduce local funding have created a potential crisis today of unprecedented proportions.

The most recent full year for which NAPH has comprehensive national data from its annual survey of members is 1989. The results of this survey (which are attached to my testimony) reveal the full scope of the trying conditions under which safety net hospitals must operate, and the significant differences between these hospitals and the rest of the health industry:

- Safety net hospitals are bursting at the seams, providing an extraordinary volume of inpatient and outpatient care. NAPH members provided, on average, over 265,000 outpatient visits, 18,600 inpatient admissions, and almost 3,600 live births in 1989.
- 68 NAPH member hospitals across the nation averaged an 83 percent occupancy rate in 1989 -- up from 81 percent in 1988 -- with many hospitals approaching 100 percent. The average occupancy rate at other short-term general hospitals, according to American Hospital Association data, is 66 percent.
- Many of the patients in safety net hospitals are uninsured, even by Medicaid; in 1989, 44 percent of all discharges and 37 percent of all inpatient days were unsponsored in NAPH member hospitals; on average, over 175,000 outpatient visits, or 56 percent of all visits, were also uninsured.
- The average NAPH member hospital experienced nearly 70,000 emergency department and over 209,000 outpatient department visits in 1989, with some members providing as many over 200,000 emergency room visits and over 500,000 outpatient visits. Other short-term (non-safety net) general hospitals averaged less than 15,400 emergency visits and slightly more than 37,000 outpatient visits.
- Likewise, NAPH members averaged 3,600 births in 1989, compared with a national average of just 700; some NAPH hospitals delivered as many as 14,000 live babies in 1989, a number surpassed only by one other hospital in the entire world (in Singapore).
- Just 18 percent of the net operating revenues of safety net hospitals were derived from private insurance in 1989, while 52 percent of net revenues came from Medicaid and direct state/local subsidies (an average of $43 million in Medicaid revenues and $33 million in direct subsidies).
- Without direct state or local subsidies, NAPH member hospitals would experience average operating deficits of over 43 percent of revenues; even with subsidies, 65 percent of NAPH hospitals still experience operating deficits.
- The growth and persistence of these deficits have been exacerbated by new epidemics concentrated on the poor and disenfranchised, including AIDS, drug abuse, drug resistant tuberculosis, high risk infants, and inner city violence.
- The ability of safety net hospitals to cope with these new epidemics and still serve their other patients is further affected by critical personnel shortages and the inability to obtain capital for renovation, maintenance and technology.
- These new epidemics, combined with the general lack of availability of preventive health services for the uninsured, means that safety net patients are

also more likely to be sicker than insured patients – especially inner city minorities. The New England Journal of Medicine reported last year that black men in Central Harlem now have a lower life expectancy than men in Bangladesh. And here in Washington, D.C., a resident of Anacostia is ten times more likely to require hospitalization for pneumonia than a resident of Georgetown.

- Nor are these problems limited to New York and Washington – they affect middle America as well. For example, 15 percent of all babies born at Kansas City's Truman Medical Center in 1989 had traces of cocaine in their urine.

In short, while Congress is debating how to provide access to health care, the nation's safety net hospitals are providing that care **now**, and they are providing it to more and sicker people than at any other time in our nation's history.

THE NEED TO REINVEST IN THE SAFETY NET

Safety net hospitals are clearly fulfilling a vital but often overlooked role in sustaining our nation's health care system. Without these institutions, we would not have the luxury of taking months and even years to decide on the proper approach to health reform. Moreover, without these institutions, no reform plan would stand a chance of success: merely providing low income unemployed or uninsured citizens with some new form of coverage (such as expanding the Medicaid program) will not change who they are or where they live, as we have seen from the discrimination in many areas against Medicaid recipients and others. A safety net will thus always be critical to catch those who inevitably fall between the cracks.

The continued viability of safety net hospitals cannot be taken for granted. After decades of underfunding and years of recessionary pressures, the safety net infrastructure is beginning to unravel around us. The buildings and equipment on which these hospitals rely have been allowed to deteriorate to the point that delivery of care to major portions of the population is now in jeopardy.

The average age of the physical plant of urban, public hospitals is nearly 26 years, as compared to a national average of only 7 years for private hospitals. Many safety net hospitals are far older; for example, public hospitals in Los Angeles, New York, New Orleans and Chicago are over 50 years old. Providing up-to-date medical care in these environments is difficult at best.

A number of hospitals have been threatened with loss of accreditation if they do not address their infrastructure needs. Some are spending millions of dollars on patchwork repairs merely to hold on to accreditation when it is clear that major renovations are in order.

RESULTS OF NAPH CAPITAL SURVEY

A new survey conducted by NAPH, the results of which are being announced today for the first time, gives some indication of the scope of this need. (A copy of the survey results is attached to my testimony.)

The survey estimates total capital needs among NAPH's 100 members of $15 billion over ten years. The 51 hospitals responding to our survey indicated ten-year capital needs totalling $10.4 billion. Two-thirds of the dollar value of these projects entail comprehensive reconstruction. The remaining 32 percent is allocated to safety net

services, medical equipment, physical plant deficiencies, and support services and systems.

We also found, not surprisingly, that capital spending by safety net hospitals is far below that of private facilities. The average capital expenditure for urban public hospitals is $12,600 per bed, as compared to an average expenditure for all hospitals of $23,500. In New York City, public hospital capital spending per hospital bed is 59 percent of the industry average. Public hospital capital spending per bed in Louisiana is less than 15 percent of private hospital spending. In California, private hospitals spend five times as large a portion of their budgets on capital expenditures as do public hospitals. Examples of under-investment in safety net facilities can be recounted in communities all across the nation.

Consider the following examples of the infrastructure handicaps confronting some of the nation's older public hospital systems:

- 25 percent of first year residents at Cook County Hospital in Chicago have converted positive for tuberculosis because there are no isolation rooms for infected patients and no air handling system. At Bellevue Hospital in New York, the rate is 11 percent for first year residents and 5 percent for nurses, for the same reasons.
- Some of the nursing stations at Cook County are located an entire city block away from patient rooms.
- Cook County's power plant is incapable of supporting air conditioning.
- Women at Cook County may give birth on a "labor line" rather than in a labor suite, without any semblance of privacy.
- As recently as ten years ago, patients at Queens County Hospital in New York were found with maggots in their wounds. The cause turned out to be flies and vermin that gained access to the patients through the unscreened windows, which had to be left open in the summer because of the lack of air conditioning. Replacing the windows has become a top priority at Queens, displacing for the time being several other equally urgent unmet needs.
- Open wards still exist at Queens County, resembling a scene out of "Gone with the Wind." They offer no privacy; patients share gang showers and toilets. The situation is contrary to all modern notions of appropriate patient care, but no capital is available for renovations.
- Boston City Hospital's current inpatient facilities and clinical and support departments are spread over 18 different buildings occupying an entire city block. Patients must be transported long distances up and down aging elevators and through underground tunnels merely to receive routine ancillary services such as radiology. Transporting supplies is equally problematic.
- Boston City Hospital, like many other safety net facilities, lacks any air conditioning and even any mechanical ventilation; a hardship during the hot and humid Boston summers.
- At General Hospital at Los Angeles County+USC Medical Center, patients share rooms with four other people with one toilet between them. 28-32 patients share a single bath/shower.
- General also must employ "fire watchers" to circulate the hospital to check for fires – at an annual cost of $600,000 – to comply with HCFA fire safety orders.

Clearly, with needs such as these, the time for rebuilding and reinvesting in our nation's health infrastructure is long overdue. Many urban areas have struggled and

sacrificed to maintain their roads and bridges while their public health and hospital infrastructure has been left largely ignored.

If we are going to rely on these hospitals to continue to provide an adequate safety net into the 21st century, we must act now to rebuild their infrastructure. Their existing physical plants reflect an historic emphasis on inpatient, acute care services. With the shifting emphasis away from this kind health care delivery towards outpatient and ambulatory care settings, capital investment is necessary to enable these hospitals to reorient their focus to meet the new demand. Construction of new community-based primary and preventive care clinics, ambulatory surgery centers and other outpatient services is essential to the future delivery of efficient and high-quality care.

BROADER ECONOMIC BENEFITS OF INVESTING IN THE HEALTH INFRASTRUCTURE

The desperate need of America's safety net hospitals for an infusion of capital is in itself a sufficient reason for making a new investment in their futures. Yet the benefits from such action would extend far beyond the immediate ability to delivery quality health services. The investment would be a shot in the arm for local economies no less than any other kind of public works project. Individual public hospital replacement and renovation projects often exceed $250 million. A few approach or exceed $1 billion. In fact, needed safety net hospital projects in Atlanta, Boston, Los Angeles, Chicago, New Orleans, and New York represent the single largest public works projects ever to be undertaken in those cities. The boost they provide for the local economy and employment is magnified by large multiplier effects, initially within the local construction industry, and later in the hospital-related service economy. These institutions are often the largest single employers in their communities. The revitalization of their facilities and of their operating budgets will have a continuing and positive impact on their local economies for years to come.

In fact, the history of America's health safety net has been one in which periodic federal support has been essential both to the construction and preservation of this infrastructure and to the economic vitality of the areas where these hospitals are located. As noted above, a number of our largest urban public hospitals date back to the 1930s, when they were initially constructed with substantial assistance from the WPA and other New Deal programs. In the 1960s and 1970s, the Hill-Burton program, and the increased availability of tax exempt financing, led to a second wave of hospital construction.

Unfortunately, in more recent years, many safety net hospitals have been unable to secure sufficient financing to undertake rebuilding and renovation projects of the magnitude that is needed. A number of obstacles bar these hospitals' access to adequate funding sources:

- First, the local governments that support safety net hospitals are often far too financially pressed to fund capital projects directly or through the issuance of general obligation bonds.
- Second, the Hill-Burton program essentially died out in the late 1970s, and has not been available for many years.
- Third, with budgetary constraints suppressing local government subsidies, many safety net hospitals' operating margins are far too slim to support debt service payments.

- Fourth, even where debt service payments are feasible, bond markets often view the local appropriations as too uncertain to be factored into the institution's revenue stream, resulting in low bond ratings and higher interest rates.
- Fifth, bond or mortgage insurance under the FHA program is often unavailable for much the same reason. For many safety net hospitals, access to capital is but a pipedream -- a cruel tease in the face of their relentless decay.

NEED FOR NEW FEDERAL LEGISLATION

The time has come for the federal government to step in again and form **limited, carefully targeted** partnerships with state and local governments and safety net hospitals to stem this tide of deterioration and rebuild our nation's health infrastructure. It is important to note that we are not talking about a broad new "Hill-Burton" type program. Rather, we believe that a relatively small amount of targeted, highly leveraged federal funds could make all the difference in uncorking the flow of capital to these institutions.

Towards that end, NAPH strongly urges this Committee to support immediate enactment of the National Health Safety Net Infrastructure Act of 1992, H.R. 4521. We are grateful for the leadership of Chairman Stark for introducing this important piece of legislation in March, and of Senators Daschle and Breaux who are drafting legislation to introduce a companion bill in the Senate. We have also asked that the Senate Majority Leader and the House Democratic leadership incorporate at least some elements of these proposals in the urban initiatives currently being developed.

The National Health Safety Net Infrastructure Act would establish a health safety net infrastructure trust fund in the U.S. Treasury from which public and non-profit safety net hospitals could receive loan guarantees, interest rate subsidies, direct loans and direct grants. The assistance will be targeted only to those hospitals most in need: hospitals that are publicly owned or operated, quasi-public benefit corporations, or private, non-profit hospitals with a government contract to provide indigent care representing at least 10 percent of revenues. In addition, the hospitals must qualify as "high" disproportionate share providers under Medicare, as "Pickle" disproportionate share hospital, as an Essential Access Community Hospital, or as a federally qualified health center to be eligible. (We anticipate that the version of the bill to be introduced in the Senate will have a separate definition of eligible rural provider.)

The assistance will be available in four forms, depending on the hospital's resources and need:

- **Loan guarantees** will provide federal guarantees of loan repayment to non-federal lenders making loans to qualified hospitals for hospital replacement, modernization and renovation projects. By reducing lender risk, the guarantees will improve access to capital and reduce interest rates associated with such debt.
- **Interest rate subsidies** will partially offset debt service payments where state or local governments have demonstrated a significant commitment to financing safety net hospital renovation projects.
- **Direct matching loans** will be available for projects designed to achieve compliance with accreditation standards, life safety code standards, and other certification standards, and projects related to the provision of new services.

State, local or private matching participation in the amount of at least 25 percent of the project value will generally be required for qualification.

- **Direct matching grants** will be available for projects to correct life safety or accreditation violations, for projects to maintain essential services such as obstetrics or trauma care, and for limited planning grants to hospitals requiring pre-approval assistance in order to apply for other assistance under the program.

These carefully targeted funds will leverage approximately four times their value in funding from other sources. Over five years, the Act could generate sufficient capital from all sources to meet the estimated $20 billion in immediate needs facing urban and rural safety net hospitals. Several options for financing the trust fund are available. H.R. 4521 is financed through a 1 percent premium tax on employer-provided health insurance. The Senate bill will likely tap a currently unallocated pool of funds containing assets confiscated by the U.S. Customs Service. We are not wedded to any of these financing mechanisms, although we understand the need for this bill to be self-financing; we would welcome the advice of the Joint Economic Committee. Whatever source is used, the investment will pay off handsomely in securing a vital and healthy safety net for years to come.

NAPH PRINCIPLES FOR HEALTH COVERAGE REFORM

Because the prospect of national health reform must be an integral part of the committee's assessment of the structure of the hospital industry in the 21st century, I would like briefly to set forth NAPH's principles for reform. Clearly the critical feature of any national health plan is universal access. **Universal health coverage must remain the single most important legislative and policy goal of our nation's health system.** To be truly effective, NAPH members believe that a nationwide program is an essential component of genuine health coverage reform; we would lend our support to any number of proposals which achieve this crucial goal.

NAPH members remain convinced that leadership for comprehensive reform must come from the federal government. In this context, we are pleased to set forth some essential criteria for any program of universal health access and coverage for all Americans. The following principals, at a minimum, have been endorsed by NAPH member hospitals as essential to any national health plan:

- While incremental improvements are acceptable in their own right, the goal of any national health plan must be nothing less than universal access or coverage for all.
- However, not every individual needs to receive **insurance** coverage to be guaranteed true access under a universal health plan; it must be recognized that there will always be individuals who fall through the cracks, and that it is acceptable to provide access for such persons through the preservation of a strong and well-financed **institutional safety net.**
- A national health plan must require the federalization of the Medicaid program, and quite possibly its elimination and merger with Medicare.
- A core national minimum benefit package must be developed that is neither so rich that it is unaffordable, nor so poor that it fails to cover essential preventive, primary care and hospital services or guard against the prospects of catastrophic illness.
- The present system of private insurance can continue under a national health plan, but insurance reform is an essential part of any national health package;

the federal government should preempt state regulation to the extent necessary to set national standards for health insurance plans, which include mandating minimum benefit packages on all employers above a reasonable size, reinstatement of community rating, and curbing current trends toward exclusion of preexisting conditions (or setting post-illness limits on specific diseases such as AIDS).

- States must be permitted wider latitude to experiment with new plans, including the ability to waive ERISA constraints on the regulation of self-insured businesses.
- Any national plan must include a heavy emphasis on preventive and primary care and must provide adequate support for initiatives to encourage changes in lifestyles.

CONTINUED NEED FOR SAFETY NET HOSPITALS

Our current health safety net is extremely fragile and underfunded today, and for many reasons, even if national health insurance were adopted this year, these institutions will need continued support well into the future:

- Any new system is likely to be phased in over a long period of time.
- Even under a universal system, many of the currently uninsured will fare little better than patients on Medicaid today, who in many states find their access restricted to those few "open door" hospitals and clinics who are willing to serve them.
- In addition, many of the currently uninsured suffer from a variety of health and social problems very different from those of middle America; AIDS, drug abuse, tuberculosis, and teenage pregnancies are often augmented by homelessness, joblessness, and lack of education. While no health care provider can fully cope with all of these problems, our urban safety net hospitals are currently the only ones even attempting to do so.
- With the dramatic cost containment efforts already being imposed under the current system by both public and private payers, even insured individuals are more likely to receive many expensive and unprofitable services (such as trauma, burn care, and neonatal intensive care) in safety net hospitals.
- Finally, many safety net hospitals are simply located in the geographic areas where most uninsured Americans reside – areas which, even if national health coverage were fully implemented, most other health care providers would be unwilling or unable to serve.

For these reasons, in the final section of my prepared testimony, I would like to call your attention to a number of other short term needs that must be met over the next several years to ensure that the nation's safety net hospitals can continue to fulfill their mission.

MEETING THE IMMEDIATE NEEDS OF SAFETY NET HOSPITALS

1. <u>The Medicare Disproportionate Share Hospital and Medical Education Adjustments Must Be Preserved and Increased</u>

Medicare represents a relatively smaller proportion of the patient load in safety net hospitals than in the rest of the industry (only 18%, as compared to 40% on average for the industry as a whole). Nevertheless, it is usually the single most important non-

indigent payor in many safety net hospitals, and as such, constitutes an essential part of patient care revenues.

Congress has made great strides in mandating Medicare payment adjustment increases for "disproportionate share hospitals." This program has grown from paying just $200 million in its first year to well over $1.4 billion in 1991. In the last three years, Congress has also refrained from making any further reductions in the indirect teaching adjustment. This has resulted for the first time in actual real dollar gains in Medicare reimbursement for safety net hospitals, although these gains have not succeeded in erasing the significant operating deficits of such hospitals (such deficits currently average over $14 million, or –9%).

2. Direct Institutional Operating Support for Safety Net Hospitals Must Become an Immediate Federal Priority.

While Medicare clearly has a role to play in sharing the financial burden of safety net hospitals, additional measures are also needed. In particular, as the debate over universal health coverage drags on, it is imperative that the Congress enact some form of **nationwide institutional support for safety net hospitals.**

Ideally, such support should take the form of a national uncompensated care trust fund, with dedicated sources of revenue. Legislation originally introduced in the last Congress as H.R. 754 could serve as a model. That legislation would create a trust fund with the proceeds of a small tax on health insurance premiums; such a tax could generate potentially $600 million to $1 billion for distribution to high volume providers of uncompensated care. Other potential funding sources that have been mentioned include taxes on alcohol, tobacco and firearms, as well as a national excise tax on hospital utilization.

3. Unless and Until Universal Coverage Becomes a Reality, Continued Efforts Must Be Made to Reform the Medicaid Program.

Continued reform of the Medicaid program is an equally essential priority, at least so long as no universal coverage program is in place. Recent Medicaid improvements have expanded eligibility for pregnant women and children, permitted states to continue using a variety of mechanisms for providing extra payments to disproportionate share hospitals, and permitted public and private hospitals to participate in the financing of Medicaid expansions through broad-based provider taxes and the transfer of funds by local governments to states. **It is imperative that states be permitted to continue to make use of these alternative sources of revenues, especially at a time when many are suffering severe budget crises.**

Even with the availability of the augmented payment sources described above, only about half of all states pay significant differentials to "disproportionate" safety net hospitals. In fact, as a result of Medicaid legislation enacted last December, it may prove more difficult in the future for states that have not already improved Medicaid disproportionate share hospital payments to do so now. And a number of states continue to subject hospitals to inadequate base payment rates as well, as evidenced by the proliferation of lawsuits brought by hospitals against state Medicaid agencies around the country. **Both reasonable and adequate Medicaid payment rates, and meaningful disproportionate share hospital payments, must be enforced upon all states.**

In closing, let me just urge that in our preoccupation with developing systemic health reform, we not lose sight of the important and ongoing need for an institutional safety net. These hospitals are here today serving millions of uninsured and underinsured; they will be here serving those with no other coverage in the future as well. It is essential for us to take the kinds of steps I have outlined today to ensure the continued viability of the safety net for generations to come.

I would be pleased to answer any questions you may have at this time.

AMERICA'S HEALTH SAFETY NET INFRASTRUCTURE

NEW REPORT ON THE CAPITAL CRISIS

FACING METROPOLITAN AREA SAFETY NET HOSPITALS

Tables to accompany the testimony of
Larry S. Gage
President
National Association of Public Hospitals
Before the Joint Economic Committee
U.S. Congress, Washington, D.C.

Not for release prior to
10:00 a.m., Wednesday, June 17, 1992

The National Association of Public Hospitals completed a comprehensive survey of the capital needs and spending patterns of 51 members. The members studied operate 51 acute care public hospitals in urban areas across the country with 25,993 beds. Major findings of the study include:**

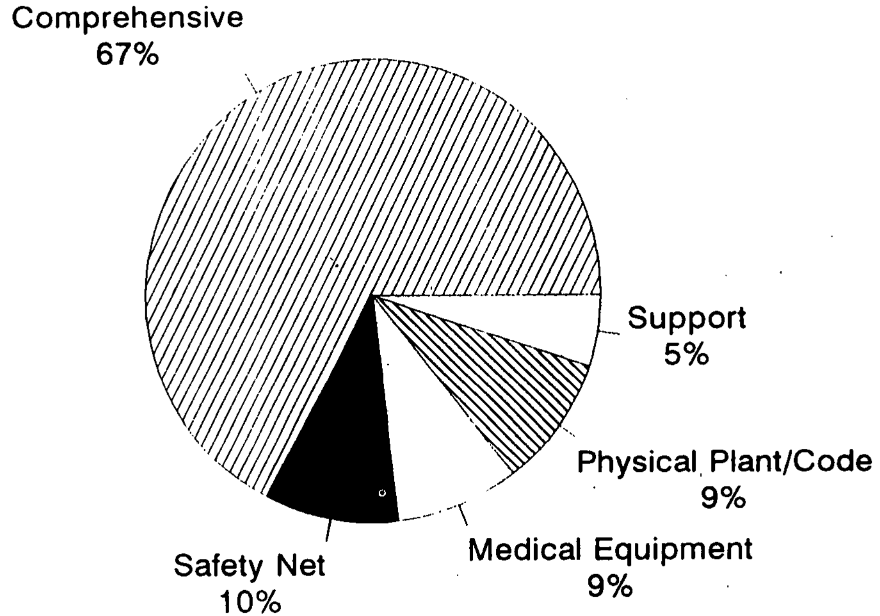
* The infrastructure needs of these hospitals total $10.4 billion over the next 10 years. Conservatively, the ten year capital needs of all major public hospitals is estimated to exceed $15 billion.

* Over two-thirds of the dollar value of the need is devoted to comprehensive reconstruction projects.

* Almost one-tenth or $946 million of the required investments are for safety net projects.

* The remaining 23 percent is allocated to medical equipment, physical plant or code deficiencies, and support services and systems.

Infrastructure Needs of NAPH Member Hospitals



Data from the 1990 and 1991 NAPH Capital Financing Survey

The infrastructure investments required were categorized into the following project types:

- **Comprehensive reconstruction:** major new or replacement project effecting most or all patient care areas

- **Safety net service:** renovation, expansion, or replacement of such services as obstetrics, neonatal, emergency and trauma, outpatient services

- **Medical equipment:** purchases of equipment used in direct patient care

- **Physical plant:** correction of life-safety and JCAHO violations, and structural and building deficiencies

- **Support:** administrative, lab, materials management, and other services and systems sustaining clinical functions

EXAMPLES OF INFRASTRUCTURE NEEDS OF SAFETY NET HOSPITALS

Major Reconstruction Projects:

Grady Memorial Hospital, Atlanta, GA	$ 320 million
Denver General Hospital, Denver, CO	$ 100 million
Boston City Hospital, Boston, MA	$ 170 million
Cook County Hospital, Chicago, IL	$ 550 million
Los Angeles County+USC Medical Center, Los Angeles, CA	$1,230 million
Los Angeles County/East Valley Medical Center, City of Industry, CA	$ 400 million
Olive View Medical Center, Sylmar, CA	$ 110 million
Harbor/UCLA Medical Center, Torrance, CA	$ 121 million
High Desert Hospital, Lancaster, CA	$ 248 million
Ranchos Los Amigos Medical Center, Downey, CA	$ 298 million
Charity Hospital, New Orleans, LA	$ 197 million
Kings County Hospital Center, New York, NY	$ 614 million
Queens County Hospital Center, New York, NY	$ 115 million
Highland General Hospital/Fairmont Hospital, Alameda County, CA	$ 400 million
D.C. General Hospital, Washington, D.C.	$ 140 million
Harborview Medical Center, Seattle, WA	$ 150 million
Jackson Memorial Hospital, Miami, FL	$ 122 million
San Mateo County General Hospital, San Mateo, CA	$ 60 million
Santa Clara Valley Medical Center, San Jose, CA	$ 238 million
Merrithew Memorial Hospital, Martinez, CA	$ 85 million
University of Chicago Hospital, Chicago, IL	$ 80 million
South Broward Hospital District, Hollywood, FL	$ 32 million
Stanislaus Medical Center, Modesto, CA	$ 30 million
Wishard Memorial Hospital, Indianapolis, IN	$ 75 million
Truman Medical Center, long term care facility, Kansas City, MO	$ 19 million
EK Long Memorial Hospital, Baton Rouge, LA	$ 48 million
HP Long Medical Center, Pineville, LA	$ 36 million
Elmhurst Hospital Center, New York, NY	$ 53 million
Kings County Hospital Center skilled nursing facility, New York, NY	$ 34 million
Queens Hospital Center, skilled nursing facility, New York, NY	$ 40 million
Erlanger Medical Center, ancillary wing, Chattanooga, TN	$ 38 million
Natividad Medical Center, Salinas, CA	$ 82 million
Univ of North Carolina Hospital, children's hospital, Chapel Hill, NC	$ 72 million

Safety Net Services Projects:

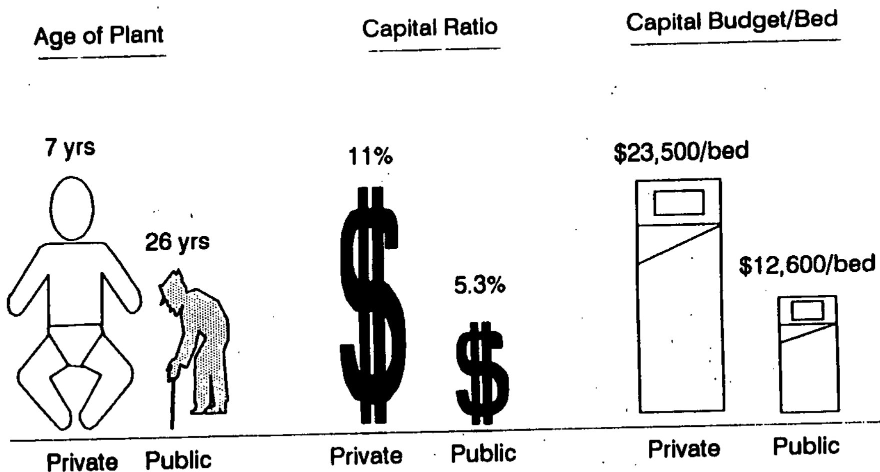
Project	Amount
King/Drew Medical Center, trauma center, Los Angeles, CA	$ 77 million
Regional Med Ctr at Memphis, burn center expansion, Memphis, TN	$ 6 million
Parkland Memorial Hospital, Trauma Center, Dallas, TX	$ 18 million
Denver General Hospital, emergency room renovation, Denver, CO	$ 3 million
Harlem Hospital Center outpatient facility, New York, NY	$ 35 million
Milwaukee County Medical Center, ambulatory care building, Milwaukee, WI	$ 38 million
Los Angeles County, perinatal expansion, Los Angeles, CA	$ 32 million
Wishard Memorial Hospital, special care nursery, Indianapolis, IN	$ 2 million
Truman Medical Center, ICU expansion, Kansas City, MO	$ 13 million
University Medical Center, expansion and renovation of post partum, labor and delivery and neonatal areas, Lafayette, LA	$ 11 million
Regional Medical Center at Memphis, ambulatory care building, Memphis, TN	$ 34 million
Nassau County Medical Center, Emergency room expansion, East Meadow, NY	$ 12 million
New York City Health and Hospitals Corp., offsite ambulatory care, New York, NY	$ 23 million
University of Texas Health Center at Tyler, ambulatory care expansion, Tyler, TX	$ 11 million
Los Angeles County health centers	$ 80 million

Medical Equipment:

Project	Amount
Regional Medical Center at Memphis, medical equipment for the newborn center and radiation oncology, Memphis, TN	$ 11 million
Westchester County Medical Center, Valhalla, NY	$ 24 million
Cook County Hospital, Chicago, IL	$ 6 million
Boston City Hospital, Boston, MA	$ 8 million
Wishard Memorial Hospital, MRI facility, Indianapolis, IN	$ 3 million
Highland General Hospital, Oakland, CA	$ 11 million

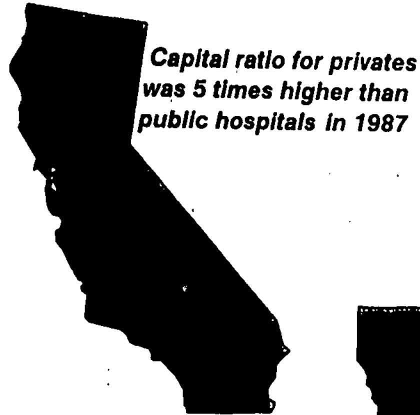
Physical Plant Projects:

Project	Amount
Wishard Memorial Hospital, fire protection, incinerator, warehouse projects, Indianapolis, IN	$ 6 million
New York City Health and Hospitals Corp., asbestos removal, New York, NY	$ 3 million
Cook County Hospital, life safety, Chicago, IL	$ 20 million
Los Angeles County, fire/life safety, accreditation, Los Angeles, CA	$ 11 million

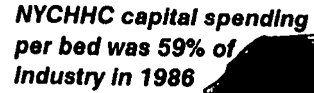


Note: Public data are from NAPH member surveys; private data are from industry sources

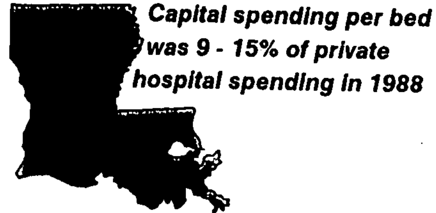
These results are consistent with the findings of local studies



Capital ratio for privates was 5 times higher than public hospitals in 1987



NYCHHC capital spending per bed was 59% of industry in 1986



Capital spending per bed was 9 - 15% of private hospital spending in 1988

SELECT CHARACTERISTICS OF SAFETY NET HOSPITALS

AN UPDATE OF FINANCIAL AND UTILIZATION TRENDS

Data to accompany the testimony of
Larry S. Gage
President
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Before the Joint Economic Committee
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Not for release prior to
10:00 a.m., Wednesday, June 17, 1992

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The National Association of Public Hospitals (NAPH) has for the last decade represented a significant proportion of American's metropolitan area safety net hospitals. Today, NAPH members include 100 hospitals. These 100 institutions taken together comprise America's most important health and hospital systems. With combined gross revenues of over $12 billion, these major, tertiary hospitals truly serve as "national health insurance" by default, in most of our nation's metropolitan areas.

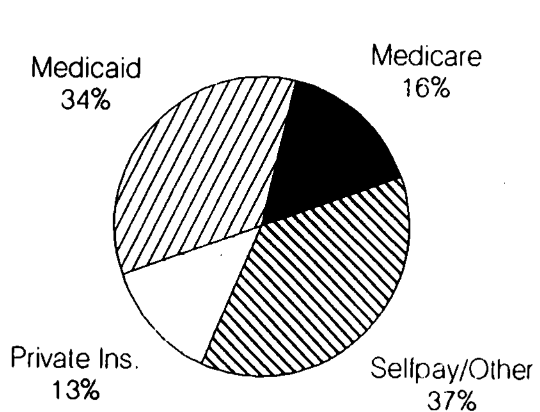
The need for America's safety net hospitals in the 1990s will be greater than ever. The volume of services provided continues to increase placing a greater burden on safety net hospitals. The average NAPH member hospital had 499 beds and admitted over 18,600 patients a year in 1989. NAPH member hospitals experienced an average of almost 70,000 emergency department visits in 1989. NAPH member hospitals also delivered an average of 3,600 babies.

A substantial proportion of the patients of safety net hospitals are uninsured and their number is growing. Thirty-seven percent of inpatient days and 56% of outpatient visits to NAPH member hospitals were by uninsured patients in 1989. Thirty-four percent of inpatient visits and 22% of outpatient visits were by Medicaid patients; 16% and 13% of visits were by Medicare patients and only 13% and 9% of visits to safety net hospitals were by patients with private insurance.

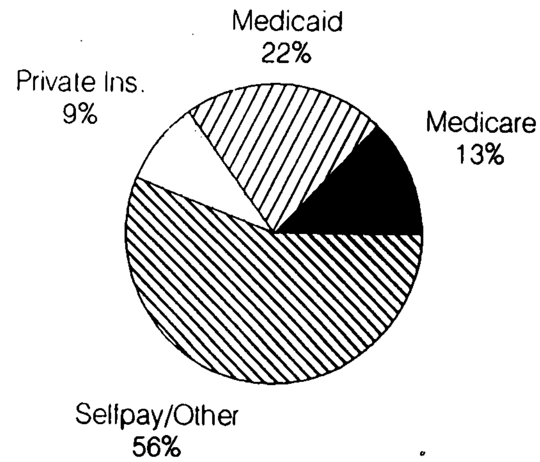
Safety net hospitals are losing money on every category of patients they serve. Sixty-five NAPH member hospitals recorded gross revenues of $12.6 billion. However, 35% of these gross charges were attributable to uninsured ("self-pay) patients. Sixty-five percent had a negative operating margin with the average hospital losing $14.1 million in 1989. Gross charges for Medicaid patients averaged $63.8 million, while collections averaged only $43.4 million. Gross charges for Medicare patients averaged $34.6 million and the collections averaged only $24.7 million. The average safety net hospital even lost money on its few privately insured patients, averaging $27.8 million but just $23.9 million in collections.

The following figures and charts illustrate these numbers and give additional statistics on utilization and financing characteristics for NAPH member hospitals for 1989.

Figure 1: Payer Source for NAPH Hospitals 1989

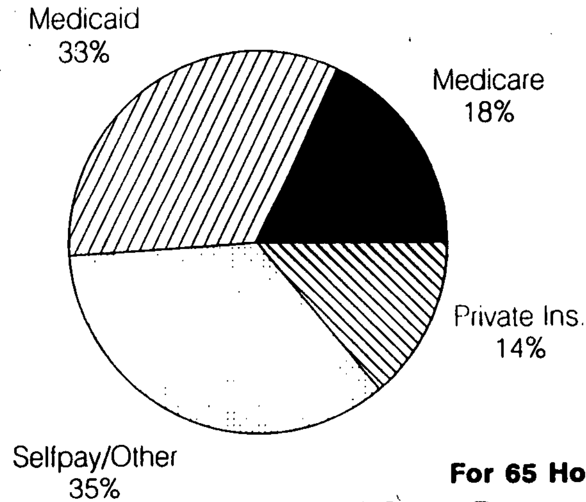


Inpatient Days



Outpatient Visits

Figure 2: Gross Revenues
NAPH Member Hospitals, 1989



For 65 Hospitals
Total Gross Revenues = $12.6 Billion

Figure 3: Net Patient Revenues NAPH Member Hospitals, 1989

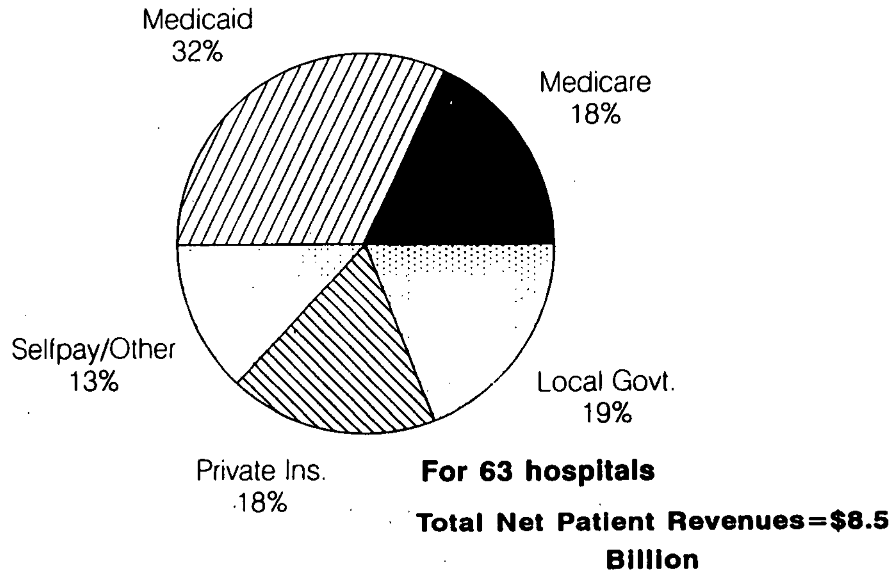


Figure 4: Operating Margins 1986 -1989

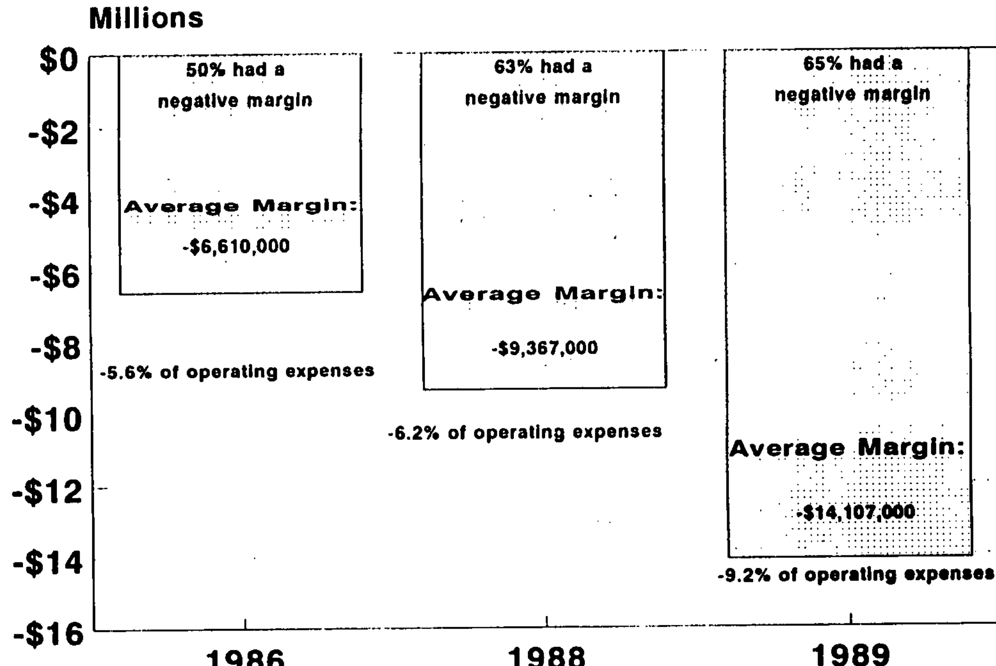


Figure 5: Occupancy Rates for NAPH and Other Short Term General Hospitals

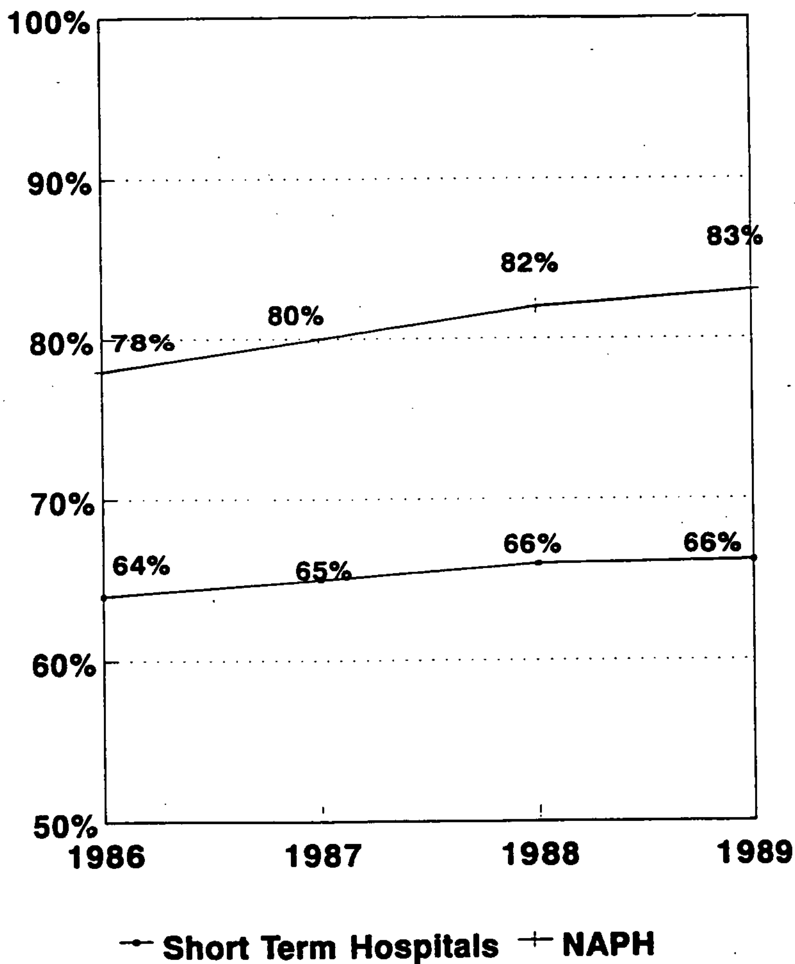


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Chart 1: Gross Revenues – 1989 (in Thousands)

Hospital	City	State	Medicare		Medicaid		Private		Selfpay/Other		Total
Bexar County Hospital District	San Antonio	TX	23,873	12%	30,767	16%	22,965	12%	114,778	60%	192,390
Cook County Hospital	Chicago	IL	27,703	14%	91,114	47%	10,824	6%	62,326	32%	191,968
Cooper Green	Birmingham	AL	5,289	14%	3,475	9%	224	1%	29,913	77%	38,901
Denver Health & Hospital	Denver	CO	24,057	13%	37,695	21%	24,951	14%	95,122	52%	181,825
D.C. General	Washington	DC	19,891	15%	31,934	24%	11,637	9%	71,852	53%	135,314
Erie County Medical Center	Buffalo	NY	38,405	30%	43,384	34%	25,019	20%	20,828	16%	127,637
Erlanger	Chattanooga	TN	78,807	30%	49,515	19%	90,689	35%	40,004	15%	259,014
Fairmont Hospital	san Leandro	CA	11,490	23%	26,837	53%	2,159	4%	10,550	21%	51,036
Grady Memorial Hospital	Atlanta	GA	59,123	24%	45,508	19%	24,065	10%	115,381	47%	244,076
Harris County Hospital	Houston	TX	35,807	10%	67,552	18%	8,255	2%	257,255	70%	368,869
Hurley Medical Center	Flint	MI	47,300	25%	53,000	28%	45,500	24%	43,618	23%	189,418
Jackson Memorial Hospital	Miami	FL	81,944	18%	108,264	23%	93,693	20%	180,753	39%	464,655
Kern Medical Center	Bakersfield	CA	12,618	11%	53,357	48%	10,789	10%	34,211	31%	110,975
Kula Hospital	Kula	HI	311	5%	3,924	69%	132	2%	1,353	24%	5,720
LAC–Harbor–UCLA	Torrance	CA	16,743	6%	116,916	41%	15,675	6%	133,325	47%	282,659
LAC–High Desert Hospital	Lancaster	CA	3,797	12%	14,257	45%	876	3%	12,467	40%	31,396
LAC–Martin Luther King/Drew	Los Angeles	CA	11,878	5%	81,238	37%	11,550	5%	114,345	52%	219,012
LAC–Olive View Medical Center	Sylmar	CA	6,375	4%	74,380	42%	4,069	2%	91,984	52%	176,808
LAC–Rancho Los Amigo	Downey	CA	21,715	12%	108,154	59%	12,746	7%	41,962	23%	184,577
LAC+USC	Los Angeles	CA	24,644	4%	277,699	43%	12,806	2%	328,527	51%	643,676
Louisiana State Univ. Med. Ctr.	Shreveport	LA	22,977	16%	43,998	31%	10,004	7%	63,341	45%	140,320
Maricopa Medical Center	Phoenix	AZ	33,476	20%	79,865	48%	1,303	1%	51,120	31%	165,764
MD Anderson	Houston	TX	50,280	21%	8,256	3%	104,119	43%	82,024	34%	244,679
Medical Center of Central Georgia	Macon	GA	80,819	41%	30,307	15%	70,717	36%	16,164	8%	198,007
Merrithew Memorial Hospital	Martinez	CA	14,100	18%	35,147	45%	3,674	5%	25,382	32%	78,302
Milwaukee Medical Complex	Milwaukee	WI	48,446	26%	24,185	13%	50,279	27%	61,966	34%	184,876
Nassau County Medical Center	East Meadow	NY	53,905	26%	62,529	30%	47,203	23%	42,085	20%	205,721
NYC– Bellevue Hospital	NY	NY	46,962	13%	223,350	60%	16,261	4%	88,291	24%	374,863
NYC– Bronx Municipal	Bronx	NY	53,020	19%	145,222	52%	16,556	6%	62,177	22%	276,974
NYC– Coney Island	Brooklyn	NY	60,171	38%	54,493	34%	12,385	8%	31,250	20%	158,299
NYC– Elmhurst	Elmhurst	NY	44,192	19%	106,096	46%	12,519	5%	66,587	29%	229,395
NYC– Harlem Hospital	NY	NY	47,527	18%	149,529	57%	7,047	3%	57,359	22%	261,462
NYC– Kings County	Brooklyn	NY	40,071	10%	216,398	56%	24,477	6%	104,312	27%	385,258
NYC– Lincoln Medical	Bronx	NY	19,377	9%	137,188	63%	10,575	5%	50,294	23%	217,434
NYC– Metropolitan Hospital	NY	NY	32,001	16%	120,296	61%	7,070	4%	38,380	19%	197,748
NYC– North Central Bronx	Bronx	NY	19,291	13%	89,254	61%	9,161	6%	28,842	20%	146,548
NYC– Queens Hospital Center	Jamaica	NY	35,565	18%	109,306	55%	9,281	5%	43,382	22%	197,534
NYC– Woodhull Hospital	Brooklyn	NY	25,644	12%	139,526	63%	7,265	3%	47,849	22%	220,285
Parkland Memorial Hospital	Dallas	TX	53,916	16%	33,773	10%	52,043	16%	193,874	58%	333,606
Phoebe Putney Memorial Hospital	Albany	GA	35,155	35%	16,318	16%	38,391	38%	10,726	11%	100,590
Pontiac General Hospital	Pontiac	MI	37,309	33%	21,078	18%	53,499	47%	2,513	2%	114,399
Regional Medical Center	Memphis	TN	23,165	11%	62,341	30%	34,738	17%	84,435	41%	204,679
Riverside General Hospital	Riverside	CA	14,601	11%	45,995	34%	7,348	5%	67,170	50%	135,113
San Bernardino County	San Bernardino	CA	13,014	9%	64,543	43%	12,715	9%	59,027	40%	149,299
San Joaquin	Stockton	CA	12,171	15%	29,011	36%	9,178	12%	29,169	37%	79,529
San Mateo County General	San Mateo	CA	10,467	22%	11,946	25%	2,285	5%	22,436	48%	47,132
South Louisiana Medical Center	Houma	LA	6,368	15%	22,098	54%	5,228	13%	7,531	18%	41,225
St. Louis Regional	St. Louis	MO	17,852	18%	26,731	27%	3,970	4%	50,705	51%	99,259
SUNY at Syracuse	Syracuse	NY	39,226	33%	19,626	17%	34,121	29%	25,526	22%	118,500
Tampa General	Tampa	FL	104,176	30%	60,132	17%	110,507	31%	76,788	22%	351,604
Tarrant County Hospital	Fort Worth	TX	9,413	9%	10,751	11%	5,066	5%	76,846	75%	102,076
Temple University	Philadelphia	PA	112,633	28%	133,630	34%	81,882	21%	67,416	17%	395,560
Thomason	El Paso	TX	10,448	10%	25,618	25%	17,581	17%	46,816	47%	100,463
Truman Medical Center	Kansas City	MO	24,386	21%	36,715	32%	8,046	7%	44,781	39%	113,928
U of Chicago	Chicago	IL	122,446	25%	121,786	25%	125,895	25%	124,563	25%	494,690
UMDNJ	Newark	NJ	19,716	11%	41,373	22%	34,135	18%	90,977	49%	186,200
University Hospital of Brooklyn	Brooklyn	NY	42,289	31%	38,255	28%	40,793	30%	13,361	10%	134,697
University Medical Center,	Lubbock	TX	13,151	17%	19,660	25%	21,540	27%	24,915	31%	79,266
University of Nebraska	Omaha	NE	24,149	17%	27,005	19%	68,921	49%	21,728	15%	141,803
University of New Mexico	Albuquerque	NM	20,256	13%	37,009	24%	36,010	23%	61,841	40%	155,117
University of North Carolina	Chapel Hill	NC	57,114	27%	39,532	19%	75,664	36%	37,668	18%	209,978
UT Galveston	Galveston	TX	43,830	19%	34,518	15%	37,884	16%	118,083	50%	234,314
Vanderbilt	Nashville	TN	75,012	23%	59,687	18%	28,213	9%	160,658	50%	323,571
Washington–St. Tammany	Bogalusa	LA	888	32%	1,777	63%	136	5%	0	0%	2,801
Wishard Memorial Hospital	Indianapolis	IN	27,062	21%	16,546	13%	15,438	12%	66,983	53%	126,029
TOTAL			2,248,806	18%	4,151,359	33%	1,808,763	14%	4,347,889	35%	12,558,823
AVERAGE			34,612		63,867		27,843		66,891		193,213
COUNT			65		65		65		65		65
MINIMUM			311		1,777		132		0		2,801
MAXIMUM			122,446		277,699		125,895		328,527		643,676

Chart 2: Net Revenues – 1989 (in Thousands)

Hospital	City	State	Medicare	Medicaid	Private	Selfpay/Other	City/County/State	Total Patient Revenues	Non-Patient Operating	Total Operating	Non-Operating	Total Revenue
Cook County Hospital	Chicago	IL	38,814	[illegible]	16,764	[illegible]	[illegible]	387,771	[illegible]	[illegible]	0	[illegible]
Cooper Green	Birmingham	CA	3,811	[illegible]	149	7,880	[illegible]	[illegible]	1,880	37,880	[illegible]	[illegible]
DC General Hospital	Washington	DC	14,387	[illegible]	[illegible]	[illegible]	44,430	[illegible]	8,129	110,809		110,809
Denver Health & Hosp.	Denver	CO	18,001	21,813	28,418	0	30,121	108,080	7,879	[illegible]	[illegible]	[illegible]
Erie Cty Med Ctr	Buffalo	NY	37,887	40,078	21,880	[illegible]	[illegible]	[illegible]	7,732	[illegible]	1,247	[illegible]
Erlanger	Chattanooga	TN	46,738	[illegible]	[illegible]	[illegible]	3,000	178,130	4,428	178,578	[illegible]	184,272
Fairmont Hospital	San Leandro	CA	8,764	21,164	[illegible]	[illegible]	[illegible]	38,840	1,887	38,807		38,807
Grady	Atlanta	GA	[illegible]	40,719	14,078	12,080	[illegible]	308,091	3,800	[illegible]	[illegible]	213,375
Harris County Hospital	Houston	TX	13,880	[illegible]	[illegible]	0	[illegible]	214,741	8,381	220,101	[illegible]	[illegible]
Jackson Memorial Hospital	Miami	FL	[illegible]	70,881	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]		[illegible]
Kern Medical Ctr.	Bakersfield	CA	11,168	28,176	6,307	[illegible]	18,100	70,141	1,111	71,752	[illegible]	74,081
Kula Hospital	Kula	HI	221	2,870	129	815	[illegible]	[illegible]	80	4,734		4,734
LAC–Harbor–UCLA	Torrance	CA	14,319	70,080	[illegible]	[illegible]	80,307	184,781	6,742	[illegible]	30,130	[illegible]
LAC–High Desert Hospital	Lancaster	CA	2,401	6,317	670	[illegible]	[illegible]	[illegible]	830	18,172	10,774	[illegible]
LAC–Martin Luther King/Drew	Los Angeles	CA	[illegible]	31,812	[illegible]	84,287	43,842	178,046	[illegible]	188,330	[illegible]	233,422
LAC–Olive View Medical Center	Sylmar	CA	4,276	37,807	2,179	18,280	23,734	83,046	2,051	[illegible]	[illegible]	128,180
LAC–Rancho Los Amigos	Downey	CA	[illegible]	68,161	12,748	[illegible]	14,574	104,348	2,789	107,147	24,801	[illegible]
LAC– USC Medical Center	Los Angeles	CA	[illegible]	[illegible]	[illegible]	44,844	128,168	[illegible]	[illegible]	[illegible]	124,374	[illegible]
La. St. Univ. Med. Ctr.	Shreveport	LA	26,185	[illegible]	8,180	0	0	84,048	0	108,165	1,789	110,051
Maricopa County Medical Center	Phoenix	AZ	28,428	47,880	1,303	11,230	[illegible]	128,187		128,187		128,187
MD Anderson	Houston	TX	48,374	[illegible]	103,374	20,274	0	[illegible]	68,827	241,815	0	241,815
Medical Center of Central Georgia	Macon	GA	51,182	12,224	[illegible]	(8,048)	4,041	127,432	[illegible]	130,830	7,102	[illegible]
Merrithew Memorial Hospital	Martinez	CA	11,843	23,877	2,083	6,801	27,474	[illegible]	1,674	73,482	435	[illegible]
Milwaukee Medical Complex	Milwaukee	WI	32,875	16,317	38,416	42,476		128,094	6,042	[illegible]	0	[illegible]
Nassau County Medical Center	East Meadow	NY	[illegible]	63,489	[illegible]	3,846	6,676	[illegible]	5,780	[illegible]	45,748	217,403
NYC– Bellevue Hospital	NY	NY	38,467	163,130	14,210	[illegible]		246,811	17,574	263,384		263,384
NYC– Bronx Municipal	Bronx	NY	41,676	118,671	17,128	38,275		211,848	[illegible]	218,776		218,776
NYC– Coney Island	Brooklyn	NY	81,457	[illegible]	8,282	[illegible]	38,734	181,132	472	181,604	[illegible]	185,870
NYC– Elmhurst	Elmhurst	NY	30,682	68,833	11,837	38,673		[illegible]	7,221	168,148		168,148
NYC– Harlem Hospital	NY	NY	38,373	115,462	8,462	8,057		163,374	[illegible]	175,287		175,287
NYC– Kings County	Brooklyn	NY	34,282	163,273	17,711	34,518		249,783	21,080	270,887		270,887
NYC– Lincoln Medical	Bronx	NY	16,819	117,393	6,840	31,811		[illegible]	[illegible]	181,178		181,718
NYC– Metropolitan Hospital	NY	NY	28,400	108,788	6,744	[illegible]		147,887	12,189	160,028		160,089
NYC– North Central Bronx	Bronx	NY	13,357	68,077	8,821	13,380		104,336	3,277	107,612		107,612
NYC– Queens Hospital Center	Jamaica	NY	[illegible]	73,538	8,885	20,462		[illegible]	8,819	130,174		130,174
NYC– Woodhull Hospital	Brooklyn	NY	19,175	131,787	7,851	23,180		181,673	4,043	185,715		185,715
Parkland Memorial Hospital	Dallas	TX	[illegible]	11,782	[illegible]	[illegible]	117,578	[illegible]	8,207	219,480	7,785	[illegible]
Phoebe Putney Memorial Hospital	Albany	GA	27,104	8,328	38,839	0	1,825	77,088	1,280	78,384	2,847	80,811
Pontiac General Hospital	Pontiac	MI	[illegible]	11,776	37,782	0		[illegible]	2,138	[illegible]	3,880	77,284
Regional Medical Center	Memphis	TN	19,215	88,828	34,134	(2,341)	0	110,836	29,525	140,181	[illegible]	140,780
Riverside General Hospital	Riverside	CA	[illegible]	28,041	6,414	17,456	28,880	87,308	1,807	88,879	381	89,338
San Bernardino County	San Bernardino	CA	8,820	31,179	10,462	20,815	6,808	80,814	13,872	94,786	0	94,786
San Joaquin	Stockton	CA	[illegible]	16,087	7,342	4,424	14,118	48,817	1,825	51,642	8,867	60,410
San Mateo County General	San Mateo	CA	[illegible]	[illegible]	2,880	6,819	24,000	[illegible]	880	45,453	847	46,801
South Louisiana Medical Center	Houma	LA	4,804	14,241	898	341	7,304	[illegible]	89	27,844	0	27,844
St. Louis Regional	St. Louis	MO	10,028	18,814	3,176	480	31,024	64,319	5,792	70,110	603	70,718
SUNY @ Syracuse	Syracuse	NY	38,181	18,008	20,854	18,789	[illegible]	[illegible]	823	128,546	0	128,546
Tampa General	Tampa	FL	70,288	[illegible]	88,851	4,413	22,719	218,847	11,825	219,822	8,138	228,088
Tarrant Cty Hosp	Fort Worth	TX	8,083	1,872	2,734	13,474	88,351	79,484	3,115	[illegible]	1,808	84,818
Temple University	Philadelphia	PA	41,184	[illegible]	47,830	14,200	2,883	148,142	8	184	8	183
Thomason	El Paso	TX	8,028	14,391	12,801	(8,411)	22,318	60,127	2,804	63,081	374	63,426
Truman Medical Center	Kansas City	MO	24,080	23,489	[illegible]	1,882	[illegible]	[illegible]	5,844	93,411	815	94,028
U of Chicago	Chicago	IL	66,111	46,391	119,340	41,347	(8,488)	[illegible]	16,161	270,842	18,409	288,351
U of New Mexico	Albuquerque	NM	15,372	28,189	27,878	13,085	18,024	100,320	8,318	108,842	0	108,842
UMDNJ	Newark	NJ	16,329	38,025	20,035	[illegible]	0	139,379	2,819	[illegible]	[illegible]	188,815
University Med. Ctr	Lubbock	TX	8,015	4,185	18,849	12,830		[illegible]	730	[illegible]	6,185	60,184
University of Nebraska	Omaha	NE	18,089	[illegible]	68,097	11,865	0	108,027	5,818	113,847	640	114,487
Univ. Hosp. of Brooklyn	Brooklyn	NY	38,773	23,823	37,346	8,230		108,878			1,400	104,379
Univ. of NC	Chapel Hill	NC	61,885	27,027	63,844	[illegible]	0	160,234	12,388	172,622	[illegible]	203,878
UT Galveston	Galveston	TX	28,353	17,708	28,304	11,388	108,842	192,403	10,213	202,705	0	202,708
Vanderbilt	Nashville	TN	47,223	43,007	27,393	120,034	0	237,657	5,816	243,574	4,173	247,746
Wash–St. Tammany	Bogalusa	LA	[illegible]	1,777	138	0		2,801	3,182	5,982	0	5,982
Wishard Memorial Hospital	Indianapolis	IN	23,315	12,807	11,849	18,824	31,803	98,798	12,412	111,210	229	111,439
Total			[illegible]	2,734,767	1,510,820	1,070,811	1,803,738	[illegible]	441,488	[illegible]	803,610	[illegible]
Average			24,731	43,409	23,981	16,882	33,411	134,570	7,358	137,771	10,482	147,383
Count			63	63	63	63	46	63	60	63	48	63
Minimum			221	1,777	129	(8,048)	(8,488)	2,801	0	0	0	183
Maximum			70,288	163,273	119,340	120,034	308,851	380,338	68,827	385,838	124,374	[illegible]

Chart 3: Revenues and Expenses — 1989
(In Thousands)

Hospital	City	State	Operating Revenues	Total Revenues	Operating Expenses	Total Expenses
MD Anderson	Houston	TX	241,915	241,915	224,088	224,088
Cook County Hospital	Chicago	IL	331,328	331,328	317,168	317,168
University of Nebraska	Omaha	NE	113,647	114,487	100,422	100,422
U of New Mexico	Albuquerque	NM	108,842	108,842	98,754	98,754
University of Cincinnati	Cincinnati	OH	218,219	224,314	208,841	208,841
Maricopa Medical Center	Phoenix	AZ	129,044	130,256	122,739	122,739
Bexar County Hospital District	San Antonio	TX	148,136	153,736	140,675	140,675
Phoebe Putney Memorial Hospital	Albany	GA	78,364	80,911	73,409	73,409
Harris County Hospital	Houston	TX	220,101	224,594	215,291	215,291
Vanderbilt	Nashville	TN	243,574	247,746	239,172	239,172
U of Chicago	Chicago	IL	279,842	295,251	275,708	275,708
Medical Center of Central Georgia	Macon	GA	130,930	136,033	128,382	128,382
Parkland Memorial Hospital	Dallas	TX	219,490	227,285	217,232	217,232
Truman Medical Center	Kansas City	MO	93,411	94,026	91,219	91,219
Riverside General Hospital	Riverside	CA	86,976	89,336	86,944	86,944
San Mateo County General	San Mateo	CA	45,453	45,801	43,468	43,468
Erlanger	Chattanooga	TN	179,578	184,272	177,708	177,708
Tampa General	Tampa	FL	218,922	225,058	218,150	218,150
Pontiac General Hospital	Pontiac	MI	73,894	77,284	72,731	72,731
Merrithew Memorial Hospital	Martinez	CA	73,462	73,898	72,617	72,617
SUNY @ Syracuse	Syracuse	NY	128,548	128,548	127,925	127,925
South Louisiana Medical Center	Houma	LA	27,844	27,644	27,215	27,215
Wash-St. Tammany	Bogalusa	LA	5,992	5,992	5,986	5,986
Temple University	Philadelphia	PA	154	163	165	165
San Bernardino County	San Bernardino	CA	94,786	94,786	94,982	94,982
St. Louis Regional	St. Louis	MO	70,110	70,718	70,718	70,718
Regional Medical Center	Memphis	TN	140,161	140,750	140,809	140,809
Denver Health & Hosp.	Denver	CC	110,629	110,938	111,400	111,400
Erie Cty Med Ctr	Buffalo	NY	122,386	123,633	123,574	123,574
Tarrant Cty Hosp	Fort Worth	TX	82,609	84,518	84,376	84,376
Thomason	El Paso	TX	53,051	53,425	54,950	54,950
Kula Hospital	Kula	HI	4,734	4,734	6,830	6,830
LAC-Martin Luther King/Drew	Los Angeles	CA	186,330	233,422	189,023	189,003
Fairmont Hospital	san Leandro	CA	38,907	38,907	41,683	41,893
Hurley Medical Center	Flint	MI	145,488	149,209	148,652	148,652
Cooper Green	Birmingham	AL	37,850	38,059	41,237	41,237
University Med. Ctr.	Lubbock	TX	44,266	50,184	48,371	48,419
NYC- Coney Island	Brooklyn	NY	151,604	155,970	155,970	155,970
Wishard Memorial Hospital	Indianapolis	IN	111,210	111,439	116,415	116,415
D.C. General Hospital	Washington	DC	110,909	110,909	118,048	118,048
Kern Medical Ctr.	Bakersfield	CA	71,752	74,091	80,193	81,293
San Joaquin	Stockton	CA	51,542	60,410	60,231	60,231
Milwaukee Medical Complex	Milwaukee	WI	134,636	134,626	144,143	147,187
LAC-High Desert Hospital	Lancaster	CA	16,172	26,945	27,472	27,489
UT Galveston	Galveston	TX	202,706	202,706	214,402	214,402
La. St. Univ. Med. Ctr	Shreveport	LA	109,165	110,951	121,732	123,050
Jackson Memorial Hospital	Miami	FL	390,086	437,282	406,290	442,895
Grady	Atlanta	GA	212,991	213,375	232,142	232,142
LAC-Rancho Los Amigo	Downey	CA	107,147	131,948	131,953	132,780
Univ. of NC	Chapel Hill	NC	172,622	203,678	199,828	199,828
LAC-Harbor-UCLA	Torrance	CA	170,503	200,658	198,645	200,942
NYC- Metropolitan Hospital	NY	NY	160,026	160,026	191,033	191,033
NYC- North Central Bronx	Bronx	NY	107,612	107,612	142,112	142,112
Nassau County Medical Center	East Meadow	NY	171,654	217,403	207,961	207,961
NYC- Bronx Municipal	Bronx	NY	219,776	219,776	258,456	258,456
LAC-Olive View Medical Center	Sylmar	CA	86,095	128,150	127,421	127,884
NYC- Elmhurst	Elmhurst	NY	168,146	168,456	210,694	210,694
UMDNJ	Newark	NJ	142,895	199,818	189,144	199,512
NYC- Queens Hospital Center	Queens	NY	130,174	130,174	181,466	181,466
NYC- Lincoln Medical	Bronx	NY	181,718	181,718	233,448	223,448
NYC- Woodhull Hospital	Brooklyn	NY	185,715	185,715	242,192	242,192
NYC- Bellevue Hospital	NY	NY	283,364	283,384	339,482	339,482
NYC- Kings County	Brooklyn	NY	270,867	270,867	361,650	361,650
NYC- Harlem Hospital	Harlem	NY	175,267	175,267	272,195	272,195
LAC+USC	Los Angeles	CA	395,835	520,209	512,184	524,365
Univ. Hosp. of Brooklyn	Brooklyn	NY	0	104,379	0	137,954
TOTAL			9,200,583	9,871,743	10,117,518	10,813,829
AVERAGE			139,402	149,572	153,296	159,272
COUNT			66	66	66	66
MINIMUM			0	163	0	165
MAXIMUM			395,835	520,209	512,184	524,365

Chart 4: Utilization – 1989

Hospital	City	State	Licensed Beds	Staffed Beds	Admissions	Days	Births	Occup-Rate
Amarillo Hospital District	Amarillo	TX	383	361	13,227	85,741	2,831	85%
Bexar County Hospital District	San Antonio	TX	584	552	22,080	138,810	4,804	69%
Cook County Hospital	Chicago	IL		920	35,706	226,545	645	67%
Cooper Green	Birmingham	AL	319	130	7,519	37,088	2,448	79%
D.C. General Hospital	Washington	DC	410	445	13,918	122,148	2,107	75%
Denver Health & Hosp.	Denver	CO	349	311	13,833	79,124	2,965	70%
Erie City Med Ctr	Buffalo	NY		654	13,866	215,794	0	90%
Erlanger	Chattanooga	TN	754	543	25,003	149,356	3,875	79%
Fairmont Hospital	San Leandro	CA	264	239	1,687	73,581	0	84%
Grady	Atlanta	GA	1,162	834	40,336	267,222	7,889	78%
Harris County Hospital	Houston	TX	1,045	931	40,572	280,706	14,840	83%
Hurley Medical Center	Flint	MI	543	543	18,581	137,272	3,386	69%
Jackson Memorial Hospital	Miami	FL	1,485	1,424	64,729	429,319	14,222	83%
Kern Medical Center	Bakersfield	CA	234	220	13,657	53,382	4,647	66%
Kula Hospital	Kula	HI	105	101	62	35,233	0	96%
LAC – Harbor – UCLA	Torrance	CA	553	504	34,047	156,853	7,540	85%
LAC – High Desert Hospital	Lancaster	CA	173	135	1,622	39,421	0	80%
LAC – Martin Luther King/Drew	Los Angeles	CA		383				0%
LAC – Olive View	Sylmar	CA	377	242	13,956	83,136	4,572	94%
LAC – Rancho Los Amigo	Downey	CA	735	435	4,047	155,711	0	98%
LAC + USC	Los Angeles	CA	2,045	1,378	78,281	450,516	17,324	90%
La. St. Univ. Med. Ctr.	Shreveport	LA	650	417	18,530	119,878	4,389	79%
Maricopa County Medical Center	Phoenix	AZ	555	465	22,538	133,001	5,463	78%
MD Anderson	Houston	TX	523	518	16,768	141,843	0	75%
Medical Center of Central Georgia	Macon	GA	518	542	20,063	136,755	2,837	69%
Merrithew Memorial Hospital	Martinez	CA	198	133	7,321	48,410	1,547	100%
Milwaukee Medical Complex	Milwaukee	WI		373	17,306	106,058	837	78%
Nassau County Medical Center	East Meadow	NY	615	615	17,419	185,665	3,267	83%
NYC – Bellevue Hospital	NY	NY		1,232	25,236	450,752	1,868	87%
NYC – Bronx Municipal	Bronx	NY	825	778	23,070	239,158	3,367	84%
NYC – Coney Island	Brooklyn	NY	445	445	14,839	153,033	2,078	94%
NYC – Elmhurst	Elmhurst	NY	821	611	19,300	218,260	3,070	98%
NYC – Harlem Hospital	NY	NY		682	19,837	219,058	2,718	88%
NYC – Kings County	Brooklyn	NY	1,204	1,204	31,755	378,721	5,041	86%
NYC – Lincoln Medical	Bronx	NY	646	554	21,186	172,315	3,833	85%
NYC – Metropolitan Hospital	NY	NY		569	16,196	199,378	2,356	96%
NYC – North Central Bronx	Bronx	NY	349	349	16,295	114,466	2,248	90%
NYC – Queens Hospital Center	Jamaica	NY	561	484	14,878	162,034	2,584	92%
NYC – Woodhull Hospital	Brooklyn	NY	553	552	20,724	192,456	3,848	96%
Parkland Memorial Hospital	Dallas	TX	940	858	40,585	254,007	14,530	81%
Phoebe Putney Memorial Hospital	Albany	GA	450	399	18,648	107,028	2,890	73%
Pontiac General Hospital	Pontiac	MI	376	294	10,778	70,550	1,903	66%
Regional Medical Center	Memphis	TN	620	443	22,883	149,073	7,727	92%
Riverside General Hospital	Riverside	CA	358	298	14,688	87,396	3,180	80%
San Bernardino County	San Bernardino	CA	230	230	10,480	59,794	2,858	71%
San Francisco	San Francisco	CA	582	332				
San Joaquin	Stockton	CA	230	209	7,338	49,161	2,258	64%
San Mateo County General	San Mateo	CA	269	240	3,536	73,238	0	84%
South Louisiana Medical Center	Houma	CA	201	148	7,919	35,393	2,273	66%
St. Louis Regional	St. Louis	MO		278	11,784	73,058	3,289	72%
SUNY @ Syracuse	Syracuse	NY	350	330	10,865	102,187	0	85%
Tampa General	Tampa	FL	971	758	28,920	214,160	6,833	77%
Tarrant Cty Hosp	Forth Worth	TX	429	297	15,439	94,360	6,144	87%
Temple University	Philadelphia	PA	504	436	17,167	134,705	2,236	85%
Thomason	El Paso	TX	335	310	15,524	85,974	5,282	76%
Truman Medical Center	Kansas City	MO	612	524	18,464	179,561	4,115	94%
U of Chicago	Chicago	IL	662	560	21,998	164,878	3,125	81%
U of New Mexico	Albuquerque	NM	344	298	11,702	86,006	3,612	79%
UMDNJ	Newark	NJ	543	474	15,341	143,759	2,347	83%
University Med. Ctr.	Lubbock	TX	301	261	13,060	66,025	2,497	69%
University of Cincinnati	Cincinnati	OH	647	647	23,371	184,855	2,591	78%
University of Nebraska	Omaha	NE	416	320	9,785	78,004	1,391	67%
Univ. Hosp. of Brooklyn	Brooklyn	NY		377	11,000	110,084	2,083	80%
Univ. of North Carolina	Chapel Hill	NC	665	552	19,369	169,782	2,151	84%
UT Galveston	Galveston	TX		806	26,035	215,274	4,184	73%
Vanderbilt	Nashville	TN	661	605	23,496	181,481	1,543	82%
Wash – St. Tammany	Bogalusa	LA	71	53	2,109	9,059	472	47%
Westchester County Med Cntr	Valhalla	NY	633	633	19,489	210,431	978	91%
Wishard Memorial Hospital	Indianapolis	IN	573	415	15,848	104,783	3,340	69%
TOTAL			32,798	34,301	1,251,791	10,079,273	240,888	81%
AVERAGE			656	487	18,683	150,437	3,888	83%
COUNT			50	68	67	67	67	68
MINIMUM			71	53	62	9,059	0	47%
MAXIMUM			2,045	1,424	78,281	450,752	17,324	100%

CHART 4: UTILIZATION, CONT.'D

Hospital	City	State	ED Visits	Other Outpatient	Total Outpatient
Amarillo Hospital District	Amarillo	TX	47,851	82,486	130,337
Bexar County Hospital District	San Antonio	TX	94,317	290,185	384,502
Cook County Hospital	Chicago	IL	184,433	472,970	657,403
Cooper Green	Birmingham	AL	29,927	51,178	81,106
D.C. General Hospital	Washington	DC	81,569	106,025	188,594
Denver Health & Hosp.	Denver	CO	40,562	412,753	453,315
Erie Cty Med Ctr	Buffalo	NY			
Erlanger	Chattanooga	TN	100,783	53,843	154,626
Fairmont Hospital	San Leandro	CA	23,085	46,045	69,130
Grady	Atlanta	GA	259,234	567,764	826,998
Harris County Hospital	Houston	TX	97,847	497,469	595,316
Hurley Medical Center	Flint	MI	42,908	99,367	142,275
Jackson Memorial Hospital	Miami	FL	114,739	273,535	388,274
Kern Medical Center	Bakersfield	CA	59,869	95,450	155,319
Kula Hospital	Kula	HI	26	963	989
LAC–Harbor–UCLA	Torrance	CA	85,568	231,213	316,781
LAC–High Desert Hospital	Lancaster	CA		37,324	37,324
LAC–Martin Luther King/Drew	Los Angeles	CA			
LAC–Olive View	Sylmar	CA	63,858	130,995	194,853
LAC–Rancho Los Amigo	Downey	CA	0	90,168	90,168
LAC+USC	Los Angeles	CA	209,703	434,348	644,051
La. St. Univ. Med. Ctr.	Shreveport	LA	49,676	301,940	351,616
Maricopa County Medical Center	Phoenix	AZ	64,930	177,658	242,588
MD Anderson	Houston	TX		445,940	445,940
Medical Center of Central Georgia	Macon	GA	109,848	68,590	178,438
Merrithew Memorial Hospital	Martinez	CA	24,664	192,245	216,909
Milwaukee Medical Complex	Milwaukee	WI	48,287	158,778	207,065
Nassau County Medical Center	East Meadow	NY	85,315	182,789	268,104
NYC – Bellevue Hospital	NY	NY			
NYC – Bronx Municipal	Bronx	NY	120,977	326,512	447,489
NYC – Coney Island	Brooklyn	NY	69,938	307,808	377,746
NYC – Elmhurst	Elmhurst	NY	109,885	318,554	428,439
NYC – Harlem Hospital	NY	NY			
NYC – Kings County	Brooklyn	NY	218,358	583,093	801,451
NYC – Lincoln Medical	Bronx	NY	105,941	455,859	561,800
NYC – Metropolitan Hospital	NY	NY			
NYC – North Central Bronx	Bronx	NY	66,731	161,111	227,842
NYC – Queens Hospital Center	Jamaica	NY	80,910	228,987	309,897
NYC – Woodhull Hospital	Brooklyn	NY	83,876	187,729	271,605
Parkland Memorial Hospital	Dallas	TX	217,188	357,598	574,786
Phoebe Putney Memorial Hospital	Albany	GA	55,116	54,061	109,177
Pontiac General Hospital	Pontiac	MI	22,388	116,081	138,469
Regional Medical Center	Memphis	TN	98,558	88,793	187,351
Riverside General Hospital	Riverside	CA	48,003	111,233	159,236
San Bernardino County	San Bernardino	CA	32,096	106,442	138,538
San Francisco	San Francisco	CA	80,000	199,287	279,287
San Joaquin	Stockton	CA	49,100	114,550	163,650
San Mateo County General	San Mateo	CA	20,711	711,502	92,213
South Louisiana Medical Center	Houma	CA	47,651	74,066	121,717
St. Louis Regional	St. Louis	MO			
SUNY @ Syracuse	Syracuse	NY	42,592	184,215	226,807
Tampa General	Tampa	FL	49,336	42,460	91,796
Tarrant Cty Hosp	Forth Worth	TX	64,479	128,177	192,656
Temple University	Philadelphia	PA	41,749		41,749
Thomason	El Paso	TX	50,376	30,010	80,386
Truman Medical Center	Kansas City	MO	52,602	261,234	313,836
U of Chicago	Chicago	IL	50,980	235,619	286,599
U of New Mexico	Albuquerque	NM	42,802	148,900	191,702
UMDNJ	Newark	NJ	53,869	102,046	155,915
University Med. Ctr.	Lubbock	TX	32,591	63,618	96,209
University of Cincinnati	Cincinnati	OH	65,334	174,243	239,577
University of Nebraska	Omaha	NE	21,554	17,340	38,894
Univ. Hosp. of Brooklyn	Brooklyn	NY			
Univ. of North Carolina	Chapel Hill	NC	30,943	314,575	345,518
UT Galveston	Galveston	TX	58,621	283,880	342,501
Vanderbilt	Nashville	TN	30,862	234,443	265,305
Wash–St. Tammany	Bogalusa	LA	12,094	32,466	44,560
Westchester County Med Cntr	Valhalla	NY	18,609	211,951	230,560
Wishard Memorial Hospital	Indianapolis	IN	97,519	299,535	397,054
TOTAL			4,253,117	12,777,219	16,447,336
AVERAGE			69,723	209,463	265,280
COUNT			61	61	62
MINIMUM			0	963	989
MAXIMUM			259,234	711,502	826,998

REPRESENTATIVE STARK. Welcome, Ms Long. Please proceed.

STATEMENT OF OPHELIA LONG, CHIEF EXECUTIVE OFFICER, HIGHLAND GENERAL HOSPITAL, OAKLAND, CALIFORNIA

Ms. LONG. Thank you. I am very pleased to be here today to speak in support of safety-net hospitals, but more importantly, I represent the citizens of this country who receive their health care in public hospitals.

My pride and my passion for public hospitals is so strong that I would even go so far as to say that it should be the system of health care delivery for this country in the future. Not only have we proven that we can provide health care in a cost-effective manner, but we do it to a large number of people with many, varied conditions that they bring to us in our centers.

I want to also talk about the injustice in the health care delivery system. One of my favorite Psalms reads, "The just man murmurs words of wisdom." Whenever I hear that Psalm, I remember my father and all he taught me. One of life's greatest lessons learned was, "You can tolerate insults, you can tolerate pain, you can tolerate hunger, you can tolerate thirst, but you cannot tolerate injustice, for if you tolerate injustice you are no longer human." Those words have given me strength when I needed tolerance. They have given me power when I confront injustice.

I am a woman who is black; I know injustice. I have lived through the civil rights era; I know injustice. I am a woman in a position of authority who has witnessed less able people advance beyond me; I know injustice. But of all the injustices that have stung my soul these many years, none burns me more deeply than seeing the Nation divided by the haves and have-nots in health care. The dividing line between the haves and have-nots is not race nor position nor locality; the dividing line is health insurance.

Our troubled economy with the increasing numbers of unemployed and underemployed daily add to the ranks of the have-nots in our society. Their children are not vaccinated, and we have epidemics. Babies are born at high risk without prenatal care, and a generation is weakened. Our citizens are not getting early care in a disease process and require hospitalization in a tertiary setting. We have literally become one sick society.

We have never been a country without a plan to address the issues that threaten us. In this country, the public hospitals were established to ensure the health and safety of the community and to provide care essentially to those who have no independent means. But the system has been overused and not maintained. Later this month, as you read the increases in unemployment, say to yourselves, "These people are now in the public sector of health care." And also keep in mind with these frightening increasing numbers that the majority of persons without health care are

persons and their dependents who are employed. The sheer volume of patients in the public hospitals make the system stagger.

If the sheer volume of patients were the stressor to deal with, the public hospitals might continue to cope. But the problem is the public hospitals have been allowed to deteriorate over time. My own hospital, Highland General Hospital, is 28 years old. Some of the buildings are 70 years old. The hospital was built without a sprinkler or fire alarm system. We must do a manual fire watch to assure safety of the patients and early detection of any evidence of fire or danger.

Our geological studies indicate that we are seismically unsafe to add onto or build any additional buildings at our current site. In addition, our buildings do not meet current seismic requirements. Highland is a grand old lady, but like any grand old lady she creeks and groans in the night. I worry about maintaining our accreditation and keeping the doors open with the aging equipment that may be unsafe.

One example alone is in radiology. Some of the equipment is 27 years old. It is often deemed unsafe after seven years. I don't have the $11 million to replace the equipment. Would you like that outdated equipment used on you or a member of your family? That just might happen, for while health insurance creates the dividing line between the haves and have-nots in health care, trauma care is the great equalizer. Under this continually failing economy, the closure of hospitals in the last decade has shifted emergency care into existing hospitals with already overcrowded emergency rooms. Trauma care for major accidents and gunshot wounds go in the greatest majority to public hospitals.

Last year, my facility alone had 69,000 emergency room visits with an additional 2,500 trauma cases. Our clinic visits rose in one year from 95,000 to 110,000 visits per year. These figures are not just numbers important to a hospital administrator. They represent care to individual citizens. They represent the hub of trauma care in the East Bay Area of Oakland, California, and they represent the area center of training for interns and residents in emergency medicine, surgeons, internal medicine, dentistry, orthopedic surgery, and trauma.

Residents and interns, numbering 154 from across the country, study with us because of our trauma center, the complexity of our patients, and our internationally renowned experts in radiology and surgery. The United States Navy sends its residents to us for study in surgery and trauma care because they do not receive trauma or emergency cases at the Naval Hospital.

The deterioration that undermines our hospital, due to an irrepairable plant and outdated, outmoded equipment, jeopardizes the care that our patients receive and risks the termination of our residency and intern programs. There is no other hospital in the Bay Area that could provide care to these patients or assume the teaching of these nationally needed residents and interns.

My brief story is the story of the vast majority of American public hospitals today. In the private sectors, as Mr. Gage said, the average age of a hospital is seven years. In the public sector, the average age of hospitals is 30. All are overflowing with patients, and few have the opportunity to develop services of contemporary primary care in modular units, and, yet, the public hospital is a hub of community care.

Congressman, you have been to our hospital, not just in a ceremonial capacity. You are part of the family at Highland; you have seen our emergency rooms overflowed; you have seen our neonatal intensive care unit filled with crack-cocaine infants. You have been a part of what has happened there.

We feel as strongly as you do about safety-net hospitals. As you do, we feel that Highland should be the people's choice for health care. We have every intention to make it that, if the dollars are provided for us to do that. We know that the public health care delivery system should be the delivery system of choice. We will do everything within our power to assure that that happens.

The great injustice for me at Highland is that I cannot persuade banks to authorize a loan of the magnitude that we need for replacement, and bond resolutions are not making it at the polls, although there is universal agreement for the need.

Your bill would relieve the greatest pressure in health care delivery today without developing a whole new system of health care nationally. It is a form of protection for the insurance industry, just as surely as it protects public hospitals. It would allow us the opportunity to rebuild the hubs of community health care, and last but not least, in my heart, I could tell my father that justice has been served.

Thank you very much.

[The prepared statement of Ms. Long follows:]

PREPARED STATEMENT OF OPHELIA LONG

Congressman Stark, and other distinguished Members of the Subcommittee:

One of my favorite Psalms reads: "The just man murmurs words of wisdom". Whenever I hear that psalm, I remember my father and all he taught me. One hot afternoon in Alabama, I was quite upset about something that by now I've quite forgotten, and my father taught me a lesson that has governed my life these many years, "Ophelia," he said, "You can tolerate insults, you can tolerate pain, you can tolerate hunger, you can tolerate thirst, but you cannot tolerate injustice. **If you tolerate injustice, you are no longer human". Those words have given me strength when I needed tolerance. Those words have given me power when I confront injustice.**

I am a woman who is Black. I know injustice.

I have lived through the civil rights era. I know injustice.

I am a woman in a position of authority who has witnessed less able people advance beyond me. I know injustice.

But of all the injustice that has stung my soul these many years, none burns me more deeply than seeing this nation divided by the haves and the have nots in health care. The dividing line between the haves and have nots is not race, nor position, nor locality. The dividing line is health insurance. Our troubled economy with increasing numbers of unemployed and underemployed daily add to the ranks of the have nots in our society. Their children are not vaccinated and we have epidemics; babies are born at high risk without prenatal care and a generation is weakened; our citizens are not getting care early in a disease process and require hospitalization in a tertiary setting. We have become literally one sick society.

We have never been a country without a plan to address the issues that threaten us. In this country, the public hospitals were established to ensure the health and safety of the community, and to provide care essentially to those who had no independent means. But the system has been overused and not maintained. Later this month, as you read the increases in unemployment, say to yourselves: "These people are now in the public sector of health care". And also keep in mind with those frightening increasing numbers, that the majority of persons without health care are persons and their dependents who are employed. The sheer volume of patients in the public hospitals make the system stagger.

It is a professionally trying time in health care as we see the teeter totter slant from the private sector to the public sector, and witness a vast percentage of the population slide in our direction to health care. If the sheer volume of patients were the only stressor to deal with, the public hospitals might continue to cope. But the problem is that the public hospitals have universally been allowed to deteriorate over time. My own hospital, Highland Hospital, is 28 years old. Some of the buildings are 70 years old. The hospital was built without a sprinkler or fire alarm system. We must do a manual fire watch to assure safety of the patients and early detection of any evidence of fire or danger. Our geological studies indicate we are seismically unsafe to add on or build any additional buildings at our current site. In addition, our buildings do not meet current seismic requirements. She is a grand old lady, but like any grand old lady she creaks and groans in the night. I worry about maintaining our accreditation and keeping the doors open with aging equipment that is unsafe. One example alone is in Radiology. Some of the equipment is 27 years old; it is often deemed unsafe after

seven years. I don't have the eleven millon dollars to replace the equipment. Would you like that outdated equipment used on you, or a member of your family? That just might happen. For while health insurance creates the dividing line between the haves and have nots in health care, trauma care is the great equalizer. Under this continually failing economy, 10,000 hospitals have closed in the last decade. That has shifted emergency care into existing hospitals with already overcrowded emergency rooms. **Trauma care for major accidents and gunshot wounds go in the greatest majority to public hospitals.**

Last year at my facility alone, we had 69,000 emergency room visits, with an additional 2,500 trauma cases. Our clinic visits rose in one year from 95,000 to 110,000 visits per year. These figures are not just numbers important to a hospital administrator. They represent **care to individual citizens**; they represent **the hub of trauma care** in the East Bay Area of Oakland, California, and they represent the area **center of training for interns and residents** in Emergency Medicine, Surgery, Internal Medicine, Dentistry, Orthopedic Surgery and Trauma. Residents and Interns, numbering 154 from across the country, study with us because of our trauma center, the complexity of our patients, and our internationally recognized experts in radiology and surgery. The United States Navy sends its residents to us for study in Surgery and Trauma Care because they do not receive trauma or emergency cases at the Naval Hospital. The deterioration that undermines our hospital due to an irreparable plant and outdated outmoded equipment, jeopardize the care our patients receive, and risks the termination of our residency and intern programs. **There is no other hospital in the Bay Area that could provide care to these patients, or assume the teaching of these nationally needed residents and interns.**

My brief story is the story of the vast majority of American public hospitals today. In the private sector, the average age of hospitals is seven years; in the public sector the average age of hospitals is thirty years. All are overflowing with patients, and few have had the opportunity to develop services of contemporary primary care in modular units. And yet, **the public hospital is the hub of community care**. It is the destination of the prosperous and non-prosperous to receive trauma care. It is the center of learning for interns and residents in highly complex care.

It is the site of education for interns and residents in highly complex care. It is the site of education for the armed service physicians to prepare themselves for the types of trauma care required in national defense. It is where persons of all races, ages, and educational backgrounds gain basic knowledge about nutrition, disease and disease prevention. It is the place where the greatest percentage of high risk babies are born. **It is the hub of the health care system in this country and the hub is deteriorating**... **And this is an injustice that cannot be tolerated.**

To replace my hospital alone will cost $400 Million. If it were possible to finance those costs through loans or bond issues, I would have done it when I came to Highland two years ago. Those sources of capitalization are not available to public hospitals. **We are at a critical juncture in health care where we either rebuild the hub or lose the only nationally systematic approach to health care for private citizens we have in this country.** If the hubs are not rebuilt, there is no viable solution for alternate care delivery, public health care will run smack into the wall. If the hubs are

not rebuilt, we are placing a large percentage of our citizens in positions of danger in receiving health care.

Congressman Stark has been a frequent visitor to Highland. His visits have not been purely ceremonial; he knows our secrets; we consider him family. He knows our pride in the quality of care we provide. He knows we love our patients. He knows that its hard to be humble at Highland. And he has seen our patients piled into our waiting rooms before clinic hours begin. He has seen our Neonatal Intensive Care Unit crowded beyond capacity with crack babies. He has seen our emergency rooms reach full capacity with patients lying on gurneys treated in the halls, and ambulances still arriving. He has seen our outdated equipment in a building that cannot be accommodated into one more structural change. He cannot have helped but compare our public hospital to those in the private sector. And yet both treat the same community ,and everyone feels the injustice.

The great injustice for me is that I can't persuade banks to authorize a loan of the magnitude that we need for replacement. And bond resolutions are not making it at the polls; although there is universal agreement for the need. Congressman Stark's Bill would relieve the greatest pressure in health care delivery today without developing a whole new system of health care nationally. It is a form of protection for the insurance industry, just as surely as it protects public hospitals. It would allow us the opportunity to rebuild the hubs of community health care. And last but not least; in my heart, I could tell my father that justice has been served.

REPRESENTATIVE STARK. Mr. Renford, please proceed.

STATEMENT OF EDWARD J. RENFORD, ADMINISTRATOR, MARTIN LUTHER KING, JR./CHARLES R. DREW MEDICAL CENTER

MR. RENFORD. Thank you, Mr. Chairman.

I am Edward J. Renford, the Administrator at Martin Luther King, Jr./Charles R. Drew Medical Center, and we will work on becoming your second-most-favorite hospital. King/Drew is one of the six hospitals owned and operated by the Los Angeles County Department of Health Services. King/Drew and two other hospitals are designated Level 1 trauma centers. Fifty percent of all major trauma runs in the entire county are transported to these three hospitals.

The Department of Health Services facilities provide 28 percent of county-wide Medi-Cal days of service. We provide 80.2 percent of all uncompensated care in the county, and Los Angeles County's uncompensated care represents 45.5 percent of all uncompensated care in the State of California. In fiscal year 1990-1991, the cost of this county-provided, uncompensated care was $532 million.

Over the past years, hospitals in surrounding areas have downgraded their emergency rooms, downsized their operations, or closed their doors altogether, leaving King/Drew as the primary and often sole source of health care for the residents of south central Los Angeles. As a result, we have experienced sharp increases in the amount of emergency and trauma care we provide.

We receive an average of 15,000 emergency 911 runs annually. Our utilization rates are far above industry average. We admit 31,400 patients annually as compared to an industry average of 5,665. We provide 210,000 outpatient visits as compared to an average of 37,022; and we deliver an extraordinarily high number of babies, 9,000 per year, or almost 13 times the national average of 697.

Our workload is high, but the need we fill is great. Of the 1.2 million inhabitants of our service area, 52 percent are African-American, 45 percent are Hispanic, and 1 percent are white. The remaining 2 percent are made up of Filipinos and Asians. Only 4 percent of our patients have private health insurance coverage and 1.9 percent have Medicare; 60 percent are on Medi-Cal—the California version of Medicaid—and 23 percent are medically indigent. The remaining 11 percent are self-paid or paid for by some other source.

The recent Los Angeles riots occurred in King/Drew's backyard. The medical center went on disaster alert for five days treating 254 riot victims, the highest of any hospital in the county. The injuries included 54 gunshot wounds, 94 lacerations, 87 assault and battery injuries and 19 stabbings. In the first five hours alone, King/Drew received 25 gunshot wounds. The riot-related injuries were in addition to 314 nonriot traumas and emergency cases.

King/Drew has only two trauma bays. Its staff had to improvise during the riots using extra gurneys in the trauma bays, converting the five critical care bays into makeshift trauma bays, and putting extra beds in the hallways. King/Drew is in desperate need of a new trauma center. The Los Angeles riots shed the spotlight on a major deficiency that we all knew had to be corrected.

Reality dictates that a safety-net hospital in the 1990s must, at a bare minimum, have the ability to meet an ever-increasing demand for balance-related trauma care services. We simply do not have that ability at the present time, at least not with the appropriate level of care, comfort and basic privacy that the community deserves.

We project that construction of a new 24-bed trauma and diagnostic center will cost $66.5 million, with a completion date set for 1995. Our annual debt service will amount to $7.3 million. In order to ensure a basic level of safety and protection for our patients and employees, we also need to replace our obsolete fire system, which has been cited by the State Fire Marshal, at a cost of $3 million, and install fire sprinklers at a cost of $800,000.

Our other urgent capital needs include a $1 million upgrade of our 20-year-old elevator system, a $365,000 renovation of our emergency room area to accommodate the increasing patient population, improved patient care and reduced response time, and a $315,000 expansion of our pediatrics step-down unit to add a four-bed intensive care unit and two isolation rooms.

Taken together, five of the six county-owned hospitals have major capital needs totaling $2 billion that simply cannot be put off any longer. Several of those facilities have been issued citations for major fire, life and safety code violations. The perinatal and trauma capacity throughout the system is stretched way past its limits. We are faced with a choice of either drastically retrenching our operations, which could result in collapse of trauma, emergency, public health, and indigent care systems for all of southern California, or devising some way of financing a major capital rebuilding program that will place us back on track for years to come. We have chosen the latter because the former is unthinkable.

Part of the problem, of course, is then obtaining the financing for such an ambitious grant. A large chunk of it is slated to come from general obligation bonds of the county. In order to issue the bonds, we must obtain a two-thirds majority in a voter referendum set to go on the ballot this year.

It will obviously be a difficult task to convince the electorate to approve such a bond issuance in the midst of a recession when many voters are struggling to meet their tax burden at its current level. If we are unsuccessful, we will be hard pressed to obtain substitute financing, even if the bonds are approved. However, the proceeds will not meet the entire need.

Simply put, Mr. Chairman, states, local governments and public hospitals can no longer carry this entire burden alone. We need the help of the Federal Government to gain access to invest the funding that we know is out there, but is simply unavailable to us in our present financial circumstances. H.R. 4521, the National Health Safety Net Infrastructure Act, would provide that assistance. It is precisely the kind of local-state-federal partnership envisioned in this bill that would allow us and other safety-net hospitals like us to address the urgent capital it needs that we have so long postponed.

On behalf of King/Drew Medical Center, Mr. Chairman, and our patients, I would like to thank you very much for your bill; and we will be working hard to support you.

[The prepared statement of Mr. Renford follows:]

PREPARED STATEMENT OF EDWARD J. RENFORD

Mr. Chairman, members of the Committee, I am Edward J. Renford, Administrator at the Martin Luther King, Jr./Charles R. Drew Medical Center. King/Drew is one of the six hospitals owned and operated by the Los Angeles County Department of Health Services. King/Drew and two others (LAC+USC Medical Center and Harbor-UCLA Medical Center) are designated Level 1 Trauma Centers. 50 percent of all major trauma runs in the entire County are transported to these three hospitals. DHS facilities provide 28 percent of County-wide Medi-Cal days of service. We provide 80.2 percent of all uncompensated care in the County, and LA County's uncompensated care represents 45.5 percent of all uncompensated care in the state of California. In fiscal year 1990-91, the cost of this County-provided uncompensated care was $532 million.

Since its inception, King/Drew has served as the principal health care resource for the 1.2 million people residing in its service area. I am pleased to have the opportunity to testify today on behalf of King/Drew and the Los Angeles County system at large, and to describe for you both the vital role an institution such as ours plays in the inner city, and the desperate needs we confront if we are to continue to serve as a health care safety net. I will begin by providing you with some background about King/Drew and other County institutions, and the people we serve. Next, I would like to relate in some detail our experience during the recent riots as an illustration of the necessity for maintaining a strong and vibrant safety net. Third, I will describe for you the deteriorating condition of the County's equipment and facilities and our inability to obtain sufficient financing to bring them up to date. I hope to impress upon you the importance of investing in public hospitals such as LA County's and maintaining their ability to provide quality health care services to those in need.

THE KING/DREW MEDICAL CENTER: IN SERVICE TO THE COMMUNITY

King/Drew is located in the southeast section of Los Angeles, in close proximity to the scene of the recent riots in the wake of the Rodney King verdict. We were intensely involved in treating riot victims in the aftermath. In a sense, our role was fitting: the Medical Center's very existence is a direct result of the historic Watts riots of 1965. A Governor's Commission appointed to study the cause of those earlier riots concluded that a number of societal factors had contributed to the rage and turmoil. The most serious factor identified was the lack of quality, accessible health care facilities within the community. King/Drew Medical Center opened its doors for service on March 27, 1972.

The King/Drew Medical Center is a 480-bed major teaching and acute care facility designated as a Level 1 Trauma Center. We have a 76-bed psychiatric facility and have established a comprehensive Community Health Plan. The Medical Center is affiliated with the Charles R. Drew University of Medicine and Science and we have 14 approved clinical residency training programs. In addition, we operate a paramedic base station and an emergency heliport. In short, we provide a full range of medical, surgical, psychiatric, emergency and comprehensive ambulatory care services, and we provide those services to anyone who enters our doors, regardless of ability to pay.

Over the past few years, hospitals in surrounding areas have downgraded their emergency rooms, downsized their operations, or closed their doors altogether, leaving

us as the primary and often sole source of health care for the residents of this area. As a result, we have experienced sharp increases in the amount of emergency and trauma care we provide. We receive an average of 15,000 emergency 911 runs annually. Our utilization rates are far above industry average: we admit 31,400 patients annually as compared to an industry average of 5,665; we provide 210,000 outpatient visits, as compared to an average of 37,022; and we deliver an extraordinarily high number of babies – 9,000 per year or almost 13 times the national average of 697.

Our workload is high, but the need we fill is great. Of the 1.2 million inhabitants of our service area, 52 percent are African-American, 45 percent are hispanic, and 1 percent are white. Only 4 percent of our patients have private health insurance coverage, and 1.9 percent have Medicare. 60 percent are on Medi-Cal (the California version of Medicaid), and 23 percent are medically indigent. The remaining 11% are self-paid or paid for by some other source.

THE SAFETY NET IN ACTION: KING/DREW IN A TIME OF URBAN CRISIS

Exactly seven weeks ago today, on April 29, 1992, a jury in Simi Valley, California announced a verdict declaring four officers charged with the beating of Rodney King virtually innocent. We are all painfully aware of the upheaval that ensued. The societal implications of the verdict and the enraged rioting will be debated nationwide for a long time to come. I would like to focus today on the public health aspects of such violent unrest, and in particular on the critical role of the public hospital in a time of urban crisis.

As I stated earlier, the rioting occurred in King/Drew's backyard. It was a virtual war zone in South Central L.A. As the violence raged, King/Drew was in the heart of this war zone, caring for the wounded and attending to the dead. We may not be the most state-of-the-art facility, but I must admit, when the calling came, King/Drew was there to respond. We were born out of a frustration over a lack of adequate health care for a particular community; 27 years later, we lived up to our heritage by serving that community in their time of desperate need.

Let me describe for you the scene at King/Drew during those fateful days. The unrest began at about 6:00 p.m. Wednesday, April 29. By 11:00 that night, we were on disaster status with all operations being controlled from an activated Command Post. Although the riots lasted three days, the Medical Center remained on disaster alert for five full days, with some staff working in excess of 24 hours at a time merely to keep the hospital running.

Our staff's dedication was a rare bright spot in a sea of horror and despair. Many of them risked their lives travelling through the riot areas just to get back and forth to work during this period. We set up a special van pool with a hospital security police escort to transport employees. Some of our African-American employees provided rides for their Asian colleagues who had to hide in the back of the car in order to escape the violence.

Over the course of the five days, the emergency room was deluged with 254 victims of the violence, whom we treated in addition to our normal caseload of 314 emergency and trauma patients suffering from non-riot related illnesses and injuries. 59 of the victims had to be admitted. All in all, we treated 54 gunshot wounds, 94

lacerations, 87 assault and battery injuries, and 19 stabbings. 25 of the gunshot wounds came in the first five hours of rioting alone. We were called upon to treat more riot victims than any other hospital in the area, although 87 facilities provided care.

As I said before, I believe we rose to the task and served our community in its time of need. But, Mr. Chairman, I must confess that it was a struggle. Our emergency room has only two bays dedicated to trauma patients, with one bed each. As you may know, trauma bays are specialized areas for evaluating and treating critically injured patients. These patients demand all the immediate attention and resources that a modern day hospital can provide. A highly coordinated team of doctors and nurses are on the ready to provide any necessary emergency treatment, including surgical procedures. The trauma bays, therefore, must be both well stocked with all potentially required supplies, equipment and lighting, and they must be roomy enough to accomodate the fast paced action of the team.

Needless to say, we had to improvise during the riots. We rolled extra gurneys into the bays, cutting down on the freedom of movement, slowing response time and adding to the general chaos. We also converted our 5 critical care bays that are usually used for non-trauma emergencies (such as cardiac arrests) into make-shift trauma bays. The overflow had to be cared for in the hallways. Of course, none of these other areas had the specialized equipment necessary to treat trauma victims, which meant that runners had to fly back and forth between the bays swapping equipment and supplies. Patients were being treated in the bays and then removed as quickly as possible to make room for other victims, although we would normally not move trauma patients until they are stabilized. Many of the victims required immediate surgery, yet in addition to the 2 trauma bays, we only have 6 operating rooms, all of which were active. To say that our facilities were stretched to their limit is an understated understatement. Which brings me to the larger point I want to make.

SAFETY NET NEEDS CAN NO LONGER BE POSTPONED

As you may have guessed, King/Drew is in desperate need of a new trauma center. The Los Angeles riots shed the spotlight on a major deficiency we all knew had to be corrected. Reality dictates that an inner city safety net hospital in the 1990s must, at a bare minimum, have the ability to meet an ever increasing demand for violence-related trauma care services. We simply do not have that ability at the present time, at least not with the appropriate level of care, comfort and basic privacy that the community deserves.

We project that the construction of a new 24-bed trauma and diagnostic center will cost $66.55 million, with a completion date set for 1995. The annual debt service will amount to $7.29 million. In order to ensure a basic level of safety and protection for our patients and employees, we also need to replace our obsolete fire alarm system (which has been cited by the State Fire Marshall) at a cost of $3 million, and install fire sprinklers at a cost of $800,000. Our other urgent capital needs include a $1 million upgrade of our 20-year old elevator system; a $365,000 renovation of our emergency room area to accommodate the increasing patient population, improve patient care, and reduce response time; and a $315,000 expansion of our pediatric step-down unit to add a four-bed intensive care unit and two isolation rooms.

King/Drew is not the only County facility in need of repair and reconstruction. General Hospital at LAC+USC (the Los Angeles County+University of Southern California Medical Center), a 2,045-bed medical center that treated 155 riot victims, is now 60 years old. Three other buildings on the campus are about 35 years old. In facilities of that age, there are always pressing capital needs. Some of LAC+USC's are:

- 5-patient rooms with one toilet, and one shower for 28-32 patients;
- Inadequate isolation facilities;
- No sprinklers in most of the facilities;
- Almost no piped-in medical gases, necessitating the transport of 40,000 gas cylinders per year;
- No air conditioning in most areas;
- Limited emergency electrical power distribution;
- Extreme difficulty in remodeling due to the nature of the concrete/steel construction and deteriorated infrastructure;
- Deteriorated or non-existent communication systems, such as telephones, doctors' paging system, and nurse call system;
- Limited compliance with the requirements of the Americans with Disabilities Act;.

Taken together, five of the six county-owned hospitals have major capital needs totaling nearly $2 billion that simply cannot be put off any longer. Several of the facilities have been issued citations for major fire, life and safety code violations. The perinatal and trauma capacity throughout the system is stretched way past its limits. We are faced with a choice of either drastically retrenching our operations (which could result in a collapse of trauma, emergency, public health, and indigent care systems for all of southern California), or devising some way of financing a major capital rebuilding program that will place us back on the track for years to come. We have chosen the latter because the former is unthinkable.

The County Department of Health Services has therefore recently launched a "Healthy LA Year 2000" plan. The goal is to fulfill our most severe capital needs by the year 2000. The plan includes the new trauma and diagnostic center for King/Drew and a completely new 950-bed acute care facility for LAC+USC. I am submitting at the end of my testimony more specifics about this plan, including a detailed list of the projects to be undertaken and their estimated costs.

The exciting part about the rebuilding plan is the multifaceted benefits it will bestow upon the community. First and most important, of course, are the desperately needed improvements in our capacity to deliver quality health care services to County residents, many of whom have no other health care source to which they can turn. But the benefits go far beyond these direct hospital enhancements. A public works project of this magnitude will provide the kind of economic boost to the local economy that everybody has been hoping for in this recessionary period. We estimate that the projects will create 64,185 full-time new jobs between now and 2000. They will generate $4.7 billion in new economic activity, and add $1.4 billion to personal income in the County. A three-fold return is not a bad bargain for a $2.1 billion investment.

The problem, of course, is in obtaining the financing for such an ambitious plan. A large chunk of it is slated to come from general obligation bonds of the county. In order to issue the bonds, we must obtain a two-thirds majority in a voter referendum set to go on the ballot this year (most states only require a simple majority approval).

It will obviously be a difficult task to convince the electorate to approve such a bond issuance in the midst of a recession when many voters are struggling to meet their tax burden at its current level. If we are unsuccessful, we will be hard-pressed to obtain substitute financing. Even if the bonds are approved, however, the proceeds will not meet the entire need.

Simply put, Mr. Chairman, states, local governments, and public hospitals can no longer carry this entire burden alone. We need the help of the federal government – your help – to gain access to investor funding that we know is out there but is simply unavailable to us in our present financial circumstances. H.R. 4521, the National Health Safety Net Infrastructure Act, would provide that assistance, in the form of loan guarantees, debt service subsidies, direct loans and direct grants. It is precisely the kind of local-state-federal partnerships envisioned in this bill that would allow us, and other safety net hospitals like us, to address the urgent capital needs that we have so long postponed. I urge you, on behalf of King/Drew, the Los Angeles County hospital system, and the thousands of patients we serve each year, to support this important piece of legislation, and give our nation's health care safety net a chance to fulfill its mission. Remember, there is no safety net under the safety net; if we don't fulfill our mission, nobody will.

Thank you. I would be happy to answer any questions you may have.

Los Angeles County
Department of Health Services

Healthy LA Year 2000

Health Facility Replacement and Improvement Plan

to

Improve Patient Access
Replace Crumbling Infrastructure
Create Thousands of New Jobs

June, 1992

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
HEALTHY L A ACCESS AND INFRASTRUCTURE IMPROVEMENT PLAN
(ALL AMOUNTS IN $1000)

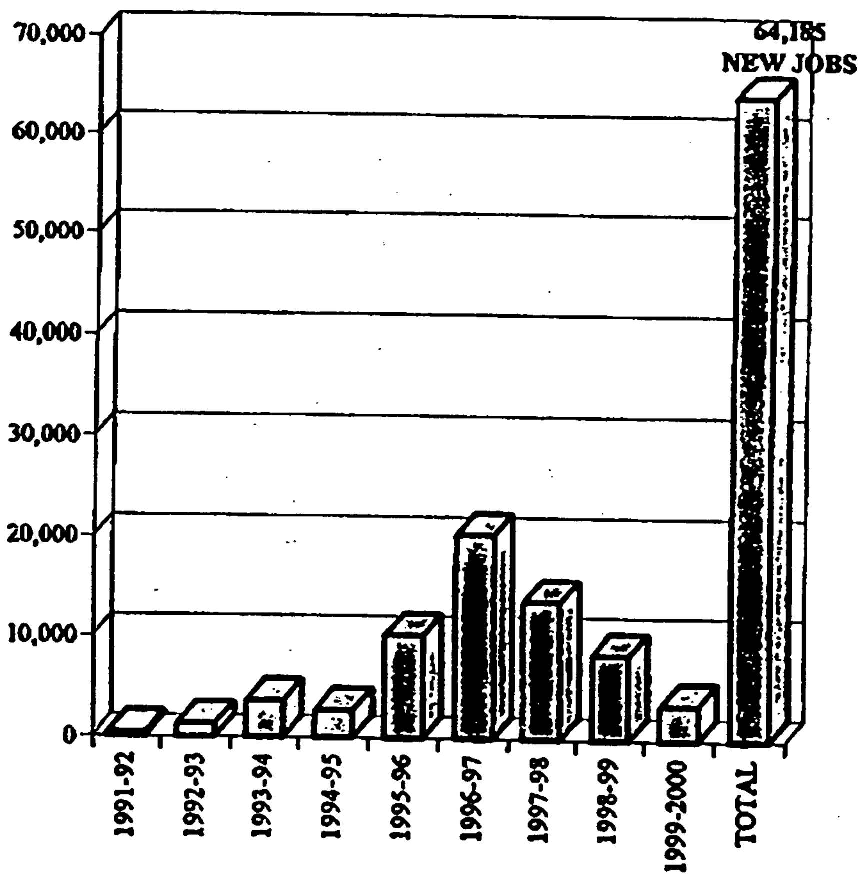
FACILITY	PROJECT	ESTIMATED PROJECT COST	ANNUAL DEBT SERVICE	PROJECTED CONSTRUCTION COMPLETION
LAC+USC	Replace existing, deteriorating inner city 1450-bed hospital with 950-bed cost efficient acute care facility	$1,230,829	$134,822	1999-2001
EVMC	Improve patient access and trauma care with new 350-bed acute care urban facility	377,463	$41,346	1999
H/UCLA	Replace and expand critical patient care services, including trauma, surgery and intensive care, with 100-bed addition to this acute care facility	159,713	$17,495	1998
K/D MC	Expand emergency services access with state-of-the-art replacement trauma center	66,550	$7,290	1995
OVMC	Enhance pediatric, obstetrical, and emergency services with 100-bed addition to this acute care facility	108,923	$11,931	1997
PHP&S	Improve and expand neighborhood access to preventive and ambulatory care services in 49 health centers throughout Los Angeles County	35,500	$3,889	1994-2000
	TOTAL	$1,978,978	$216,772	

NOTE: Annual Debt Service is based on 30-year Certificates of Participation at 7.45% annual interest.

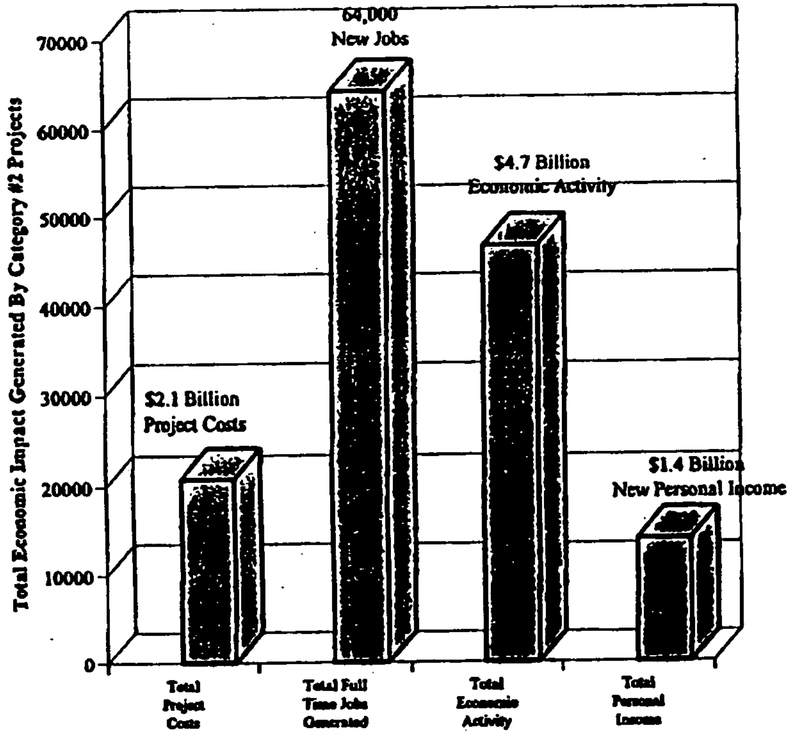
LEGEND:

LAC+USC Los Angeles County+University of Southern California Medical Center
EVMC East Valley Medical Center
H/UCLA Harbor-UCLA Medical Center
K/DMC Martin Luther King, Jr./Charles R. Drew Medical Center
OVMC Olive View Medical Center
PHP&S Public Health Programs and Services

HEALTHY LA YEAR 2000
Replacement Projects for LAC+USC Medical Center
Full Time New Jobs by Year and Total
Fiscal Years Ended June 30, 1992-2000



HEALTHY LA 2000
Aggregate Economic Impact of Implementation of LAC+USC Replacement Projects
Los Angeles County, 1992-2000



Representative Stark. Thank you very much.
Ms. Fraiche, please proceed.

STATEMENT OF DONNA D. FRAICHE, CHAIRMAN, MEDICAL TASK FORCE OF THE DOWNTON DEVELOPMENT DISTRICT OF NEW ORLEANS, LOUISIANA

Ms. Fraiche. Thank you, Congressman Stark. It is indeed an honor to speak with you today concerning one of the greatest sleeping giants of our governmental industry, the health care capital expansion program. I have had the opportunity and privilege to serve as the Chair of the Downtown Development District's Medical Task Force and the New Orleans Regional Medical Center. Therefore, I speak to you as a voice of the voluntary sector, committed to the creation of a consortium of government, business, academic and medical partners who have developed a strategic economic development plan for the regional New Orleans area, and we recognize in that plan, as our centerpiece, the strong public hospital system that we operate in Louisiana.

We reviewed our economic strengths and, of course, our weaknesses. You pointed out that food is, of course, one of our strengths. It was also the health care industry that we recognized as a strength. We are between Houston and Birmingham, in terms of regional health care—international health care delivery—in New Orleans, but we stand at the crossroads. Our economy indeed can be jump-started by recognizing that investing in our public infrastructure will not only create construction jobs, but permanent professional lifestyles for our citizens and for those that we can hope to attract to our community. That is one road. But down the other path, we see inevitabilities too frightening to comprehend decay, despair and degradation. So, while we must act wisely, it is clear that we must nevertheless act.

Health care is our second largest industry. It is squeezed right in there between tourism and oil and gas, and it is a multibillion dollar growing industry, which, in the New Orleans regional area alone, employs between 40,000 and 50,000 people. Unemployment enjoys no home in this major industry. In the inner-city 36-block area, which has been designated as the New Orleans Regional Medical Center, sits the Louisiana Medical Center at New Orleans, formerly known as our "Charity Hospital." We have two major medical schools, research institutions, a Veterans Administration Regional Medical Center, and we have medical businesses growing within enterprise zone boundaries.

Once considered empty and worthless, we now have office space that we envision as part of a research park high-tech complex, which will surely entice our youth to be educated with the prospect of new job opportunities in the health care sector.

"Big Charity," as it has been known for many years, was first developed in 1736, so it is one of our oldest institutions. But it operated in

1938 at its current facility, 3,000 beds, and now struggles to keep 600 open—not because you can't occupy 600 beds, which are almost always fully occupied, but more because we have to depend on state revenue financing for survival. We are part of a nine-hospital statewide charity system that operates to take care of indigent health care in Louisiana. In a state with four million people, we have 900,000 people who are indigent.

According to the June 10, 1992, *USA Today*, emergency rooms in public hospitals treat three times as many violently induced wounds as six years ago, and through years of crumbling, these public hospitals and the primary care system networks that have been funded through state appropriations are losing dollars.

You heard Larry Gage talk about the comparison between what other hospitals spend on their plant and physical equipment, as compared to public hospitals, and in our state, $1,500 is spent at charity hospitals, as compared to $12,000 in other hospitals in our state.

Sixty-six percent of our population in New Orleans is comprised of minorities; 25 percent of that population is on public assistance, and 5,000 of our poor citizens are born in the public hospital system each year. We have lost over 100,000 residents to suburbs and elsewhere, and we have a dropout rate that exceeds 45 percent. We have 13,000 public housing units and over 10,000 homeless people, most of whom have no place else to go except Big Charity. The clear implication from the studies that have been done is that we have a city with economic decline and that has had a greater impact on its minority community.

Public attention gets focused, unfortunately, through crisis, and that happened when the charity system almost lost its federal accreditation. We learned that the domino effect of closure of a major public hospital would impact the two major medical schools, their teaching programs, and thousands of people who are not only people who were in the delivery health-care system, but who were employed by that system. Concerned citizen leaders now comprise the strongest advocates for capital improvements in our public health care system.

We have learned the cry that crisis management is only a Band-Aid and not a cure, and that loss of accreditation is still threatened if we do not replace the antiquated and blighted physical structures that dare call themselves hospitals. Further, with the resurgence of communicable diseases and the need to isolate and treat this population, public hospitals are seeing entire wards designated for the care of only a few patients.

May I proceed for a few more moments?

REPRESENTATIVE STARK. Go right ahead.

MS. FRAICHE. Thank you very much.

I want to address the health care industry as a major economic force in this country and in the New Orleans economy. We forged alliances to review the economic impact of health care as a service industry, and we found that in New Orleans, from 1987 to 1991, 24 percent of all of our

newly created jobs were medically related, with combined payrolls of over $2.4 million as a direct and indirect economic impact of health care. Twenty-three percent of our job openings are in the managerial and professional occupations, and there are 2,663 professional slots that are opening each year in health care.

We argued then, and we plead now, that in a city like New Orleans, which has a vacancy in over 2,000 jobs for qualified professionals, we have an industry that can immediately put people to work. This industry is as significant a priority as a new hotel, as a new B-1 bomber, with entry levels far in excess of that of our tourism industry. We find that our universities, and our high schools, our school boards can participate in the excitement that can be created by new recruitment avenues, new construction opportunities, endowed chairs, and new labs.

But building a medical industry in Louisiana and elsewhere demands restructuring and rebuilding of our outmoded public hospital facilities. We project that we are going to need at least $400 million to replace this system in Louisiana, but the construction impact alone should generate an additional $450 million in secondary or spinoff spending. Our studies have shown that the total economic impact of this described construction will be approximately $850 million. That is a real boost to our economy.

During this construction period, we note that we can produce $17 million in State and local government tax revenue, 12,400 jobs in the States' economy in construction trade; and with ongoing projects that are at Tulane University and LSU, at those medical school campuses, we see $500 million worth of construction. We see cranes in the sky for the first time in a long time. The termination of any of these projects will have a direct and severe impact on our fragile economy.

We have described this economic impact as Louisiana's largest public works project in history, the equivalent of four Superdomes. But why health care capital replacement and why expansion? Why now? Because we stand at the crossroads. And the most important aspect of the construction of a new public hospital system and facility is the impact on the health care system, generally. The efficiency of charity care costs and the access it provides in public institutions absolutely supports investment in public hospital infrastructure and the primary care delivery system that it affords.

We expect that we will, at the conclusion of these projects, generate over $13.8 million in tax revenues for the state and local government and consequent enhancement to the federal tax regime. Those are real investment dollars.

In conclusion, public hospital systems are in jeopardy throughout the United States due to inadequate financing, deplorable medical equipment, and physical plants. Unstable and declining support from State general funds increase the physical deterioration of these facilities. To turn our backs now on our country's public hospital systems, I think, would be foolhardy, at best; for our children and our children's children

will surely reap the bitter harvest of this cruel neglect. And just as preventive medical care offers the best chance for the future of health care in this country, so too should attention be given to our health care crisis to realize its benefits, in both a human and an economic sense.

Thank you for the opportunity to share our plans for the use of Louisiana's public hospital systems.

[The prepared statement of Ms. Fraiche follows:]

PREPARED STATEMENT OF DONNA D. FRAICHE

It is indeed an honor to speak with you today concerning one of the greatest sleeping giants of our governmental industry -- health care capital expansion. As I have had the privilege and opportunity of serving as the Chair of the New Orleans Downtown Development District Medical Task Force and the New Orleans Regional Medical Center Foundation, I speak to you now as a voice of the voluntary sector committed to the creation of a consortium of government, business, academic and medical partners who have developed a strategic economic development plan for the regional New Orleans area. Our plan recognizes as its centerpiece the strong public hospital system we operate in Louisiana. We understand both by statistics and reality that the health care industry in our beleaguered community represents one of our greatest opportunities for progress. But we stand at the crossroads. Our economy can be jump-started by acknowledging that investing in our public infrastructure will not only create construction jobs, but permanent professional lifestyles for our citizens and those we can hope to attract to our community. That is one road. Down the other path we see inevitabilities almost too frightening to contemplate -- continued decay, despair and degradation. So while we must act wisely, it is clear that we must nevertheless act.

Health care is our second largest industry squeezed between tourism and oil and gas. As a multi-billion dollar, growing industry, it serves as a tremendous potential for economic development. In the New Orleans regional area alone, the health care industry employs over 50,000 people. In urban New Orleans the healthcare economic impact has been estimated at over $1.3 billion. Unemployment enjoys no home in this major industry. There are 26 hospitals in the New Orleans metropolitan area. In the inter-city 36 block area which has been designated as the New Orleans Regional Medical Center sits the Louisiana Medical Center at New Orleans (formerly known as "Charity Hospital") as its centerpiece. We have two major medical schools, research institutions, a Veterans Administration Regional Medical Center, and medical businesses growing within enterprise zone boundaries. Once considered empty and worthless office space is now envisioned as part of a research park high tech complex which will surely entice our youth to be educated with the prospect of new job opportunities in the health care sector.

As we begin to rebuild, we must focus on our devastated centerpiece, the Charity Hospital. "Big Charity," as it has been known for many years, is one of the oldest institutions in the United States, with its origins in the Eighteenth Century. Created in 1736, it serves as a major teaching hospital for the Tulane University and Louisiana State University medical schools. As part of a nine hospital statewide system, the Charity system is the safety net for providing indigent care in Louisiana. When the existing "Big Charity" at New Orleans opened in 1938 it operated 3,000 beds, and now it struggles to operate fewer than 600 beds. It supports a typical inter-city major trauma center comparable to those in public hospitals throughout the United States. According to the June 10, 1992 USA Today, such emergency rooms treat three times as many violently induced wounds as six years ago. Through years of crumbling, this hospital and primary care network system was funded through direct state appropriation. The per bed expenditures on plant and physical equipment at charity system

facilities have been an average $1,500 annually as compared to other hospitals at $12,000.

With a population of approximately four million people, Louisiana has about 900,000 citizens with little or no healthcare insurance. In New Orleans alone, over 33% of our population is classified by national standards as poor, having annual income levels below federal poverty guidelines. The Louisiana unemployment rate for April of 1992 was 7.9%, compared to the national unemployment rate of 7.2%. 66% of our population is comprised of minorities. 5,000 of our poorest citizens are born in our public hospital system each year. We have lost over 100,000 residents to suburbs and elsewhere since our last census count. Our drop out rate exceeds 45%, we have 13,000 public housing units and over 10,000 homeless people, most of whom have no place to go for health care except "Big Charity." New Orleans is a city seeking to rise from the ashes of economic disaster in large part created by the downturn in the oil and gas industry. Once boasting a million people, it now has less than 500,000.

Crisis

Public attention is unfortunately and usually found through crisis and such was the case in Louisiana when the Charity Hospital system became dangerously close to loss of its national accreditation and federal certification. Our community was called to the rescue. In the process of developing a plan of action to deal with the crisis, we were struck by the impact the public hospital has on our local economy. We learned that the domino effect of closure of a major public hospital would impact the two major medical schools, their teaching programs and the thousands of people who still are employed in health care. We learned that the cost of providing care at Charity is at least 50% less per patient day than at other institutions. Concerned citizen leaders who never realized that health care issues affect our economy now comprise the strongest advocates for capital improvements in our public health care system. We have learned that crisis management is only a band-aid, not a cure. The loss of that accreditation is still threatened if we do not replace the antiquated and blighted physical structures that dare call themselves hospitals, lacking the necessary technological and life safety code requirements.

Rebuilding will afford public hospitals the ability to deliver care more efficiently to the poor and desperately ill who have no other place to go. Public hospitals built or planned before 1965 were constructed with multiple patient wards. This concept is a nightmare in today's arena. Same sex wards in some instances are underutilized with one or two patients, while five or six patients of the opposite sex wait in the emergency room for a bed. Further, with the resurgence of communicable diseases and the need to isolate and treat this population, public hospitals are seeing entire wards designated for the care of only a few patients.

Health Service Industry is a Major Economic Force in the New Orleans Economy

As a result of the crisis, business and government came together and studied the necessity for needed appropriation. Together, this forged new alliance reviewed the economic impact of health care as a service industry. We found that during the period from 1987 through 1991, 24% of all newly created jobs in the New Orleans area were medically related. The combined payroll of all health services including public and private sectors reached close to $1 billion in 1987 for 50,000 employees, ranking

health care services as our area's largest employer among all service industries. A total of receipts and revenues for all hospital services in 1987 reached $2.4 billion.

With these statistics as our ammunition, grass roots organizations such as the local chapters of NAACP, Urban League, the Chamber of Commerce, the Business Council, together with CEOs of major industries and presidents of universities banded together to request from our legislature appropriate and necessary funding to replace these antiquated public facilities. We argued then and plead now that in a city like New Orleans, which has a vacancy of 2,500 jobs for qualified professionals, we have an industry that can put people to work. We submit that this industry is as significant a priority as a new hotel which provides numerous hospitality-related jobs for our tourism industry. With entry level jobs in healthcare far in excess of that of our tourism industry, our universities, high schools, and school boards shared in the excitement created by new recruitment avenues, construction opportunities, endowed chairs and new labs.

These plans cannot become a reality without your help. Building a medical industry in Louisiana demands restructuring and rebuilding of our outmoded public hospital facilities. We project that at least $400 million is required to replace this system in Louisiana or $150,000 per bed. The construction impact should generate an additional $450 million in secondary or spin off spending. Studies have shown a total economic impact of this described construction of approximately $850 million. During this construction period the $400 million in construction spending will produce $17 million in state and local government tax revenue and 12,400 jobs in the state's economy in construction trade. It should be noted that at this time Tulane University and Louisiana State University medical schools have capital projects on the drawing board in excess of $500 million. It is important to look at these projects together since they depend upon the Charity hospital system greatly for their survival. The termination of any of these projects will have a direct and severe impact to the fragile New Orleans area economy. We have described this economic impact as one of the largest public works projects in Louisiana's history – an equivalent of 4 Superdomes.

But why health care capital replacement and expansion now? Because, as I have said, we stand at the crossroads. In the midst of a national health care crisis, it is our belief that the most important aspect of the construction of a new public hospital facility is the impact on the health care system generally. In Louisiana of the $400 million charity hospital system budget, approximately $240 million is provided to patients who have no alternative health care coverage. In other words, $240 million of health care spending would not occur through the charity hospital system if it did not exist. This does not mean care would be forfeited. It means that the cost of health care could be tripled to accommodate indigent care rendered in more expensive facilities. The efficiency of charity care costs at public institutions supports investment in the public hospital infrastructure.

Finally, in addition to the construction jobs impacted by infrastructure development, we have projected approximately 11,000 permanent new jobs in the state economy including higher than entry level professional positions with opportunity for minorities and other groups normally not in the mainstream of the economy. These new jobs and new spending should generate a projected $13.8 million annually in tax

revenue for state and local government and consequent enhancement of the federal tax regime.

In conclusion, public hospital systems are in jeopardy throughout the U.S. due to inadequate financing, deplorable medical equipment and physical plants. Unstable and declining support from state general funds increase the physical deterioration of facilities. Use of medical school affiliation agreements keeps quality up and cost down to provide indigent care. Teaching institutions require state of the art facilities to attract and retain appropriate professional staff and students. Finally, public health care facilities must be seen as the major employers they are in urban centers and indeed throughout rural America. To turn our backs now on our country's public hospital systems would be foolhardy at best, for our children and our children's children will surely reap the bitter harvest of such cruel neglect. And just as preventive medical care offers the best chance of future health, so does attention given now to our health care crisis realize its benefits -- in both a humane and economic sense -- in the years to come.

Thank you for the opportunity to share our plans for Louisiana's public hospital system, plans that require your help to ensure the future of public health care services for our state.

REPRESENTATIVE STARK. Thank you.
Mr. Morrisey, please proceed.

STATEMENT OF MICHAEL A. MORRISEY, PROFESSOR, LISTER HILL CENTER FOR HEALTH POLICY, UNIVERSITY OF ALABAMA AT BIRMINGHAM

MR. MORRISEY. Mr. Chairman, thank you.

I run the Lister Hill Center for Health Policy at the University of Alabama at Birmingham.

What I would like to do with the time that is available to me is to step back a little bit and look at the health services research literature and what it has to say about public hospitals. Particularly, I want to look at issues of care for the uninsured, the cost of care, the changing nature of hospital competition and particularly the effect that the changing competition might have on public hospitals. I also want to look at some issues of rural hospitals, because a number of public hospitals are in fact rural facilities. Finally, I want to take these bits of research findings, and extrapolate a little bit to look at the possible impacts of some major reforms to the health care system, and focus primarily on the effects that they may have on public hospitals.

With respect to public hospitals, they are usually defined as state or local government-owned institutions. It turns out that about 25 percent of the hospitals in the country are public hospitals under that definition. It is also the case that between 1985 and 1990 the admissions at those hospitals have dropped by about 13.5 percent, about twice the rate of community hospitals generally.

It is certainly the case that public hospitals provide a disproportionate amount of care to the uninsured. In fact, public hospitals under that definition provide about 12 percent of their admissions to the uninsured; about 13 percent goes to Medicaid patients. Those are about double the rates at other community hospitals.

It is important to appreciate that not all public hospitals provide the same amount of care to the uninsured. Large public urban teaching hospitals tend to provide about 6 percent more care for the uninsured than do other public hospitals. It is also important to appreciate that the presence of a public hospital in a community has a significant impact on the provision of care to the uninsured among the other hospitals in the community. Research that I have undertaken with Frank Sloan suggests that the presence of a public hospital reduces the amount of unsponsored care provided by other community hospitals by about one-sixth. The aggregated amount of unsponsored care in a community is higher, community hospitals providing less and public hospitals providing more, so the net effect is a larger amount of care to the uninsured.

REPRESENTATIVE STARK. We call that dumping, don't we?

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Mr. Morrisey. Dumping implies that the community hospitals are explicitly choosing not to admit, and indeed some are, but I suspect what is going on in lots of communities is a more implicit form of dumping. Everyone knows that the public hospital cares for the uninsured, and that is where they go to get care. So, it is almost an implicit dumping, if you will.

The second major issue, with respect to the health services research, is that public hospitals tend to have lower costs for admissions. The estimates range from about 6 to 8 percent lower. There is some fuzziness with respect to these estimates because the researchers haven't been able to control for amenities and case mix particularly well, but it does clearly suggest that their costs are lower.

Third, with respect to competition, earlier this morning there was the discussion of the effects of more hospitals in a community on hospital costs; and it is certainly the case from the research literature that more hospitals in the community lead to, if you would, a medical arms race with higher costs and higher services. At least, that has been the case under the patient driven form of competition that has existed through the last few decades.

But there is some evidence coming out of California to suggest that if you change the financing system, you may, in fact, change the nature of competition. Some work that Glenn Melnick and Jack Zwanziger at UCLA and Rand have done looks at the effects of preferred provider organizations in the State. Their analysis says that in the period between 1980 and 1982 in those California communities where there were more hospitals, there was a higher rate of increase in hospital costs; higher than in communities where there are fewer hospitals.

On the other hand, between 1983 and 1985, after the State enacted some legislation encouraging preferred provider organizations and their ability to contract with hospitals, the researchers found that in communities with more hospitals that the real rate of increase in hospital costs was negative—seven-tenths of 1 percent lower. In those communities where there was less hospital competition, costs had increased 2.8 percent, suggesting that when you change the nature of the payment system that you may indeed introduce some price competition—in this case, HMOs and PPOs trying to negotiate deals with providers.

The implication of this for public hospitals is significant, because what it suggests is that those community hospitals that have been providing care for the uninsured find that their profit margins get squeezed and that they are no longer able to provide care for the uninsured to the extent that they have been in the past. Increasingly, those patients will find themselves at the doors of the public hospital.

Changing gears to speak a moment about rural hospitals. Janet Bronstein and I at UAB have been looking at rural pregnant women in Alabama, and trying to see where they go for care. It turns out, looking at data from 1988, that literally 50 percent of them bypass the closest rural

hospital that provides obstetric services to go elsewhere for care. Two-thirds of those go to an urban community.

What we find—trying to tease out statistically the determinants of that bypassing—is that higher income women are more likely to bypass, and strangely enough, that those women who have Medicaid coverage are more likely to bypass. There are two explanations for that last result. One is that the local providers are unwilling to provide care to Medicaid patients, but another interpretation, which we are not able to dismiss, is that the Medicaid coverage effectively provides them with insurance coverage and broadens the range of options they have in seeking care. This suggests that at least some proposals for expanding coverage to the uninsured may lead to increased bypassing in rural communities and, perhaps, in urban communities as well.

All of which brings me to implications for the future. What all of this suggests is that economic growth is likely to reduce the demand for public hospital services simply because higher incomes and smaller numbers of uninsureds lead patients to, by definition, have insurance and, therefore, potentially seek care from other providers.

REPRESENTATIVE STARK. Are you suggesting that there may be fewer uninsured and more growth in the economy? Is that——

MR. MORRISEY. Yes, sir.

REPRESENTATIVE STARK. That is a leap of faith, but——

MR. MORRISEY. The data that we looked at in the period of the mid-1980s, trying to look at the care provided to the uninsured in community hospitals, led us to conclude that a 3.5 percent increase in real family income was associated with a 1 percent reduction in the proportion of care provided to the uninsured in community hospitals.

One explanation is that they choose not to see those patients. Another explanation is that fewer uninsured were there.

The second implication of our studies, looking at rural hospitals, is that if public policy were to take the approach of expanding Medicaid, it may indeed be a boon to public hospitals by providing them monies to pay for the uninsured, but on the other hand, it is quite possible that patients, newly enfranchised in the Medicaid program, may indeed seek care from the other providers.

It is also the case that if one were to implement mandates or expense credits and vouchers that these expansion in insurance coverage to the uninsured should result in fewer uninsured. But they may result in less demand for public hospital services. And in that sort of scenario, the issue for the public hospitals becomes one of their ability to compete on the basis of services as well as price for those patients.

Thank you.

[The prepared statement of Mr. Morrisey, along with an Appendix, follows:]

PREPARED STATEMENT MICHAEL A. MORRISEY

My name is Michael Morrisey. I am a health economist and professor in the School of Public Health at the University of Alabama at Birmingham. I am also acting director of the University's Lister Hill Center for Health Policy. I am speaking in my private professional capacity.

In these brief remarks I wish to do three things: First, provide an overview of public hospitals, focusing on their number, costs relative to other hospitals, and provision of care for the uninsured. Second, discuss the effects of the changing hospital and insurance markets on hospitals generally and public hospitals in particular. Third, comment on the likely effects of health system reform proposals on public hospitals. In each instance I will draw upon the findings of the health services research literature.

OVERVIEW

A. Numbers and Admissions

Public hospitals are usually thought of as short term acute care hospitals owned by state or local government entities. Using this definition the American Hospital Association reports that there were 1,469 public hospitals in 1990. They provided over 5.25 million hospital admissions. This was a decrease of 13.5 percent from the number of public hospital admissions in 1985 and is nearly twice the 6.9 percent decline in admissions experienced by nonfederal short term hospitals over the same period.[1]

B. Costs

Comparisons of costs between categories of hospitals is difficult because of differences in the complexity of the cases treated, the prices of inputs, and the levels of services and amenities provided. However, health services researchers have generally concluded that public hospitals have somewhat lower costs per admission than private nonprofit and investor owned hospitals. Using sophisticated multiple regression techniques, Grannemann et al. found that public hospitals had costs per admission that were approximately 8 percent lower than other nonprofit hospitals.[2] Grosskopf and Valdmanis used a sample of urban California hospitals to demonstrate that public hospitals were marginally more efficient relative to private nonprofit hospitals.[3] However, both studies suggest that the cost differences may be overstated due to an inability to adequately control for casemix and amenity differences.

C. Care for Uninsured Patients

A particularly important feature of public hospitals is the extent to which they provide care for the poor and uninsured. Three points are paramount:

Public hospitals as a group provide proportionately more care for the uninsured and for Medicaid patients than do other hospitals. Using 1984 nationally representative data, Richard Frank and colleagues found that 11.6 percent of public hospital discharges consisted of uninsured patients, another 13.2 percent were to Medicaid sponsored patients. In contrast, private nonprofit hospitals had 6.5 percent uninsured

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1 American Hospital Association, AHA Hospital Statistics (Chicago: AHA 1992).

2 Grannemann, T.W., R.S. Brown, and M.V. Pauly, "Estimating Hospital Costs: A Multiple-Output Analysis," Journal of Health Economics (June 1986):107-128.

3 Grosskopf, S. and V. Valdmanis, "Measuring Hospital Performance: A Non-parametric Approach," Journal of Health Economics (June 1987):89-108.

discharges and 8 to 10 percent Medicaid. Investor owned facilities had 4.3 and 7 percent of their discharges from uninsured and Medicaid patients, respectively.[4]

The presence of a public hospital in a town results in less uninsured care being provided by other hospitals in the community, but in a higher overall amount of care for the uninsured. Colleagues at Vanderbilt University and I examined 1985 patient discharge data from over one million patients in 501 hospitals. We found that, controlling for other factors, the presence of a public hospital in a community reduced the proportion of uninsured patients by about one-sixth.[5] Thorpe and Brecher used 1982 data from the 100 largest cities. They found that public hospital care is not wholly offset by reductions in care provided by other hospitals. The presence of a public hospital had a net effect of increasing the ratio of uninsured admissions to poor people by about two percent.[6]

All public hospitals do not provide comparable amounts of care for the uninsured. Our work indicated that, controlling for employment, Medicaid coverage, and family income among other things, large public teaching hospitals provided six percent more of their admissions for the uninsured than did other public hospitals. Private nonprofit and investor owned hospitals provided a 1.5 and 2 percent smaller share of their admissions to uninsured patients, respectively, than did public hospitals.[7]

NATURE OF HOSPITAL COMPETITION

To understand the likely impact of policy changes it is important to appreciate the impact of hospital competition, such as it is, on hospitals generally, and on public hospitals in particular. I will focus on two issues: the effects of the growth of health maintenance organizations (HMOs) and preferred provider organizations (PPOs) on hospital markets, and the nature of rural hospital markets.

A. Managed Care

The decade of the 1980s saw the emergence and growth of managed care particularly in the form of HMOs and PPOs. This development is having and will continue to have a profound effect on hospital markets. California has been in the forefront of this development and has served as a natural experiment. The evidence suggests that HMO and PPO contracting with hospitals has been effective in reducing the rate of increase in hospital costs, <u>when there are sufficient numbers of competing hospitals</u>. This is in contrast to earlier time periods when greater numbers of hospitals were associated with higher levels of costs.

Glenn Melnick and Jack Zwanziger examined the California data and found that in the 1980-82 period communities with more hospitals had hospital expenses per admission that increased at a 6.6 percent rate. Communities with fewer hospitals had increases of 5.9 percent. California implemented legislation encouraging PPO contracting and authorizing selective contracting for California Medicaid in 1983.

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[4] Frank, R.G., D.S. Salkever, and F. Mullann, "Hospital Ownership and the Care of Uninsured and Medicaid Patients: Findings from the National Hospital Discharge Survey 1979 - 1984," Health Policy (1990):1-11.

[5] Sloan, F.A., M.A. Morrisey, and J. Valvona, "Hospital Care for the 'Self-Pay' Patient," Journal of Health Politics, Policy and Law (Spring 1988):83-102. A copy of this paper is included as an appendix.

[6] Thorpe, K.E. and Brecher, C., "Improved Access to Care for the Uninsured Poor in Large Cities: Do Public Hospitals Make a Difference?" Journal of Health Politics, Policy and Law (Summer 1987):313-324.

[7] Sloan, et al., 1988.

During the 1983-1985 period (even after adjusting for Medicare prospective payment) hospital expenses in "many hospital" markets had a .7 percent reduction in hospital expenses. Hospitals in communities with "few hospitals" had expense increases of 2.8 percent.[8] These results are summarized in Table 1.

The implication of these results is that PPOs have been able to negotiate with community hospitals, obtain a lower price and control utilization. Indeed, forthcoming work by Melnick and colleagues using Blue Cross and Blue Shield data from California shows just this result.[9]

Table 1
Hospital Expenses Per Admission Pre and Post Selective Contracting

	Many Hospitals	Few Hospitals
1980 - 1982	6.6 %	5.9 %
1983 - 1985	- 0.7 %	2.8 %

Under these circumstances it is unlikely that non-public hospitals will be able to use their "profits" to provide care to the uninsured. It is unlikely that "cost shifting" will serve as a mechanism to pay for the care of the uninsured. When HMOs and PPOs negotiate discounts and most of the privately insured market is covered by such insurers, there is little room to cost shift. Evidence from a HCFA funded study of the effects of PPS on Blue Cross utilization and claims payments bears this out. Richard Scheffler and his colleagues examined Blue Cross plan data over the period 1980 - 1986. They concluded that, after controlling for other factors including Blue Cross's own utilization review tools, the Medicare prospective payment system reduced Blue Cross admissions by over 500,000 in 1986 and hospital claims declined by $727 million (in 1986 dollars).[10] Rather than hospitals shifting Medicare costs to the private payers, it appears that changes in practice patterns under Medicare lead to reduced hospital use by privately insured patients.

B. Rural Hospital Markets

In many regions of the country rural public hospitals play a significant role in providing care to rural residents. The salient feature in rural hospital markets is the tendency of rural residents to bypass the nearest rural hospital to obtain care elsewhere. My own work with Janet Bronstein indicates that in 1988, literally fifty percent of rural pregnant women bypassed the nearest rural hospital to obtain care elsewhere; two-

[8] This findings are from Melnick, G. and J. Zwanziger, "Hospital Behavior Under Competition and Cost-Containment Policies," Journal of the American Medical Association (November 11, 1988):2669-2675. For a more rigorous analysis see: Zwanziger, J. and G. Melnick, "The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California," Journal of Health Economics (1988):301-320. The findings are consistent with Robinson, J.C., "HMO Market Penetration and Hospital Cost Inflation in California," Journal of the American Medical Association (November 20, 1991).

[9] Melnick, G.A., J. Zwanziger, A. Bamezai, and R. Pattison, "The Effects of Market Structure and Bargaining Position on Hospital Prices," Journal of Health Economics (forthcoming).

[10] Scheffler, R.M., J.O. Gibbs, and D.A. Gurnick, The Impact of Medicare's Prospective Payment System and Private Sector Initiatives: Blue Cross Experience, 1980 - 1986. HCFA Grant No. 15-C-98757/5-01 (July 1988).

thirds of these went to an urban hospital.[11] While these findings relate only to OB care, they are consistent with older but broader data from Nebraska.[12] Nontheless, obstetrics and the care of newborns constitute the largest categories of care provided to the uninsured. We estimate that diagnoses in these categories constitute nearly 40 percent of hospital discharges by the uninsured.[13]

The evidence on rural hospital bypassing makes three important points. First, public hospitals are no different from other rural hospitals in this regard; they are regularly bypassed. Second, those residents with higher incomes and those more likely to have Medicaid coverage are more likely to bypass. Finally, the rate of bypassing has increased throughout the 1980s even as rural hospitals have closed. Thus, rural hospitals, including public facilities, are seeing a declining base of paying patients.

THE FUTURE OF PUBLIC HOSPITALS

A. Economic Growth

Before discussing the implications of health care reform, it is worth noting that economic growth is likely to have spinoff effects on the uninsured patient load of hospitals. In examining the period 1980 through 1985 Frank Sloan, Joe Valvona and I found that a 3.5 percent increase in real family income was associated with a 1 percent reduction in a typical hospital's share of uninsured patients. Holding family income and other factors constant, a one percent increase in the percent of the population employed would decrease a typical hospital's share of admissions to the uninsured by about 1/3 of 1 percent.

Thus, growth would decrease the pool of uninsured patients. What is not clear is the effect on public hospitals. One the one hand since public hospitals see more uninsured patients, they could stand to benefit disproportionately. On the other hand, if newly insured patients go elsewhere for care, the benefits may occur among the non-public hospitals. I suspect that the latter effect will out-weigh the former.

B. The Current Health Care System

With no change in the current environment we should expect to see continued growth of managed care throughout the nation. I suspect that the California experience will be repeated. That is, HMOs and PPOs will successfully negotiate for low expenditures in communities which have several hospital providers. In these communities public hospitals and particularly large-public-teaching hospitals will see a greater inflow of uninsured patients as private hospitals can no longer afford to treat them.

There are some mitigating circumstances already in place. The recent expansions of Medicaid to cover pregnant women and young children means that a large portion of this segment of the uninsured has coverage. However, this may be a mixed blessing for rural public hospitals. One interpretation of our Alabama data is that with expanded access brought about by Medicaid coverage, residents will more frequently bypass local rural providers.[14]

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[11] Bronstein, J. and M.A. Morrisey, "Determinants of Rural Travel Distance for Obstetrics Care," Medical Care (September 1990):853-865. Bronstein, J. and Morrisey, M.A., "Bypassing Rural Hospitals for Obstetrics Care," Journal of Health Politics, Policy and Law (Spring 1991):87-118.

[12] Morrisey, M.A., Sloan, F.A. and Valvona, J., "Geographic Markets for Hospital Care," Law and Contemporary Problems (1988):165-194.

[13] Sloan et al 1988.

C. Medicaid Expansion

Further Medicaid expansions would reduce the pool of uninsured. My work with Sloan suggests that a one percent increase in the proportion of the population covered by Medicaid results in a 1/2 of one percent reduction in the proportion of uninsured patients seen by hospitals.[15] The unanswered question is whether these patients will continue to use the public hospital.

D. Employer Mandates, Tax Credits and Vouchers

While these policy options differ in important ways, they have at least one thing in common. They provide private health insurance to the uninsured. This has the benefit of reducing the number of uninsured. This reduces the strain that is disproportionately borne by public hospitals. However, in many ways most attempts to expand coverage puts the public hospital at risk for its survival. Rather, than being the provider of last resort, it would be faced with competing for insured patients. The issue for them would be whether their lower costs will be attractive when bundled with a perception of lower levels of amenities and quality.

Thank you.

Appendix

Sloan, F.A., Morrisey, M.A., and Valvona, J., "Hospital Care for the 'Self-Pay' Patient," Journal of Health Politics, Policy and Law 13(1):83-102 (Spring 1988).

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[14] Bronstein and Morrisey, 1991.

[15] Sloan et al, 1988.

Hospital Care for the "Self-Pay" Patient

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Abstract. The number of hospitalized patients lacking an identifiable source of third-party payment has risen substantially in recent years. This study examines trends in the hospitalization of "self-pay" patients and investigates causal influences on the propensity of hospitals to accept such patients for treatment. Our analysis pays particular attention to the relationship between Medicare's prospective payment system (PPS) and hospitals' self-pay patient share. Our results show an overall increase in both the number and proportion of self-pay patients treated by hospitals between 1980 and 1985. Substantial differences existed among the types of hospitals that accepted such patients, with major teaching hospitals treating an increasingly disproportionate share. The mix of self-pay patients in terms of age, sex, and reason for hospitalization remained stable during the period under study. Our conclusion is that the regression analysis shows no evidence that PPS reduced hospitals' willingness to treat uninsured patients.

The number of persons without private or public health insurance has grown dramatically in recent years. In 1980, approximately 29 million persons—nearly 15 percent of the U.S. population under age 65—were uninsured. By 1984, slightly over 35 million had no insurance, representing over 17 percent of the population under age 65 (Sulvetta and Swartz 1986). In other words, the number of uninsured grew by well over one million per year during the first half of the 1980s. Empirical evidence is lacking, but several reasons for this increase have been suggested: the rise in the percentage of persons living in poverty, changes in the demographic composition of American families (more single-head families and more unrelated persons living in the same household), higher unemployment rates, shifts in the industrial composition of the labor force toward sectors in which insurance is less likely to be provided, and cutbacks in eligibility for public insurance programs such as Medicaid (Danzon and Sloan 1986).

The increase in the number of uninsured persons raises several public policy concerns. To what extent has access to health services been impaired? Have these

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persons been exposed to substantial risk of financial hardship, or are many services in fact paid for by various types of cross-subsidies? Important payers, most notably Medicare, implemented major cost-containment programs for hospital care during the early 1980s, in particular the prospective payment system (PPS). Did this program reduce the willingness of hospitals to cross-subsidize uninsured patient care because the new payment arrangement caused hospital decision-makers to act more "businesslike" and/or because funds for cross-subsidies were simply no longer as available as before?

This study addresses seven specific questions. First, how did the number of hospital inpatients for whom the expected primary source of payment at discharge was "self-pay" or "no charge" (hereafter termed "self-pay" patients) change between 1980 and 1985? Did the implementation of PPS legislation affect hospitals' self-pay inpatient loads? Second, which types of hospitals (delineated by hospital ownership, teaching status, metropolitan or nonmetropolitan location, and dependence on Medicare patients) cared for the greatest share of such patients? Have the shares been changing—especially since 1983, when PPS was first implemented? Third, what are the most frequent diagnoses of self-pay patients? Have there been major shifts in the frequency distribution of diagnoses? Fourth, once admitted to a hospital, is the self-pay patient more likely to be transferred to another acute care facility? Was the probability of such a transfer higher in 1985 than in 1980 or 1983? How did transfer rates from acute care hospitals to other facilities (such as long-term care units and home health agencies) compare with those for insured persons under age 65? Did these transfer rates change after the implementation of PPS? Fifth, four states—Maryland, Massachusetts, New Jersey, and New York—had Medicare waivers at some time during the period 1980–85 that exempted their hospitals from the provisions of PPS. These states either implicitly compensated hospitals for the care of the indigent or established explicit pooling arrangements to finance the care of the un- or underinsured patient. Between 1983 and 1985, did patterns of hospital care for the self-pay patient in those states differ from those of the rest of the U.S.? Sixth, did changes in states' Medicaid eligibility policies affect hospitals' self-pay patient loads? Finally, did private sector cost containment (as reflected in the growth of HMO enrollments) affect the willingness of hospitals to treat self-pay patients?

Methods

Data for this study came from discharge abstracts submitted to the Commission on Professional and Hospital Activities (CPHA). Each CPHA discharge abstract collects patient demographic information such as age, sex, race, source of payment, principal and secondary discharge diagnoses, operative and diagnostic procedures performed during the stay, length of stay, intensive care use, source of admission, nature of admission (emergency, urgent, etc.), disposition of the patient (to the home, another acute facility, a skilled nursing facility, etc.), and dates of admission and discharge.

To be included in our sample, a hospital had to be a nonfederal, short-term general hospital and be part of the CPHA's data collection system during the third quarter (July–September) of 1980, 1983, 1984, and 1985. The hospital also had to be willing to sign a data release form permitting the empirical analysis to be performed at Vanderbilt University. Of the 882 requests sent to hospitals during early 1985, 608 (68.9 percent) agreed to release their data. Of these respondents, 107 hospitals had to be dropped because third-quarter 1985 data were ultimately not provided to CPHA. The final result was a sample of 501 hospitals.

We restricted the sample to one quarter's data per year to reduce the number of records analyzed. Even narrowing our sample to three months of data yielded over one million abstracts. We drew a weighted random sampling of cases to further reduce the quantity of data (Sloan, Morrisey, and Valvona 1987). The result was an average of about one-quarter million records per year, with about 19,000 abstracts per year listing "self-pay" or "no charge" as the principal expected source of payment. The reported results were reweighted to reflect all third-quarter discharges for the 501 hospitals.

Based on data from the American Hospital Association's *Annual Survey of Hospitals*, each hospital was assigned to one of seven mutually exclusive categories: flagship teaching; other member of Council of Teaching Hospitals (COTH); other public standard metropolitan statistical area (SMSA); other public non-SMSA; voluntary SMSA; voluntary non-SMSA; and investor-owned. A flagship teaching hospital, as designated by the American Association of Medical Colleges, is a hospital which is owned by a medical school or is a separate nonprofit or public hospital in which the majority of hospital service chiefs and medical school department chairs are the same person. There were seven such hospitals in our sample, four of which were public. Among the 38 other COTH hospitals, only one was public. Both flagship and other COTH hospitals are almost always located in SMSAs. Because of the small size of the investor-owned sample, we did not distinguish such hospitals on the basis of metropolitan location. It is notable that only 33 percent of the investor-owned hospitals in our sample were part of chains. It should also be noted that some of the public and other private hospitals have limited teaching programs.

We used each hospital's teaching and ownership status as it was defined in 1980; the 1980 classification was used throughout the analysis. Overall, compared to nonfederal, short-term general hospitals in the United States in 1980, hospitals in our sample were larger, more likely to be found in the North Central census division, less likely to be in the South, and less likely to be investor-owned.

We used two measures of case mix: the Medicare Casemix Index (MCI) and the CPHA Resource Need Index (RNI). The MCI was constructed by the Health Care Financing Administration and was formulated exclusively for Medicare patients (Pettengill and Vertrees 1982). The RNI is based on resource use associated with the treatment of specific illnesses. It is defined by a matrix of 351 diagnoses,

five age categories, and the presence of a surgical treatment (Ament, Kobrinski, and Wood 1981). The RNI is based on all patients in the institution.

To assess determinants of a hospital's self-pay load, we specified an equation that used as the dependent variable the hospital's proportion of self-pay discharges to total discharges. By definition, the dependent variable is bounded between zero and one. In our sample, only 2.6 percent of the observations had self-pay fractions less than 0.01, while 10 percent of the observations had self-pay shares over 0.14. The highest self-pay share was 0.39, the median was 0.06, and the observational mean was 0.08. We estimated the equations with two dependent variables: the fraction of discharges which were self-pay (p), and a logit transform of p. As expected, the logit and ordinary least squares (OLS) results were very similar because of the few observations at the limit values. We present only the OLS results below. We also used three types of independent variables: those influencing the pool of uninsured in the community, those influencing the share of care provided by a given hospital, and those designed to gauge the effects of PPS and waiver status. We discuss each of the variables in turn.

Labor force participation has been shown to be an important determinant of the percentage of the population under age 65 without insurance (Monheit et al. 1985; Danzon and Sloan 1986). Hence, we used the percentage of the population aged 16 and over in the hospital's state which was (1) either not in the labor force or unemployed, (2) employed in wholesale or retail trade, (3) employed in construction, (4) employed in service industries, (5) employed by a government, (6) employed in agriculture, and (7) employed in other industries. Manufacturing employment was the reference category (U.S. Bureau of Labor Statistics 1980, 1983, 1984, 1985). We also included a measure of family income—effective buying income deflated to 1980 dollars—because it too has been shown to explain insurance coverage and use of services (Phelps 1973, 1976; Sales and Marketing Management 1980, 1983, 1984, 1985). This variable was defined for the SMSA for metropolitan hospitals and for the county for nonmetropolitan hospitals. Availability of Medicaid was measured as the unduplicated Medicaid enrollee count for the state divided by state population. Medicaid enrollment data are not published at a level of aggregation below the state, since Medicaid policy is made at the state level.

We also included several factors affecting the share of self-pay patients cared for by a particular hospital in the community: whether the hospital was the only hospital in the county, whether there was another public hospital in the county, and the ownership/teaching status of the hospital. The presence of other hospitals in the county, especially public hospitals, has been shown to be associated with a lower rate of uncompensated care provided in a given hospital (Sloan, Valvona, and Hickson 1985). We included the percentage of admissions arriving through the emergency room because such admissions often lack health insurance, and a large emergency department is positively associated with higher bad debt and charity care (Schiff et al. 1986; Sloan, Morrisey, and Valvona forthcoming). Also

included was a measure of local health care competition, i.e., the percentage of the population enrolled in an HMO (InterStudy 1983, 1986). Many have argued that increased price competition will result in less care for those unable to pay (Reinhardt 1986).

We measured the effect of Medicare waivers by a dichotomous variable that took the value of one in New York, Massachusetts, and Maryland (there were no New Jersey hospitals in our sample). This variable was also interacted with dichotomous "year" variables. The effect of PPS was captured by the percentage of inpatient days of care received at the hospital by Medicare beneficiaries and interaction terms of the hospital's Medicare share and binary variables for the year. Past research on the determinants of a state's decision to adopt mandatory rate-setting programs for hospitals has identified such factors as state outlays for Medicaid as a percentage of the state budget, for-profit beds as a percentage of total beds, and the historical growth rate in hospital costs (although the effect of hospital cost trends is unclear from these studies). No one has identified a high or low self-pay share or uninsured population percentage as factors. At least for purposes of this investigation, waiver states can be treated as exogenous (Dranove and Cove 1985; Fanara and Greenberg 1985).

Results

As Table 1 indicates, the number of discharges of patients from the sample hospitals who were identified as "self-pay" at the time of discharge increased between 1980 and 1985, with increases occurring mainly between 1980 and 1983. This increase occurred in most of the hospital categories and in both waiver and nonwaiver states. At the same time, total discharges decreased by 10.7 percent in nonwaiver and by 0.2 percent in waiver states.

The percentage of self-pay patients discharged increased by one-third in nonwaiver states between 1980 and 1985, as shown in Table 2. In similar hospitals in waiver states, the increase was comparable. (Because of the limited size of the waiver sample, our ability to detect significant differences among the years was limited.) The increase was particularly notable for the flagship hospitals in our sample, all of which were located in nonwaiver states. Their percentage of self-pay patients increased from 10 to 17 percent during the first half of the decade. Changes for other COTH and public hospitals were about the same as for nonteaching voluntary and investor-owned hospitals.

Viewed across hospital types, flagship and nonmetropolitan, nonteaching public hospitals had the highest percentages of self-pay patients. Flagships also had the largest proportion of Medicaid patients. Overall, the Medicaid share increased only slightly over the five-year period. In contrast, the percentage of patients with private insurance decreased markedly during the first half of the 1980s. The decrease was less for flagship hospitals than for other types, but flagships began the decade with a relatively low percentage of privately insured patients. The

Table 1. Number of Discharges from Sample Hospitals: Self-Pay Patients and Total

	All	Flagship	Other COTH	Other Public SMSA	Other Public Non-SMSA	Other Voluntary SMSA	Other Voluntary Non-SMSA	Investor-Owned
Self-pay, nonwaiver								
1980	71,432	3,423	6,854	15,000	6,840	24,700	13,890	725
1983	77,510	4,197	8,440	16,860	6,180	26,120	14,920	793
1985	77,946	6,073	8,354	15,360	5,712	26,580	15,140	727
Self-pay, waiver								
1980	4,908	—[a]	1,902	—	—	1,470	890	590
1983	6,405	—	3,094	—	—	1,910	1,000	353
1985	6,165	—	3,214	—	—	1,890	620	345
Total, nonwaiver								
1980	1,110,025	33,387	116,736	216,900	67,560	468,610	195,430	11,402
1983	1,079,385	35,250	118,366	213,690	61,264	452,360	187,250	11,205
1985	990,983	35,987	112,326	192,900	50,996	421,920	167,140	9,714
Total, waiver								
1980	88,307	—	22,924	—	—	38,600	12,930	10,799
1983	88,102	—	24,176	—	—	39,860	11,910	10,826
1985	88,122	—	25,264	—	—	40,180	10,780	10,728

a. Entry is blank when there are less than three hospitals in the category.

overall percentage of Medicare patients has increased over the period, with the bulk of the increase occurring before PPS was implemented.

Table 3 shows that the demographic characteristics of self-pay patients remained remarkably stable between 1980 and 1985. In both years, these patients were less likely to be female and much more likely to be white than were Medicaid patients. Further, newborns are disproportionately represented among self-insured patients.

Between 1980 and 1985, about 45 percent of self-pay cases were concentrated in 14 of the 468 diagnosis-related groups (DRGs) (see Table 4). The percentages of these diagnoses/procedures remained virtually unchanged over the years. The data are arrayed by the 1985 ranking of the DRGs. With the exception of DRG 372 (vaginal delivery with complicating diagnosis) in 1980, the DRGs listed in Table 4 were the 12 most frequent diagnoses/procedures in the years 1980, 1983, and 1985. Normal newborns and uncomplicated deliveries constituted between 27 and 30 percent of all self-pay patients in 1980, 1983, and 1985. Neonates with other significant problems, cesarean sections, and abortions comprised the next most frequent diagnoses in all years.

Using either the Medicare Casemix Index (MCI) or the Resource Need Index (RNI) shows that the self-pay cases were more complex in 1985 than in 1980. As displayed in Table 5, the increase was about the same for self-pay patients and all patients under age 65. Both the MCI and the RNI suggest that the change occurred throughout the five years, not just from 1983 to 1985. Further, self-pay patients required fewer resources on average than did privately insured patients, and as many or more resources than Medicaid patients.

The number of live discharges to other treatment facilities decreased between 1980 and 1983, then increased between 1983 and 1985 (see Table 6). This phenomenon undoubtedly is a result of the dramatically shortened lengths of stay for all patients (American Hospital Association 1986). Transfer patterns for self-pay patients over time were similar to those of insured patients. In 1985, 2 percent of self-pay patients were transferred to other acute care hospitals. While this percentage was more than twice as large as that of 1983, it was approximately equal to the corresponding value for 1980.

Table 7 shows variable means and standard deviations for the sample of 501 hospitals pooled over the years 1980 and 1983–85. Table 8 presents results of a regression analysis using the percentage of the hospital's discharges identified as "self-pay" or "no charge" at the time of discharge as the dependent variable. We estimated separate equations for each year and for the years combined. Although the parameter estimates were generally similar from year to year with respect to sign and significance, there were changes in magnitude of implied effect. An F-test of equality among coefficients of the estimated equations for the four years rejected the null hypothesis that the coefficients across years were equal. The regressions explained about one-fourth of the variation in the dependent variable.

Table 2. Percentage of Patients Discharged, by Type of Hospital and Expected Source of Payment

	All	Flagship	Other COTH	Other Public SMSA	Other Public Non-SMSA	Other Voluntary SMSA	Other Voluntary Non-SMSA	Investor-Owned
Nonwaiver states, 1980								
Self-pay	6	10	6	7	10*	5	7	6
Medicaid	10	16*	10	10	10	9	8	6
Medicare	26	22	25	24	26	26	27	29
Private insurance	54	40	54	54	50	56	53	53
Other insurance	4	12	5	5	4*	4	5	6
Nonwaiver states, 1983								
Self-pay	7	12	7	8	10	6	8	7
Medicaid	10	16	11	11	10	9	9	5
Medicare	29	24	29	27	30	30	31	33
Private insurance	49	38	49	49	46	50	48	50
Other insurance	5	10	4	5	4	5	4	5
Nonwaiver states, 1985								
Self-pay	8	17	8	8	11	6	9	7*
Medicaid	11	16*	12	10	12	11	10	4
Medicare	30	23*	29*	29	29	30	32	33*
Private insurance	45	37	46	45	43	47	45	49*
Other insurance	6	7	5	8	5	6	4	7
Waiver states, 1980								
Self-pay	5	—*	8	—	—	4	7	5
Medicaid	9	—	13	—	—	6*	10	11
Medicare	28	—	29	—	—	27	31	27
Private insurance	55	—	49	—	—	60	48	54
Other insurance	3	—	1*	—	—	3	4	3

Waiver states, 1983								
Self-pay	7	—	13	—	—	5	8	3
Medicaid	9	—	11	—	—	7	13	9
Medicare	31	—	31	—	—	29	36	39
Private insurance	49	—	44	—	—	52	40	56
Other insurance	4	—	1	—	—	7	3	3
Waiver states, 1985								
Self-pay	7	—	13*	—	—	5*	6	3*
Medicaid	9	—	13	—	—	7*	12*	8
Medicare	30	—	29	—	—	28	36*	31
Private insurance	48	—	43	—	—	51	42	54*
Other insurance	6	—	2	—	—	9	4	4

*Not significantly different from 1983, 5 percent level, two-tailed t-test.
a. Entry is blank when there are less than three sample hospitals in the category.

Table 3. Demographic Characteristics of Hospital-Discharged Patients Under Age 65, by Source of Payment

	All	Self-Pay	Medicaid	Private Insurance	Other Insurance
1980					
Male	40	42	32	40	56
Female	60	58	68	60	44
Newborn	13	23	17	12	11
One month–5 years	5	4	10	4	3
6–16 years	7	5	9	8	5
17–44 years	48	54	49	48	56
45–64 years	27	14	15	28	25
White	85	81	64	90	79
Black	11	12	28	7	13
Hispanic	3	5	6	2	3
Other	1	2	2	1	5
1985					
Male	40	42*	31	40*	49
Female	60	58*	69	60*	51
Newborn	16	23*	21	14	15
One month–5 years	4	4	8	4	3
6–16 years	5	4	7	6	4
17–44 years	48	54	51	47	55
45–64 years	27	15	13	29	23
White	82	77	60	88	77
Black	13	15	30	8	13*
Hispanic	3	5*	7	2	4
Other	2	3	3	2	6

*Not significantly different from 1983, 5 percent level, two-tailed *t*-test. 1983 values are not shown.

The first nine variables in Table 8 measured the pool of uninsured persons in the hospital's market area. As expected, hospitals serving areas that were likely to contain larger proportions of uninsured persons treated a greater share of such persons. More specifically, in areas with a higher percentage of adults not employed—either unemployed or not in the labor force ("not employed")—the uninsured constituted a higher proportion of the hospital's inpatient load. Several variables accounted for variations in employment mix by industry. The percentage of employees in manufacturing was the reference category. Since employees in manufacturing had relatively comprehensive insurance, it is not surprising that the majority of the signs of the coefficients on the other industry variables are positive (Monheit et al. 1985). The "% service employment" variable, which has negative coefficients, included both professional service industries with extensive employee coverage and other service industries with rel-

Table 4. Most Frequent Diagnoses of Self-Pay Discharges

DRG	Diagnosis	Rank in 1985	Percentage of Self-Pay Discharges 1980	1983	1985
391	Normal newborns	1	16.8	15.1	14.7
373	Vaginal deliveries without complications	2	13.6	12.3	12.0*
390	Neonates with other significant problems	3	2.1	2.6	3.2
370–71	Cesarean section	4	2.0	2.6	3.1
380–81	Abortion	5	2.7	2.4	2.3
389	Full-term neonate with major problems	6	1.1	1.8	1.8
430	Psychoses	7	1.4	1.6	1.6*
183	Esophagitis, gastroenteritis and miscellaneous digestive diseases, age 18–69	8	1.8*	1.7	1.4
243	Medical back problems	9	1.4	1.4	1.3*
438	Alcohol- and substance-induced organic mental syndrome	10	1.5	1.0	1.3
372	Vaginal delivery with complicating diagnosis	11	1.0*	1.0	1.1
450	Toxic effects of drugs, age 18–69	12	1.3	1.1	1.0*
	Total percentage		46.7	44.6	44.8

*Not significantly different from 1983, 5 percent level, two-tailed t-test.

atively poor employee coverage. Another factor affecting a community's level of insurance is real family income, which has a positive effect on the probability of having insurance. As Table 8 indicates, income in the hospital's area (with the exception of 1985) led to a lower hospital self-pay share (Phelps 1976; Monheit et al. 1985). In addition, the ratio of Medicaid enrollees to state population consistently had the anticipated negative influence on hospitals' self-pay inpatient loads.

Relative to public nonteaching hospitals located in metropolitan areas (the referent hospital teaching/ownership category), on average flagship hospitals treated the highest self-pay share, while investor-owned hospitals had the lowest share of such patients. The parameter estimates on the "flagship hospitals" variable increased appreciably between 1980 and 1985, confirming the impression from Tables 1 and 2 that the relative self-pay patient burden of such hospitals rose during the first half of the 1980s. The other coefficients on the hospital teaching/

Table 5. Case Mix of Discharged Patients Under Age 65, by Payer Source

Case Mix Index	All	Self-Pay	Medicaid	Private Insurance	Other Insurance
1980					
Medicare Case Mix Index	.76	.68	.69*	.76	.82*
Resource Need Index	.97	.91	.87	.96	1.00
1983					
Medicare Case Mix Index	.79	.71	.68	.80	.83
Resource Need Index	1.00	.95	.86	1.00	1.01
1985					
Medicare Case Mix Index	.82	.73*	.70*	.80	.80*
Resource Need Index	1.06	.99	.93	1.06	1.06

*Not significantly different from 1983, 5 percent level, two-tailed *t*-test.

ownership category variables—the vast majority of which were negative—either remained stable between 1980 and 1985 or showed no consistent pattern. When there was no other public hospital in the county (no "other public hospital"), the hospital had a higher uninsured inpatient burden. In contrast, being the only hospital in the county ("only hospital in county") had no effect. Neither the percentage of hospital discharges admitted through the emergency room ("% emergency room discharges") nor the percentage of Medicare discharges relative to total discharges ("% Medicare discharges") had a statistically significant impact on the dependent variable.

Since we treated a hospital's self-pay discharge share as endogenous, a hospital's Medicare discharge share could logically be considered endogenous as well. Unfortunately, except for the area's proportion of persons over age 65, there are no good instruments for predicting an individual hospital's Medicare discharge share. Rather than specify the Medicare share as an endogenous variable and apply a two-stage instrumented variable technique, we reestimated the four year-specific equations, excluding the Medicare variable. There was virtually no effect on the coefficients of the other explanatory variables.

Our analysis also showed that competition/private cost containment had no impact on hospital self-pay inpatient loads. This conclusion may be drawn from the parameter estimates on the percentage of area enrollment in HMOs ("% HMO enrollment") and their associated standard errors.

To test for the effect of PPS on hospitals' self-pay share, we used a two-way design. We included data for the pre-PPS period (1980 and 1983) as well as

Table 6. Discharge Destination of Live Patients Under Age 65, by Payer

Destination	All	Self-Pay	Medicaid	Private Insurance	Other Insurance
1980					
Home health	0.3*	0.4	0.7	0.2*	0.4*
Other acute care facility	1.2	1.8	1.3	1.0	1.3
Nursing home	0.4	0.3	0.8	0.1	0.3
Other facility	0.5	1.0	0.9	0.3	1.0
Total percentage to other than home	2.4	3.5	3.7	1.6	3.0
1983					
Home health	0.4	0.3	0.8	0.2	0.2
Other acute care facility	0.6	0.8	0.8	0.6	0.7
Nursing home	0.2	0.1	0.4	0.1	0.1
Other facility	0.3	0.4	0.6	0.1	0.4
Total percentage to other than home	1.5	1.6	2.6	1.0	1.4
1985					
Home health	0.9	0.7	1.5	0.7	0.6
Other acute care facility	1.5	1.9	1.4	1.4	2.0
Nursing home	0.5	0.3	0.8	0.2	0.4
Other facility	0.8	1.2	1.3	0.5	1.2
Total percentage to other than home	3.7	4.1	5.0	2.8	4.2

*Not significantly different from 1983, 5 percent level, two-tailed t-test.

information from three states which were not covered by PPS. We also included interaction terms between the hospital's Medicare patient share and year. Judging from the parameter estimates on "waiver" in the individual year regressions, which were positive and statistically significant in 1980 and negative but insignificant after 1983, hospitals under PPS were, if anything, more likely to accept uninsured patients for treatment. The pooled regression shows a similar pattern for variables "waiver 1980" through "waiver 1985." The "waiver 1980" coefficient is positive, whereas the "waiver 1984" and "waiver 1985" coefficients are negative.

Intertemporarily, we measured the effect of PPS by the year dummies ("year 1980" through "year 1985") and the interaction of year with the hospital's Medicare share ("Medicare 1980" through "Medicare 1985"). The joint influence of PPS in 1984 and 1985 was negative, but the coefficients were quite small relative to their associated standard errors. In sum, the regression results do not

Table 7. Means and Standard Deviations: Variables Used in the Regression Analysis

	Mean	Standard Deviation
% Self-pay	7.48	5.17
% Not employed	37.29	10.76
% Wholesale retail trade employment	12.21	2.78
% Construction employment	2.43	1.05
% Service employment	10.44	3.09
% Government employment	9.14	2.50
% Agricultural employment	15.75	7.42
% Other employment	6.05	2.45
Real family income (000s)	19.19	3.21
Medicaid population	8.64	3.29
Flagship hospital	0.01	0.12
Other COTH hospital	0.05	0.23
Public non-SMSA hospital	0.14	0.35
Voluntary SMSA hospital	0.40	0.49
Voluntary non-SMSA hospital	0.31	0.46
Investor-owned hospital	0.02	0.16
Only hospital in county	0.22	0.41
Other public hospital	0.63	0.48
% Emergency room admissions	30.32	13.39
% Medicare discharge	40.85	13.09
% HMO enrollment	4.42	9.29
Waiver	0.05	0.21
Year 1980	0.25	0.43
Year 1984	0.25	0.43
Year 1985	0.25	0.43
Waiver 1980	0.012	0.11
Waiver 1984	0.012	0.11
Waiver 1985	0.012	0.11
Medicare 1980	10.21	18.87
Medicare 1984	10.21	18.87
Medicare 1985	10.21	18.87

support the view that PPS had a detrimental effect on at least this dimension of access to hospital care for the uninsured.

Discussion

The number of uninsured patients treated by hospitals increased during the first half of the 1980s, as did the pool of uninsured persons. We included in our regression analysis determinants of the pool that allowed us to gauge the influence various changes outside the health care sector had on changes in the size of the pool of uninsured persons and the resultant share of uninsured patients treated by hos-

pitals. Using coefficients from the all-years regression in Table 8, it appears that changes in employment composition and real family income had small and partly offsetting effects on the share of self-pay patients treated by hospitals. The changes that occurred in employment composition between 1980 and 1985 were relatively minor and, overall, the changes that did occur tended to decrease hospitals' self-pay share. Real income per family fell by about 6 percent, which led to an estimated increase in self-pay share of 0.1 percentage point. The year variables and the interaction of the year variables with the hospital's Medicare share accounted for other likely time-dependent determinants of the self-pay pool that could not be measured directly, such as change in household structure. The year effects were positive after 1983, although they were larger in 1984 than in 1985. Although the Medicaid parameter estimates are relatively large, the national mean ratio of Medicaid enrollees to population decreased only slightly, from 8.8 percent of the population in 1980 to 8.6 percent in 1983–85. Thus, the decline in the Medicaid enrollment rate increased hospitals' self-pay share by 0.1 percentage point on average between 1980 and 1985.

The hospital's self-pay share of total patients depends not only on the pool of uninsured in its area but also on the hospital's willingness to accept patients from the pool. In this regard, there were substantial differences among hospitals. The fact that by the early 1980s major teaching hospitals accepted a disproportionate number of uninsured patients for treatment has been documented in previous studies (Feder, Hadley, and Mullner 1984; Sloan, Valvona, and Mullner 1986). We found that both the number and share of self-pay patients in major teaching hospitals rose relative to that in other hospitals during the first half of the 1980s, even though teaching hospitals started the decade with a high self-pay patient base. There is some evidence that high-volume providers of uncompensated care, such as major teaching hospitals, have fared well under PPS. In this sense, perhaps they could have afforded to take on an increased burden of uninsured patients (Sheingold and Buchberger 1986). But once certain changes, such as elimination or reduction of Medicare's subsidy of indirect teaching costs, are implemented in PPS, it will be much more difficult for these hospitals to sustain such care.

Surprisingly, we detected little change in public hospitals' self-pay patient share; our aggregates may, of course, conceal important changes for particular public hospitals. Our results for "another public hospital in county" indicate that in all years covered in our study, the presence of a public facility provided at least some relief to the other hospitals in the locality.

One possible method for excluding "undesirable" patients, such as those with no identifiable payment source, is to transfer such patients to other facilities. In fact, there was a rise between 1983 and 1985 in the percentage of patients transferred to other facilities at discharge. There are two reasons for exercising caution in making inferences from these results: first, the transfer rate also increased for insured patients; second, transfer rates fell between 1980 and 1983 for reasons that are not well understood.

The mix of self-pay patients—measured in terms of age, sex, and reason for hospitalization—changed little between 1980 and 1985. The case mix complexity

Table 8. Regression Results of Percentage of a Hospital's Patients Classified as Self-Pay, by Year

	1980	1983	1984	1985	All Years
Constant	12.734**	9.899*	15.707**	− 0.476	10.115***
	(6.084)	(5.904)	(6.216)	(7.008)	(3.002)
% Not employed	0.052	0.067	0.038	0.170***	0.076***
	(0.055)	(0.053)	(0.057)	(0.064)	(0.027)
% Wholesale/ retail trade employment	− 0.052	0.513***	− 0.027	0.520*	0.188*
	(0.184)	(0.225)	(0.215)	(0.240)	(0.101)
% Construction employment	0.424	0.085	0.201	0.763**	0.430***
	(0.393)	(0.311)	(0.348)	(0.359)	(0.163)
% Service employment	− 0.243	− 0.388**	− 0.104	− 0.172	− 0.170**
	(0.181)	(0.168)	(0.149)	(0.121)	(0.070)
% Government employment	0.055	0.125	0.186*	0.221**	0.141***
	(0.100)	(0.104)	(0.106)	(0.107)	(0.051)
% Agricultural employment	0.030	0.017	0.044	0.110	0.040
	(0.057)	(0.062)	(0.068)	(0.076)	(0.031)
% Other employment	0.348**	0.025	0.123	− 0.172	0.048
	(0.144)	(0.147)	(0.124)	(0.113)	(0.061)
Real family income	− 0.194**	− 0.143*	− 0.091	0.007	− 0.115***
	(0.086)	(0.084)	(0.089)	(0.097)	(0.043)
Medicaid/ population	− 0.422***	− 0.453***	− 0.636***	− 0.528***	− 0.508***
	(0.085)	(0.086)	(0.098)	(0.098)	(0.043)
Flagship hospital	3.950*	4.349**	6.852***	9.198***	5.959***
	(2.060)	(1.928)	(2.076)	(2.058)	(1.005)
Other COTH hospital	− 0.489	0.244	− 2.276	0.527	− 0.421
	(1.327)	(1.235)	(1.322)	(1.316)	(0.643)
Public non-SMSA hospital	0.536	− 0.170	− 1.478	0.417	− 0.099
	(1.206)	(1.128)	(1.189)	(1.214)	(0.582)
Voluntary SMSA hospital	− 1.497	− 1.727*	− 2.324**	− 0.930	− 1.693***
	(0.967)	(0.895)	(0.962)	(0.952)	(0.467)
Voluntary non-SMSA hospital	− 0.622	− 0.956	− 2.418**	− 1.022	− 1.302**
	(1.160)	(1.088)	(1.137)	(1.151)	(0.560)
Investor-owned hospital	− 2.064	− 2.220	− 2.660	− 1.880	− 2.215***
	(1.710)	(1.566)	(1.681)	(1.668)	(0.820)
Only hospital in county	0.584	0.404	0.529	0.902	0.527
	(0.786)	(0.722)	(0.762)	(0.754)	(0.374)

Table continues next page.

Table 8. Continued

	1980	1983	1984	1985	All Years
Other public hospital	− 1.088 (0.929)	− 6.619* (0.874)	− 1.925** (0.912)	− 2.142** (0.904)	− 1.773*** (0.447)
% Emergency room admissions	− 0.017 (0.020)	0.015 (0.017)	0.003 (0.017)	0.005 (0.015)	0.001 (0.009)
% Medicare discharge	− 0.002 (0.018)	− 0.015 (0.016)	− 0.029* (0.017)	− 0.025 (0.017)	− 0.013 (0.016)
% HMO enrollment	0.038 (0.039)	0.003 (0.030)	− 0.009 (0.030)	− 0.0003 (0.028)	0.001 (0.015)
Waiver	2.037* (1.179)	0.014 (1.040)	− 0.798 (1.093)	− 0.685 (1.091)	− 0.038 (1.028)
Year 1980					− 1.712* (0.997)
Year 1984					1.194 (0.988)
Year 1985					0.899 (0.996)
Waiver 1980					2.082 (1.430)
Waiver 1984					− 0.965 (1.432)
Waiver 1985					− 0.717 (1.428)
Medicare 1980					0.014 (0.023)
Medicare 1984					− 0.017 (0.023)
Medicare 1985					− 0.013 (0.023)
R^2	022	031	034	033	0.31
N	404	404	404	404	1616

*Significant at the 10 percent level, two-tailed t-test.
**Significant at the 5 percent level, two-tailed t-test.
***Significant at the 1 percent level, two-tailed t-test.

of self-pay patients increased, but this was also true for insured patients under age 65. The overrepresentation of maternity-related self-pay cases suggests that major policy initiatives aimed at obtaining services for this type of patient could have a large impact on reducing the volume of hospitals' uncompensated care. As of 1985, competition (at least as manifested in the growth of HMO enrollments) and recently implemented cost-containment programs (such as PPS) had had no effect on hospitals' self-pay burdens.

Medicare exempted a few states from PPS. The three waiver states included in our study all implemented policies to encourage hospitals to accept uninsured patients for treatment by including consideration of charity and bad debt loads in setting hospital rates, and, in the case of New York, by implementing a bad debt/charity care revenue pool to cross-subsidize hospitals with high uncompensated care burdens (Meyer 1986). Our regression results indicate that hospitals under PPS were more likely to increase their self-pay patient shares than those which were exempt from PPS and subject to waiver provisions. Differences between hospitals in waiver versus nonwaiver states are more apparent from our regression (Table 8) than from our tabular results. The regression results are more conclusive for two reasons: first, other factors that vary with waiver states and affect hospitals' self-pay share were held constant; second, stratifying by waiver state and hospital ownership/teaching status reduced the power of our statistical tests in the tabular analysis.

Our findings can be interpreted in two ways. Either the waiver provisions did not achieve one of their most important objectives (that is, increasing the access to care of the disadvantaged) or the differential effects by waiver versus nonwaiver states reflect our unrepresentative hospital sample (that is, our waiver sample excluded flagship hospitals which, in the nonwaiver states, increased their self-pay shares relative to other hospitals). Unfortunately, it is not possible to assess the importance of this latter possibility with our database. But our finding does raise an important policy question which is worthy of further study.

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REPRESENTATIVE STARK. It seems to me that the only time a patient chooses a hospital, unaided, is when they are going to an emergency room. Is that correct?

MR. MORRISEY. I don't know that I would necessarily agree with that. I think there are instances where patients choose the physician, in part, on the basis of which hospital they are able to use.

REPRESENTATIVE STARK. But they choose the physician?

MR. MORRISEY. I am sorry?

REPRESENTATIVE STARK. They choose the physician, don't they?

MR. MORRISEY. Surely.

REPRESENTATIVE STARK. As I say, I rather suspect that short of somebody in the military, or on a college campus, where they go to the clinic, as it were, that it is in the nature of an emergency room.

MR. MORRISEY. When we look at the obstetrics patients in Alabama, the travel distances that many of these women are incurring are quite substantial, and it suggests that, in fact, at least some of them are making choices with respect to the physician and, perhaps, to the hospital they wish to use.

REPRESENTATIVE STARK. I couldn't agree more. I mean, I have felt that one of the big problems that rural hospitals have, even if we doubled the payments, a lot of people who are able to have insurance will go to a bigger medical center. I wouldn't want to represent that the public is ignorant. I think that, as a practical matter, they might presume that if they had some serious complication and they were at all sophisticated that rather than head to Highland they would go to UC Medical Center, or Stanford Medical Center. I have a hunch that information is abroad in the land and in our neighborhood, but there are damn few people who have that choice, and that is the problem.

Ms. Fraiche, let me go back to Louisiana. You tell me this: 4 million people in the State?

MS. FRAICHE. That is right.

REPRESENTATIVE STARK. You are telling me that roughly 25 percent are indigent?

MS. FRAICHE. That is correct.

REPRESENTATIVE STARK. What defines indigence?

MS. FRAICHE. That statistic came from the Department of Health and Hospitals where they have defined indigent as not having a federal program coverage of any kind or private insurance.

REPRESENTATIVE STARK. That is, it does not relate to qualifying for Medicaid or a national poverty standard. This is a determination made relative to their ability to pay for medical care?

MS. FRAICHE. That is correct. And remember, we are below the poverty line for the most part in terms of our population.

REPRESENTATIVE STARK. And how many hospitals then serve that indigent population?

MS. FRAICHE. Well, within the system that the state operates, there are nine hospitals statewide.

REPRESENTATIVE STARK. How many beds?

MS. FRAICHE. Big Charity is the biggest.

REPRESENTATIVE STARK. How many beds, roughly?

MS. FRAICHE. About 2,000 statewide, I believe.

REPRESENTATIVE STARK. Do you include in the "indigent population" the Medicaid beneficiaries, or do you add them on?

MS. FRAICHE. No, that is not Medicaid beneficiaries. That is a different number, and I can't give you that number.

REPRESENTATIVE STARK. But they are in addition to these?

MS. FRAICHE. That is correct.

REPRESENTATIVE STARK. Now, in Louisiana, all of these million people must go, in a sense, to one of the nine charity hospitals, or your system is defined to provide medical care to them; and I presume that if a hospital outside of an emergency situation will just say, if you do not have coverage, you go to one of our nine charity hospitals. Is that——

MS. FRAICHE. Many hospitals still have Hill-Burton obligations outstanding in the State of Louisiana, particularly in rural communities where those facilities had been built.

REPRESENTATIVE STARK. But absent that?

MS. FRAICHE. Absent that, if they appear in an emergency room, as well you know, because of the federal legislation, they have to be treated, screened and stabilized at those other hospitals.

Because the charity system has been around for so long, there is a tendency that certain segments of the population would prefer to go to the public hospitals for treatment. In many cases, they are centers of excellence. There are a lot of deliveries at those hospitals. We have people that go all the way from one side of the town to the other just to have their baby at Big Charity, because for them that is a family tradition.

REPRESENTATIVE STARK. Would you like to characterize that group for me and define it more distinctly.

MS. FRAICHE. By what standards, income, family——

REPRESENTATIVE STARK. By income or by any other kind of demographic standard that you want to use.

MS. FRAICHE. It used to be minorities, but it isn't anymore. Now we find more and more none minorities who are without insurance.

REPRESENTATIVE STARK. Poor?

MS. FRAICHE. That is right. The poor working class people find that Charity is their place of choice, and those statistics——

REPRESENTATIVE STARK. I am not as much of a cynic as I would appear, but I can remember a group who came to see me from a city in Virginia, which shall remain nameless, and they basically were a group of private hospitals, one proprietary and, I guess, some others not-for-profit, who were pleading the case for a basically all black hospital. It was not defined either as a charity hospital, but it was, in fact, a hospital at which

the medical staff was primarily black physicians, and the patient population was primarily black. These hospitals were in here importuning us to provide a lot of money to keep this institution alive.

But it very quickly became apparent the reason that they were pleading with us to keep the institution alive is because these hospitals didn't want either the staff or the patient population in their hospitals—not in my backyard—and I have always wondered if that was the case historically in the Louisiana charity hospitals. That it was very convenient for the more affluent areas and the nicer hospitals—the newer and more modern hospitals—to have that charity obligation taken care of out of sight. Like the AMA says, the way to solve the problem these days is to increase Medicaid. That eases their conscience and aside from the fact that every doctor can say, well, Medicaid takes care of the poor people; I don't take Medicaid patients—but that is beside the point.

You can ease your conscience by saying somebody else is doing it, but you're telling me that is not the case in Louisiana.

Ms. FRAICHE. Sixty-five percent of our population is minority in New Orleans. What I am also going to tell you is that in certain sectors of the population where there is federal qualification, those patients are fought for, competed for by other hospitals, since we do have a number of hospitals that are not charity hospitals in New Orleans. There are 26 in the regional area.

Those patients are heavily competed for. It is the safety-net patient that nobody frankly wants to have to deal with because they can't afford to pay for that patient, and those are the underinsured people. It doesn't matter what color those people are; they are working and they don't have insurance.

REPRESENTATIVE STARK. Are your Medicaid rates reasonable in Louisiana or, like in California, are they——

Ms. FRAICHE. For a disproportionate share, they are reasonable. That is why it is necessary that we keep the disproportionate share program in place in Louisiana; otherise, there would not be as much of a competition for those patients, quite frankly.

REPRESENTATIVE STARK. Ms. Long, if we could somehow separate trauma cases from the emergency room—and I don't know how you do that in Highland—in the emergency room today, it almost becomes a community health clinic and a primary care entry point for many of our friends and neighbors. I would like to separate that for a minute.

I mean, the person who is in an auto accident, or got shot up, or broke their leg, or something, and truly comes for those classifications which are emergency. If the hospitals could somehow separate that function and get reimbursed for it, would that make your life a lot easier at Highland, or not much different?

Ms. LONG. It really would not have that great of an impact, primarily because at Highland, 48 percent of our patients are medically indigent.

REPRESENTATIVE STARK. I have always wondered whether a huge share of your costs aren't generated by your very active trauma center where they are also indigent. I would suspect that you get an equally high proportion of uninsured patients, or a disproportionate share of patients, through the emergency room as well.

MS. LONG. Right.

REPRESENTATIVE STARK. It would seem to me that that is a lot more expensive operation. That is certainly the first thing I noticed that the cherry-picking hospitals quit. The first thing they do when they move to the suburbs is to close the emergency room.

MS. LONG. That is right, and close the trauma center because it does lose money. But——

REPRESENTATIVE STARK. It would give you an interesting phenomenon.

Ms. Long, in addition to the fact that half the people belong to Kaiser in our community, we have ... I will come back to it. We have a fascinating county system, and we have how many trauma care centers in Oakland now? One? Two?

MS. LONG. There is one in Oakland.

REPRESENTATIVE STARK. And Eden?

MS. LONG. Right.

REPRESENTATIVE STARK. And Walnut Creek. That is it?

MS. LONG. That is it. We are the trauma center for all of Alameda County, with the exception of Sutter County and that is Eden.

REPRESENTATIVE STARK. The issue that you touched on is, would the guarantees, by themselves, and the availability of capital solve your problems, or could you, even with the guarantees, not convince a lender that they ought to fund you?

You can have a guarantee, but if we are calling that a grant, there has to be some standard where you have to be able to show to whoever is providing this advance of funds that you are going to pay it back over some period of years.

Now, you may not have a three or four times safety margin, but you can project out in your budgeting. Could all of you convince a lender that you could repay the capital that you want if, say, there was a federal guarantee?

MS. LONG. Yes, without a doubt. Our hospital needs to be replaced at $400 million, not counting the capital x-ray equipment we need. We have been able to cost that out and then to show where, over a period of time, we could make payments and pay that loan off.

MR. GAGE. I might add, in helping you and your staff design this legislation, we have called upon several experts, including Merrill Lynch, First Boston, Lehman Brothers, and others investment advisors. They are the ones who want to do these deals, and they are making sure that we are devising something that would enable them to take this to the market.

REPRESENTATIVE STARK. I am also suspicious of those guys who caused a lot of problems in our fair city of Oakland by encouraging communities to issue bonds. As long as they have the guarantee and collected from their investors, they have an interest in whether those bonds are paid. It lasts about 30 seconds after they cash the check. If the health-care system had to rely on the social instincts of the investment community, you guys would be in a lot worse shape than you are now.

MR. GAGE. We are providing the social instincts. We are just leaving financing to them.

REPRESENTATIVE STARK. We are going to adjourn in about five minutes, so, if any of you have a burning need to get something on the record, you may do so.

One of the things that I will point out an interesting statistic—and I don't know how it varies in each state—in my county and in Ms. Long's, we provide an exemption from real estate taxes, as I suspect most communities do. But, in California, we have convinced the hospital industry to fill out a report on their earnings income, as well as on their costs. So, unlike most areas where hospitals guard their statistics with an almost insane jealousy, you can pretty much tell what each hospital is doing in uncompensated and charity care.

They define charity care—that is a tough one—but each person reports it on somewhat the same instance and with, of course, the exception of Highland Hospital, there is no hospital in our county that provides as much charity care as they are forgiven in county real estate taxes.

Now, I have often suggested to my friends the supervisors, who have to fund this hospital, why not just charge these guys real estate taxes; give them credit for everybody they take in who would be an indigent, or eligible for some kind of county assistance—whether it is Medicaid, AFDC—I am not going to charge you more than the Medicaid rate because you are going to find a way to bill them some way and then you get credit against your real estate tax? That would give us enough money to pay your deficit.

I don't know how it would help you in New Orleans, but there is, in fact, in the community, this idea that these not-for-profit hospitals somehow, just by that definition, are doing the work that most of you are doing, and I don't think that is the case. I don't think that is the case in Los Angeles.

I don't think you get a wit of charity care in some of these huge hospitals. They are going to say, it is charity because they won't pay the fee we want to charge.

There is something that the local governments may have to change and start saying, oh, you want exemption from real estate tax, what are you going to give the community back?

How do you pay for your charity hospitals?

MS. FRAICHE. Direct line-item appropriation, unfortunately.

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REPRESENTATIVE STARK. So, you don't bill the hospitals on a hospital tax as they do in New Jersey or Florida?

MS. FRAICHE. In some of the parishes, we have parishes instead of counties—they do have bond issues and tax support from the citizens. Those hospitals, by the way, for the most part, are well managed and do fairly well, and they do employ a lot of people.

MR. MORRISEY. I can't speak to Alabama, but I can speak to the health services research literature, which in fact does suggest that those non-profit community hospitals don't provide the level of charity care that the public hospitals do. And, indeed, the nature of the nonprofit hospital status is essentially one of having the community as its shareholders.

So, indeed, there seems to be an obligation to provide——

REPRESENTATIVE STARK. It would be awfully hard for us to define. That is the problem. If the industry could come up with a definition, they have Congressman Donnelly just dying to take away their tax exemption if they don't put up. But our problem has been, one person's charity care is another person's discount, and that has been a difficult thing for us to provide.

MR. GAGE. One thought on that.

REPRESENTATIVE STARK. You have the last word because I am going to have to adjourn the hearing at this point.

I want to thank you all for taking the time to work with us on this issue. The record we built today, I think, will be very helpful because we have some other groups to deal with, in terms of the merger issue and in terms of providing some capital for the infrastructure for charity care.

Go ahead.

MR. GAGE. I will be very brief. Just a comment on the numbers here, and to hammer home a point.

When Ms. Long talks about 48 percent for uncompensated care alone, we can compare that with the numbers that Mr. Morrisey discussed earlier, which are accurate as far as they go. He suggested that 25 percent, on average, were provided to Medicaid and uncompensated care combined for all public hospitals, but averages are deceptive. It is like saying my 9-year-old son and I weigh an average of 135 pounds.

The fact is, those 1,400 or 1,500 hospitals, by AHA's definition, includes hospital districts like Mount Diablo, for example, which provides much lower levels than Highland of indigent care. It is really a very small safety-net that we are talking about, no more than 200 or 300 hospitals nationally, probably another 100 or 200 sole community hospitals in rural areas, and that is it. This is not a gigantic problem in terms of numbers of hospitals, although the problems of some of these institutions are themselves very large. We are talking about a very thin layer here.

REPRESENTATIVE STARK. Thank you all. You are creative advocates for your cause. I appreciate your taking the time to help us today.

I will leave the hearing record open so we can submit written questions to the witness.

We are adjourned.

[Whereupon, at 1:45 p.m., the Subcommittee adjourned, subject to the call of the Chair.]

[The following material was submitted in response to written questions posed by Representative Stark.]

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Questions for Mr. Stuart H. Altman

In your testimony, you commented that past experience has shown that political support was not sufficient to back-up the planners in a certificate-of-need system. Do you feel a health system reform package that includes an all payer system and a global budget that requires a state or regional budget for capital is the type of support that will enable a planning process to work?

A suggestion was made by you that a good system needs both a tight reimbursement system as well as planning. Some have suggested the Maryland model of tying the reimbursement system to the planning program. Do you advocate this approach or some other means of getting the two functions to complement each other?

Would you comment on how all payer systems in Arizona, Maryland and New Jersey have impacted upon hospital bed supply and antitrust concerns?

Answers

Question 1. Yes, if we tie together an all payer reimbursemnt system with regional budgets and planning for major capital projects we would have a much more effective planning system and a much tougher cost containment system.

Question 2. Yes, as I said in my answer to question 1, we need to tie planning and reimbursement policy together.

Question 3. I'm afraid I'm not current on what the bed supply situations are in those states.

Questions for Mr. Gerard F. Anderson

In your testimony, you cited that there are 400,000 beds not used on an average day. Please elaborate on your testimony and provide any additional statistics on the current and projected hospital bed over supply of which you are aware.

You predicted that we will have a lot more inefficiency if we continue to rely on the courts to set health policy. In order to take a proactive approach to hospital bed supply, what specific mechanisms (all payer system, certificate of need, capital cap, etc.), or combination of mechanisms, do you see as the most effective to achieve a balance between hospital bed supply and demand?

In your testimony, you commented "... many of these recent court decisions are lowering the technical and allocative efficiency in the hospital industry." To the extent you are familar, please comment on the following two cases.

The case brought by the Federal Trade Commission against the Rockford Memorial Corporation was cited by the FTC as a successful application of antitrust laws to the hospital industry. What has been the experience with costs and prices in the Rockland, Illinois area since the April, 1990 conclusion of the case?

Compared to the Rockford Memorial Corporation case, what has been the experience with costs and prices in Roanoke, Virginia since February, 1989 when the Carilion Health System case brought by the Department of Justice was ruled in the favor of the hospitals?

What effect do all payer systems such as that operating in the State of Maryland have on the need for Federal antitrust enforcement and on the supply of hospital beds?

Answers

Question 1. The Johns Hopkins Center for Hospital Finance and Management did a study for the AmHS Institute which documented the number of excess hospital beds in the United States. Using data from the American Hospital Association, we calculated the number of licensed beds, staffed beds, and average daily census for each hospital in the United States. Then, using standard operations research techniques, we calculated the number of unfilled licensed beds on a typical day, the number of unfilled staffed beds on a typical day, the number of unfilled staffed beds on the busiest day of the year, and the number of unfilled

licensed beds on the busiest day of the year. Based upon these calculations, we estimated that there were:

- 450,000 unfilled licensed beds on an average day
- 375,000 unfilled staffed beds on an average day
- 225,000 unfilled licensed beds on the busiest day of the year
- 175,000 unfilled staffed beds on the busiest day of the year.

Question 2 . The most effective mechanism to eliminate unnecessary hospital beds involves both financing and regulation. Congress will need to establish an overall cap on hospital spending during the year. There could be separate caps for capital and operating costs, but this is probably not advisable since it establishes an incentive for hospitals to change their production function and substitute capital for labor or visa versa.

Question 3. In my written testimony, I provide detailed information on the Rockford and Roanoake cases. The information on their experience after the litigation is based upon reports in Hospitals, and is not based on any research I have done.

Question 4. Given that hospitals in Maryland have their rates set by the Health Services Cost Review Commission, the Department of Justice would have less of a concern about the effects of anti competitive behavior in Maryland. Maryland hospitals cannot increase their rates in response to a change with competitive positions.

Questions for Mr. James L. Scott

In concluding your analysis of the direction of hospital bed supply you stated, "The proportion of care delivered on an outpatient basis will continue to grow and the limitation is primarily a technological one." Would you provide more specific estimates of the hospital bed supply versus demand in the year 2000 if your analysis is accurate?

In your testimony you cited a survey that identified hospital CEOs as predicting that by the year 2000, 49 percent of their revenues will come from outpatient services. Would you elaborate on how the interests of hospitals are served in regard to hospital bed supply in light of this prediction?

A definitive "yes" was given by you to the question as to whether hospitals should merge, close or share facilities. What mechanisms for consolidation would you recommend that are more effective than the cutrent system that has left us with a 40 percent over supply of hospital beds?

You stated "that the more powerful approach [to reducing hospital bed over capacity] is through the reimbursement system as opposed to some kind of planning." Please comment as to the extent that a reimbursement system will influence over supply and in what ways we may want to incorporate some formal planning mechanisms into/with a reimbursement system.

Answers

Question 1. I can not provide more specific estimates of hospital bed supply versus demand in the year 2000. As was noted in my written statement, one of the lessons learned from our experience in the 1980s was the unreliability of these kinds of predictions. Trying to estimate future needs by extrapolating past experience has proven to be wholly inadequate. We have many more beds today than we need because an assumption was made that inpatient services would grow in the 1980s at the same rate they had in the two previous decades. In fact, as the chart on page 7 of our testimony so clearly illustrates, actual inpatient usage fell. We do not know if this is a one decade aberration, and growth rates will turn upward in the middle of this decade, or if we have experienced a true change in hospital use rates.

Based upon my confidence in new technology,I believe we are in the midst of a revolutionary change in how care is delivered and that in the future we will need fewer hospital beds per capita than we now have. It is not possible to make this prediction any more precise with any degree of certainty.

Question 2. It is in the best interests of hospitals to eliminate excess acute care capacity as rapidly as possible. As the proportion of revenues derived from outpatient services continues to grow it is important to convert idle inpatient facilities to meet outpatient demands.

This is not as easy to achieve as it is to recommend. Each hospital faces different local practice patterns and financing considerations that must be weighed. In addition it is important that individual community trends be evaluated. It would make no sense to close an inpatient facility today and in three years be forced to build new capacity to serve a growing population. While this kind of circumstance might not occur in many urban areas it certainly could in some of our faster growing suburbs in the south and west.

No matter how aggressive hospitals pursue capacity conversion strategies they will be some time lag. New outpatient facilities will probably be constructed faster than existing inpatient capacity is phased out or converted.

Question 3. There probably are not any practical or politically acceptable additional mechanisms for consolidation that would be more effective than those natural forces that are already in place. We have been faced with a massive change in the approaches to service delivery. It is going to take some time for the capacity/demand equation to come back into equilibrium.

What we must guard against now is legislative impatience. The current situation can be made much worse by poorly designed public initiatives intended to speed the closure and conversion of hospital facilities.

Having too many hospital beds in a community is a financing problem. Having too few hospital beds to meet the medical needs of a community is a far worse problem, with much greater consequences for the average citizen.

If the Federal Government is unable to restrain itself and feels it must take some action I would recommend that any strategy to accelerate consolidations and closures should be demonstrated first to see if it works as its proponents expect. our ability to predict how the medical community and patients respond to changed incentives have been proven to be virtually non-existent. We ought not foist off on the African public some scheme that might threaten their ability to have access to hospital services unless we have some empirical evidence it might work.

If such demonstrations are to be undertaken I would suggest that one of them examine the use of competitive bidding to limit provider participation in public programs to only the most efficient.

Question 4. There are two reasons that the reimbursement system is a more powerful approach to reducing inpatient capacity than is a

planning process. First, reimbursement restrictions work. They do change behavior. Not always as the authors of the restrictions originally envisioned, but change is always the result. Second, the evidence on planning is equally clear. Health planning does not work. The health planning process of the 1960s and 1970s was a political process posing as an analytical one. No matter how much its supporters might argue that it should work, the evidence is clear that it does not.

Past efforts to use planning to impose construction restrictions often became power struggles between the state regulators and providers, with elected officials usually on the provider side. In most instances, after much sound and fury, powerful providers were able to do as they wanted.

In only one state did the regulators routinely win. In that state the excesses of the regulators were such that there now exists a critical shortage of needed inpatient capacity. This problem has been doubly compounded because the same planners have so restricted long term care capacity that there are often not any nursing home beds available when a discharge to a nursing home is advisable.

If we allow the natural competitive forces now at work in the hospital environment to be augmented by reimbursement strategies we will have our best hope of achieving the desired balance between available and needed capacity. Although the planning notion is appealing to some, the implementation of a planning process would do nothing to improve our chances for success.

Questions for Dr. James R. Kimmey

Other than the need that you identified to financially support the planning mechanisms that may be put in place, what specific components would you include to eliminate the short-comings of the certificate-of-need efforts tried earlier?

Please elaborate on a statement you made in your testimony: "I think that we can get along without a blanket certificate-of-need structure, although I think there are some areas where that may be needed. But I don't think we can get along without planning."

How do you envision an all payer system working with the planning mechanisms that you have suggested?

Answers

Question 1. It is important clearly to differentiate between health planning and certificate of need. Health planning has a long history as a community-based voluntary activity focused on identifying more effective approaches to organizing and delivering health services. Health planning involves a *process* by which providers, consumers, and government collect and analyze data describing the health needs of the community's population; identity problems and opportunities for improving those services; identity strategies for implementation; and seek institutions and organirations participation in bringing about desirable changes. It also involves a product, the plan document, which is available to the community and its institutions as a "road map" for development of a health system more responsive to the needs of the population.

Certificate of need is a regulatory concept borrowed from public utility regulation under which a regulated enterprise is required to demonstrate that a capital investment meets a community need before proceeding with the project. These two concepts--health planning and certificate of need--became linked in the 1960s when certain states began to use the plans developed at the community level as a basis for regulatory decisions. This idea grew rapidly, and was incorporated into optional facility capital expenditure review under section 1122 of the Social Security Act in 1974 and was made a part of the mandatory state certificate of need programs required under P.L. 93-641 in 1975.

The linkage between certificate of need and health planning was initially welcomed by the health planning groups as a means of securing implementation of the plans developed by and for the community. Over time, however, the regulatory function consumed more and more of the agencies' resources, and the limited effectiveness of certificate of need in containing health care costs was interpreted not only as a failure of certificate of need but as a failure of health planning.

The major problem for the planning agencies in the linkage to regulation was not in the planning aspect of their operation, but in the complex of regulatory reviews, public hearings, appeals, and legal actions in which they became embroiled. If planning is reinstituted, the community agencies should be focused on the planning portion of the activity, supporting the process and developing the product. To the extent regulation of the certificate of need type is reinstated, it should be a function of state government, with the state having the responsibility for the due process aspect of the program. The community planning body should have standing to participate in the review, and its plan should be a principal consideration in state decisions, but the non-governmental body should not be forced to administer a regulatory process affecting the providers whose participation in planning and in implementation of non-capital recommendations is essential to bringing about change in the community's health care structure.

Questions 2 and 3. Certificate of need *per se* carries with it a defined set of legal requirements--dollar thresholds, defined scope of coverage, due process, and penalties for non-compliance. Each of these is open to manipulation, amendment, challenge, and interpretation, and that was a major factor in the wide variation among the states in the character and effectiveness of CON approaches. At the time that it was introduced, CON was a concept familiar to legislators and administrators from utility regulation. It lent itself to application in a field where there were multiple providers and multiple sources of payment and means of fmancing because it divorced the process of approval from the source of funding. Certificate of need should be viewed as a tool for securing compliance with community-endorsed plans, but came to be viewed as a tool for containing costs, a function to which it was poorly suited and bound to fail. In my view, the basic intent--to force institutions to consider community goals as well as institutional goals in their capital expansion plans, became lost.

Certificate of need is not the only way to bring discipline to institutional decision malnng on investment--it was just the most convenient and best understood one at the time it became widespread. Mandating certificate of need as the sole approach to securing compliance with planning foreclosed other options which should be considered if the goal is to secure provider consistency with a community's goals for its health system. The degree to which alternatives to CON might be applied is dependent in large part on the fmancing system and the way capital dollars flow in the system.

For example, the Medicare program had launched a ten year effort to integrate capital payment into the DRG system. This may apply discipline to provider decisions concerning the sire of capital investments; but it does absolutely nothing to influence these investments in direction of community needs. Hospitals will still invest these funds in high

return, high technology projects designed to attract physicians. That is where the incentives in the system lead them. Capital inclusion in DRGs, then, is neither an alternative to certificate of need or a means for achieving community goals.

If the certificate of need approach continues to be, or is reinstituted as, the approach of choice for directing capital investment there is probably little reason to make it as broad as it was in the 1975-1985 period. It might be targeted to areas with the greatest potential for inappropriate investment (from the community perspective) and relaxed in areas where inappropriate investment is unlikely. The former category might include high-tech diagnostic and treatment services and equipment, new outpatient programs which move secondary and tertiary type services into non-institutional settings, or relocation of entire facilities. The coverage might be relaxed for beds, which are less and less important under funding constraints and given the trend to outpatient services, or for code-related replacements and updates. Any CON approach should, in my opinion, be linked to community-generated plans, and not based on some arbitrary statewide or national standard.

Several alternatives to the CON approach might be considered once an effective planning structure was in place. These include bidding systems, competitive grant approaches, and franchising. These suggestions are based on three assumptions:

1. States will have the legal authority and responsibility for administration of any system.
2. Planning agencies are in place at the community/regional level and functioning.
3. All payers are participants.
4. Ideally, capital reimbursement from all payers will be pooled and distributed by the state in accord with one of the alternative approaches.

If these assumptions were met, then alternatives to CON which remove some of the opportunities to delay and distort the process might be considered.

Bidding Systems: Under this alternative, planning agencies would identity specific changes required in the community's health services structure and prepare "Requests for Proposals" soliciting provider projects which would meet those needs. Providers would have the option to respond to the requests within a time frame, and the planning agency would review the responsiveness of the proposals against the plans and forward a prioritized list of endorsed proposals to a designated state agency. The State agency would have the responsibility for final selection of proposals for allocation of funds from the capital pool. To the extent hearings and other processes were required in this process, they would be conducted by the state agency. The local agency would assist the state in monitoring the funded projects, particularly as to the degree to which the project meets identified community needs.

Grant Systems: Under this alternative, providers would generate their own projects based on their assessment of need and submit the project proposals to the state agency for consideration for funding from the capital pool. The planning agency would have standing to review and comment on such applications as to their consistency with community plans, which would be a requirement for granting funds from the pool. To the extent hearings and other processes were required in this process, they would be conducted by the state agency. The local agency would assist the state in monitoring the funded projects, particularly as to the degree to which the project meets identified community needs.

Franchise Systems: Under this alternative, a two-step process involving a designation and a bidding/grant system would be required. Consistency with plans would be a key factor at each step. Once consensus was achieved concerning the overall structure and mix of services which would best serve the population of an area was determined, a classification system (similar to pediatric or trauma center systems) would be applied to providers and a determination made as to the levels and amounts of specific services required by the population. Providers or combinations of providers would apply to the state agency for recognition as the source of a mix of services and/or level of care, with the local planning body and its plans a major factor in classification decisions. Recognition as a community source would not guarantee access to funds from the state pool, but non-recognition would block access to such funds for projects in franchised areas. Providers holding designation would compete for funds from the pool under either a bidding system or a grant system as described above.

Thus there are theoretical alternatives to CON as a mechanism for allocating resources in a manner consistent with community plans. I would stress theoretical--these are just examples of things that might be considered if policy were to move toward a community-determined health system rather than a provider-determined health system.

Questions for Mr. Larry Gage

Some observers have questioned whether public hospitals will be able to compete with private facilities, such as in New York under the new Medicaid managed care plan, if the amount of reimbursement for those on Medicaid were to become more attractive. Do you anticipate that the patient mix of public hospitals will become much more concentrated with uncompensated care patients if the Medicaid reimbursement amounts are increased?

You have aptly described the capital needs of many of the public hospital facilities. Currently, are there any mechanisms in place that would facilitate your identification and incorporation of surplus private sector facilities into the public hospital system?

Answers

The National Association of Public Hospitals (NAPH) appreciated the opportunity to appear before your subcommittee on June 17 to testify on the role of public hospitals in the 21st century. Your continued attention to the important contributions and significant needs of safety net hospitals is commendable.

Question 1. You have requested my response, on behalf of NAPH, to two additional questions on the future of public hospitals. First, you asked whether public hospitals will be able to compete with private facilities, such as in New York under the new Medicaid managed care plan, if the amount of reimbursement for those on Medicaid were to become more attractive. You inquired whether the patient mix of public hospitals will become much more concentrated with uncompensated care patients if the Medicaid reimbursement amounts are increased.

Although more attractive Medicaid rates could increase the willingness of private hospitals to serve Medicaid patients, we would not anticipate a significant drop in the amount of Medicaid care provided by our member hospitals. For a number of reasons, many private hospitals are currently unwilling to serve the Medicaid population even in the face of excess capacity. This unwillingness suggests that higher reimbursement rates may not be a sufficient incentive for all private hospitals to increase their Medicaid case mix. Public hospitals who, as I pointed out in my testimony, already serve large volumes of Medicaid patients, will continue to play that vital role even with competitive reimbursement rates.

Moreover, we believe that safety net hospitals have the potential to compete successfully with private facilities for Medicaid patients. In New York, the example cited in your question, the Health and Hospitals Corporation of New York City is already developing an expanded

managed care program that would permit it to be a strong and viable competitor for Medicaid managed care business. Safety net hospitals nationwide are similarly moving in that direction to better position themselves for inevitable changes in the health care delivery system. Because of their already close ties with medical schools, community providers, public health services and other social services, these hospitals are uniquely situated to develop effective managed care programs. Attractive Medicaid managed care rates will ensure their ability to provide expanded access and high quality care to all Medicaid patients.

The primary danger for safety net hospitals in the move toward greater reliance on managed care is the problem of "adverse selection," by which private providers attract the healthiest patients, leaving only the sickest and most expensive seeking care through safety net hospitals. To counter this effect, NAPH has advocated requiring "stop-loss" measures by providing reimbursement above the capitated rate in certain situations. NAPH is also strongly urging that Congress require States that implement Medicaid managed care plans to continue to fulfill their Boren amendment and disproportionate share responsibilities.

In short, while more attractive Medicaid reimbursement could increase the competition for Medicaid patients from private hospitals, we believe that there will be a continuing need for safety net providers to serve a large number of these individuals. If enhanced reimbursement is well-targeted to increase access and quality, the improvements will resound system-wide.

Question 2. Your second question asked whether any mechanisms are currently in place to facilitate the identification and incorporation of surplus private sector facilities into the public hospital system. A number of safety net hospitals have combined with or absorbed private health care facilities in recent years. For example, Cook County Hospital recently acquired Provident Hospital in the South side of Chicago, a facility that had been closed since the mid-1980s. Provident, a minority-owned hospital, had received large loans from the Department of Housing and Urban Development to build the new facility, which only opened in 1981. Soon afterwards, the hospital developed severe management problems and its census declined, leading HUD to close it just a few years after it opened. Because of the need for a community hospital in that section of town, the County finally agreed to acquire the hospital from HUD for $1 and merge it with Cook County Hospital. It is now in the process of conducting much needed major renovations to the facility, which is expected to open in the spring of 1993.

St. Louis provides another relevant example. In the mid-1980s, both the City and County of St. Louis closed their public hospital facilities and established the St. Louis Regional Health Care Corporation (SLRHCC), a non-profit entity. SLRHCC then acquired a facility that a for-profit hospital chain, the Charter Medical Corporation, had been

unable to operate successfully. The City and County provided the funding to acquire and renovate the facility, and SLRHCC uses it to provide acute care and outpatient clinic services to City and County patients.

Finally, the Regional Medical Center at Memphis (the Med) recently stepped in to save a community non-profit health care center from closure. The Memphis Health Center is a Federally Qualified Health Center that was in danger of losing its federal qualification and funding due to severe financial and management failures. Beginning in October 1991, the Med entered into a management contract with the health center to improve its operations. ass than a year later, the center has not only retained its federal qualification, but has received enhanced funding, and is achieving all of the financial and quality goals required by the federal government.

As you can see, safety net hospitals can and do utilize excess pnvate sector facilities when such an arrangement proves cost-effective for the hospital and/or when the facilities provide an important community service that might otherwise be neglected. In other cases, however, such an acquisition might not make sense for the public hospital if it can expand its own facilities more cost-effectively. The appropriateness of incorporating surplus private sector facilities into the safety net hospital system will therefore depend on the unique circumstances and needs of the individual safety net hospitals and their communities.

Questions for Ms. Ophelia Long

Some observers have questioned whether public hospitals will be able to compete with private facilities, such as in New York under the new Medicaid managed care plan, if the amount of reimbursement for those on Medicaid were to become more attractive. Do you anticipate that the patient mix of public hospitals will become much more concentrated with uncompensated care patients if the Medicaid reimbursement amounts are increased?

You have aptly described the capital needs of your hospital facility. Currently, are there any mechanisms in place that would facilitate your identification and incorporation of surplus private sector facilities into the public hospital system?

Answers

Question 1. I have a strategic plan for Highland to compete with the private sector for Medicaid patients under a managed care scenario. I am concerned that uncompensated care concentration would increase in public hospitals if there was adverse selection as a result of private facilities and physicians refusing to accept or not encouraging enrollment of higher cost Medicaid patients. If this occurred, then public hospitals would be faced not only with more concentrated uncompensated care but higher cost Medicaid patients, e.g., high risk pregnant substance abusers, homeless, mentally ill, and non-compliant patients.

Currently, most hospitals in our area accept Medicaid patients and there is a Medicaid managed care plan in our area; however, experience shows that these services attract the "good" Medicaid patients and direct the higher risk patients to the public hospital.

Question 2. We could easily identify potential surplus private sector facilities; however, incorporating these facilities into the public hospital system would be inefficient and costly. Currently, we have all services (inpatient, ancillary and outpatient) on one campus. If we had services on different campuses, inefficiencies would result from moving patients and information between facilities. If facilities were separated by more than 15 miles, then the State would require two separate hospital licenses. Also, all hospital facilities in our area are within 2 miles of a major earthquake fault (the Hayward fault). Any new use occupancy would require ensuring the facility meets current seismic standards.

Questions for Mr. Edward J. Renford

Some observers have questioned whether public hospitals will be able to compete with private facilities, such as in New York under the new Medicaid managed care plan, if the amount of reimbursement for those on Medicaid were to become more attractive. Do you anticipate that the patient mix of public hospitals will become much more concentrated with uncompensated care patients if the Medicaid reimbursement amounts are increased?

You have aptly described the capital needs of your facility. Currently, are there any mechanisms in place that would facilitate your identification and incorporation of surplus private sector facilities into the public hospital system?

Answers

Question 1. While the mix of uncompensated care patients in public hospitals will likely increase, the absolute amount of such services provided will probably decrease substantially due to reductions in total Medi-Cal funding available to help cover the fixed costs of indigent/uncompensated care services.

Public and other disproportionate share hospitals rely heavily on Medi-Cal payments, including disproportionate share payment adjustments, to maintain facilities and service access for Medical and other indigent/uncompensated care patients alike. Unlike most non-disproportionate share counterparts, disproportionate share hospitals cannot extensively "cost-shift" uncompensated care expenses to other payors, since such other payors are not a substantial portion of these institutions' business.

Potential siphoning of Medi-Cal patient loads from disproportionate share hospitals is likely to result if Medicaid managed care payments are enhanced generally, perhaps even at the expense of existing supplemental disproportionate share payments. The results could be devastating, further unraveling an already severely tattered health-care safety net. The likely result will be further erosion of the Medicaid revenue base for disproportionate share hospitals, a skimming off of "more desirable" (e.g., non-AIDS and non-Homeless) Medicaid patients and probable retrenchment of indigent/uncompensated care programs due to ensuing funding constraints.

If the rate of medicaid reimbursement is increased and there continues to be a shift to managed care, we anticipate that some of the existing problems with medicaid will continue and in some cases grow. Some of the problems now experienced which must be dealt with include inadequacy of medicaid rates, complexity of billing associated with cost-controls, and slowness in payment.

Question 2. The Department of Health Services has two mechanisms in place to evaluate the use of surplus private sector health-care facilities. The first is an ongoing function of the department, with dedicated staff resources. This group manages our contracts to treat patients in facilities owned and operated by the private sector. It also evaluates the appropriateness and potential role of private sector facilities which become available to the County through sale, lease or other mechanisms. Over the past several years, the group has reviewed numerous hospitals which the County could consider acquiring. Some of the reasons other facilities have not been acquired in the past include:

- unreasonably priced relative to the value of the capital assets;
- too small to effectively serve as an operating unit; and/or
- rundown physical plants requiring substantial investment to comply with current regulatory code and patient care standards.

A second special task force on alternative delivery options(ADO) is currently conducting an in-depth review of the potential to substitute private sector capital resources for capacity now operated by the County. The ADO task force is a part of the Department's efforts to revise the Department-wide capital plan in light of constrained resources. We are currently contacting each hospital provider in the County to explore potential relationships which would decrease the need for the Department to own and operate the beds in which public-obligation patients are treated. The advantage of this approach (compared to acquiring surplus facilities) is to minimize the amount of operational overhead in the Department. The operation of numerous small (200-300 bed) hospitals could significantly increase the Department's overhead and annual operating requirements.

Both of these groups are actively involved at this time in evaluating the potential acquisition of Long Beach Naval Hospital (scheduled to be closed in 1993) as an element in addressing the Department's capital requirements.

As a member of various local and state-wide advocacy groups, the Department will routinely be apprised of the impending closure of private sector facilities. Advocacy groups such as the Hospital Council of Southern California (HCSC), California Association of Hospitals (CAPH), and California Association of Hospitals and Health Systems (CAHHS), will announce/publish information regarding the reduction, closure, or consolidation of services at any of its member facilities. This advocacy network serves to keep the Department abreast of developments in both the public and private sector.

Questions for Ms. Donna D. Fraiche

Some observers have questioned whether public hospitals will be able to compete with private facilities, such as in New York under the new Medicaid managed care plan, if the amount of reimbursement for those on Medicaid were to become more attractive. Do you anticipate that the patient mix of public hospitals will become much more concentrated with uncompensated care patients if the Medicaid reimbursement amounts are increased?

You have aptly described the capital needs of Louisiana's public hospital facilities. Currently, are there any mechanisms in place that would facilitate your identification and incorporation of surplus private sector facilities into the public hospital system?

Answers

Question 1. Obviously, if the Medicaid reimbursement amounts are increased, private facilities will be more likely to compete for those patients; however, public hospitals have a traditional patient base and they must have the management capability and capital resources necessary to keep that patient base. A highly qualified clinical staff and a modernized physical plant that patients will feel comfortable using are essential if a hospital is to receive third party covered benefits. When public facility lacks these elements, private sector hospitals will obviously have the advantage of attracting these patients to their institutions.

Question 2. In response to this question, one needs only to review the history of public hospitals. Before 1965 (Medicare and Medicaid), poor and indigent patients flooded emergency rooms, clinics and inpatient beds of public hospitals. Today, those hospitals are significantly downsized. For example, Cook County has 2,000 less beds and 800 less patients per day. Charity Hospital has 2,000 less beds and 500 less patients per day. Once private hospitals had a vehicle for payment by Medicare and expanded Medicaid programs, public hospitals became more concentrated with uncompensated care patients. Those without insurance, the working poor, and others who do not meet the eligibility requirement of Medicaid or Medicare have no place to go except to a public hospital facility.

A solution to this increased uncompensated care patient concentration must include a positive strategic planning process to more effectively utilize community resources. Only in this way can the most favorable outcome for the patient, private hospitals and public hospitals, be achieved. *In Louisiana this week, a letter of intent was entered into by and between Charity Hospital and a private not-for-profit*

Catholic community hospital that is owned and operated by the Daughters of Charity. The decision by the State to purchase this private facility was made to assist in providing quality access and an appropriate physical plant to the expanding public hospital needs in downtown New Orleans by providing 200 extra beds to the existing 400 bed Charity Hospital facility. As you may recall from my testimony, I raised the issue of life safety code deficiencies experienced by public hospitals and the concomitant threat to HCFA certification and JCAHO accreditation. The community has thereby been forced to focus on the public hospital and its affiliated teaching programs. With renewal of accreditation imminent and no replacement physical plant in sight, the State of Louisiana necessarily focused upon the immediate need to fulfill a physical plant deficiency through the acquisition of a private facility.

Questions for Mr. Michael A. Morrisey

What effect do all payer systems such as that operating in the State of Maryland have on the need for Federal antitrust enforcement? To what extent would Federal involvement differ if an all payer system were instituted nationally?

To what extent do you see the need for planning activities to complement other means of influencing hospital bed supply?

Some have suggested that more specific guidelines than those provided in the joint FTC-Justice issued Merger Guidelines would assist in clarifying matters for both FTC and Justice, and the hospital industry. Would you support the creation of more specific guidelines that did not preempt the application of existing antitrust laws but would assist in their application to the hospital industry?

Answers

Question 1. Based Upon very limited research, state rate setting programs are likely to have little impact on the need for Federal antitrust enforcement. To my knowledge, only one research study has addressed this question. Jeff Alexander and I examined 306 hospital acquisitions which took place over the period 1980 through 1983.[1] This was the hay-day of hospital mergers. Overall, and afier controlling for other factors, we found no statistically meaningful ellect of state rate setting on the probability that a hospital would become part ofa multihospital system. When we examined investor-owned and non-profit system acquisitions separately, we did find that investor-owned systems were less likely to acquire a hospital in a state that had rate setting. In related work we examined the propensity of hospitals to enter into management contracts.[2] Here we found that hospitals were more likely to contract with an investor-owned chain but less likely to contract with a nonprofit chain in the presence of state rate setting. The net effect was no statsitically meaningful difference in the propensity to enter into a management contract. Thus, the concentration of suppliers, the traditional concern of antitrust, is unlikely to be afiected by the enactment of state rate setting programs.

In a health care market in which insurers (and individual patients) faced identical prices for hospital services one would expect to see no price competition. Further, unlike a cost-based payment system, in this system we should expect to see only limited service competition since the payment level is capped. Instead, we would see providers competing to attract the least costly patients within each payment class. The extent of such activity, obviously, depends on the payment levels. We have not seen much service shirking in hospitals as a result of Medicare

prospective pricing. Lengths of stay are shorter, but high tech services continued to be provided.[3] These sorts of concerns have not traditionally been in the purview of antitrust. Indeed, they would seem to be better suited to some form of PRO [peer review organization] monitoring.

Question 2. I do not believe that the re-emergence of health planning is likely to be effective in controlling hospital costs. In my judgement, the best review of the literature on health planning in the form of cerificate of need was conducted by Frank Sloan.[4] He concludes: "To my knowledge, no econometric study has concluded that CON has reduced costs per hospital day and per case....Studies examining increases in hospital expenditures have all found CON has had no influence on overall growth of expenditures for hospital care per capita" (p.58-9). This is consistent with my own recent re-examination of CON programs which found that, if anything, CON programs had increased health care costs per capita.[5]

I concur with Mr. Altman's observation earlier in the hearings, providers will probably always find ways around such programs. I too believe that payment systems are likely to be more effective in controlling capacity than will planning.

Question 3. Without a clearer understanding of the guidelines, I could not render an opinion. However, as a general rule, clear guidance is to be preferred, particularly in the area of antitrust.

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[1] Alexander, J.A. and Morrisey, M.A., "Hospital Selection Into Multihospital Systems: The Effects of Market, Management, and Mission," Medical Care 26(2): 159-176 (February 1988).

[2] Alexander, J.A. and Morrisey, M.A., "A Resource-Dependence Model of Hospital Contract Management," Health Services Research 24(2):260-284 (June 1989).

[3] Sloan, F.A., Morrisey, M.A. and Valvona, J., "Medicare Prospective Payment and the Use of Medical Technologies in Hospitals," Medical Care 26(9):837-853 (September 1988).

[4] Sloan, F.A., "Containing Health Expenditures: Lessons Learned from Certificate-of-Need Programs," in F.A. Sloan, J.F. Blumstein, and J.M. Perrin, ed., Cost. Quality. and Access in Healih Care, pp:44-70 (San Francisco: Jossey-Bass Publishers, 1988).

[5] Lanning, J., Morrisey, M.A. and Ohsfeldt, R.L., "Endogenous Regulation and Its Effects on Hospital and Nonhospital Expenditures," Journal of Regulatory Economics 3(2): 137-154(1991).

THE STRUCTURE OF THE HOSPITAL INDUSTRY IN THE 21ST CENTURY

WEDNESDAY, JUNE 24, 1992

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON INVESTMENT, JOBS, AND PRICES,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Committee met, pursuant to notice, at 8:45 a.m., in room 2359, Rayburn House Office Building, Honorable Fortney Pete Stark (chairman of the Subcomittee) presiding.

Present: Representative Stark.

Also present: David Podoff, Charla Worsham and Doneg McDonough, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE STARK CHAIRMAN

REPRESENTATIVE STARK. Good morning. This morning the Subcommittee on Investment, Jobs, and Prices of the Joint Economic Committee will continue hearings on "The Structure of the Hospital Industry in the 21st Century." That is on the assumption that we will have the hospital industry in the 20th century by the beginning of the 21st century.

Today's hearing will focus on hospital mergers and joint ventures. There is a perception in the health provider community that there may be an inherent conflict between health policies that stress sharing of expensive facilities and closing and/or merging facilities with excess capacity and the antitrust policies that tend to oppose or question these consolidations.

It occurs to the Chair that the government's health and antitrust policies must be perceived as internally consistent. If perceived to be inconsistent, health care provides will be reluctant to make needed changes. And, again, that is going on the presumption that we have some overcapacity, or we have capacity that is improperly allocated throughout the country.

To help clarify our objectives with respect to hospital mergers and joint ventures, a number of questions must be addressed.

What differentiates the hospital industry from other industries and can those differences be accounted for in merger guidelines?

What do we know about the effect of competition, if any exists, on hospital costs?

What are the implications of regulated prices imposed by the government and state all-payer systems and discounts obtained by HMOs and PPOs?

How we can get from the current state of 40 percent excess hospital capacity and significant redundancies, particularly in high technology equipment and services, to a more rational balance between supply and demand of the health services?

Since I have shortchanged the author of my elegant opening remarks, I will ask unanimous consent that those remarks be contained in the record in their entirety, as will be the case with all of our witnesses.

[The written opening statement of Representative Stark follows:]

WRITTEN OPENING STATEMENT OF REPRESENTATIVE STARK

Today, we continue with our series of hearings on **THE STRUCTURE OF THE HOSPITAL INDUSTRY IN THE 21ST CENTURY.**

Last week, witnesses discussed trends in the hospital industry and the role of public hospitals. Witnesses agreed that declining occupancy rates and the changing mix of in-patient and outpatient services pose series challenges to the hospital industry that need to be addressed now.

Most witnesses also recognized the need for government to shape the direction of these trends, although there was no consensus on appropriate policies. Some witnesses favored indirect intervention through reimbursement policies and budget constraints, while others advocated more direct involvement through some form of coordination. Most agreed with the statement of Stuart Altman, Dean of the Heller School, Brandeis University, who summed it by saying that "In the end...hospitals will have to get their costs in line with other sectors of the economy."

There was also general agreement that, irrespective of the direction of health insurance reform and cost containment, public hospitals will continue to play a vital role in the health care system. However, witnesses expressed concern that insufficient investment in these important public infrastructure facilities would prevent public hospitals from providing primary and outpatient care to low-income patients, and essential specialized services, such as trauma care and burn centers, to all members of the community.

In today's hearing we will focus on hospital mergers and joint ventures. There is a perception in the health provider community that there may be an inherent conflict between health policies that stress sharing of expensive facilities and closing and/or merging facilities with excess capacity and antitrust policies which tend to oppose or question such consolidations.

It seems to me that the government's health and antitrust policies must be perceived as internally consistent. If health providers perceive these policies to be inconsistent, then they will be reluctant to make needed changes.

In our hearing last week, Gerard Anderson, from The Johns Hopkins University, noted the danger of not having clearly defined objectives. He observed that in the absence of a clear policy we are inappropriately asking the judicial system "to decide between a policy which encourages hospital mergers to reduce duplication (the traditional HHS and health planning position) and a policy which tries to prevent mergers for antitrust reasons (the FTC and Justice positions)." This may be an appropriate way to resolve disputes between two parties, but this method ignores the long-run implications for the general public.

To help clarify our objectives with respect to hospital mergers and joint ventures, a number of questions should be addressed including:

What differentiates the hospital industry from other industries and can these differences be accounted for in merger guidelines?

What do we know about the effect of competition on hospital costs?

What are the implications of regulated prices imposed by governments (Medicare and Medicaid, state all-payer systems) and discounts obtained by HMOs and PPOs?

Are there ways to modify and/or clarify the DOJ/FTC guidelines so as to eliminate the alleged "chilling" effect of current guidelines?

What are the implications for antitrust policies of health insurance reforms and cost containment proposals that expand the role of regulated prices through an all payer system?

How can we get from the current state of 40 percent excess hospital capacity and significant redundancies of high technology equipment and services, to a more rational balance between supply and demand for health services?

REPRESENTATIVE STARK. I also want to insert a statement that was submitted by Congressman Dooley.

[The prepared statement of The Honorable Mr. Dooley follows:]

PREPARED STATEMENT OF THE HONORABLE CAL DOOLEY

Mr. Chairman, I'd like to thank you for holding this hearing. As a member of Congress representing a district with a number of small hospitals, the issue of hospital mergers and joint ventures is of great interest and importance to me and the constituents I represent.

In a rural area like the San Joaquin Valley in Central California, small hospitals are faced with the challenge of providing quality, state-of-the-art, affordable health care to residents of the communities they serve. However, hospitals are receiving mixed messages from the Department of Health and Human Services and the Department of Justice.

The Department of Health and Human Services is encouraging hospitals to become more efficient, avoid duplication of services and reduce costs. Hospitals in small communities and rural areas have attempted to achieve these goals through mergers, agreements to share technology, equipment and personnel and other collaborative efforts. But the Federal Trade Commission and the Department of Justice have punished them by filing costly antitrust suits.

During the last year we have seen the issue of health care reform become a major concern of many Americans. Members of Congress and representative from the Administration have spoken of health-care reform packages that incorporate innovative health-care delivery systems and that seek to control the proliferation of under-utilized medical technology and equipment. But while we encourage hospitals to become more efficient through collaborative efforts and encourage facilities to share technology and expensive medical equipment, many hospital administrators are afraid to engage in joint programs for fear of violating anti-trust laws and facing costly anti-trust lawsuits.

As the Chairman knows, access to health care is particularly limited in rural areas. Increased provider cooperation would expand access to health care while simultaneously improving the quality of care and containing costs by reducing duplicative services and reducing excess capacity.

The fact of the matter is that we should be encouraging hospitals to cooperate and share facilities and equipment. Instead, fears of federal anti-trust suits are keeping hospitals from controlling costs, improving services and better meeting the needs of the communities they serve.

I urge you, Mr. Chairman, and members of your committee to address the issue of hospital anti-trust this year. Considerable gains in cost-control and access to services could be achieved with a revision to current hospital anti-trust policies.

Mr. Chairman, thank you for providing a forum for us to discuss this very important issue. I applaud you and the committee for your willingness to address the issue of anti-trust laws and their affect on the delivery of health care and look forward to working together for a sensible resolution of the issue.

REPRESENTATIVE STARK. Also, in the nature of housekeeping, if the witnesses will bear with me for a moment, there is simultaneously going on--or there will be simultaneously going on--a markup of perhaps the silliest tax bill ever to face the Congress of the United States. While I don't mind missing it, there are some issues in there that I feel compelled to vote on. And, as I at this point am not aware of another Member joining us, I may have to recess the hearings today from time-to-time. I will try and let the witnesses know as far in advance as I can, and I apologize for the inconvenience and am very grateful for whatever indulgence they will accord the Chair and the staff.

I am delighted this morning to start the hearing with two of my distinguished colleagues. I suspect, in order of seniority, it would be the Honorable Jim Slattery of Kansas and the Honorable Peter Hoagland from Nebraska. Am I right?

REPRESENTATIVE SLATTERY. That is correct. Mr. Chairman, I would yield to my colleague from Nebraska, however, in light of the fact he did arrive here a few minutes——

REPRESENTATIVE STARK. Before any of us. He should be chairing.

Pete, go ahead. Both of your statements will appear in the record.

Why don't you enlighten me and the staff—however you are comfortable.

STATEMENT OF THE HONORABLE PETER HOAGLAND, REPRESENTATIVE FROM NEBRASKA

MR. HOAGLAND. Thank you, Mr. Chairman. I would be happy to go first.

REPRESENTATIVE SLATTERY. Or chair, right?

MR. HOAGLAND. I appreciate the opportunity, Mr. Chairman, to come before you today to discuss the antitrust problems faced by hospitals.

My interest in this subject stems back to my years in the Nebraska legislature when, in the last two years of the Carter legislation, we passed tough cost-control legislation. It also stems from our situation in Omaha where in the late 1970s, early 1980s, we were overbedded and "overhospitalized." We had five hospital vacancies exceeding 40 percent from time to time.

The proposal contained in H.R. 5244 is more limited than the proposals this Subcommittee is considering. It is limited to granting antitrust exemptions to allow hospitals to share major technology. In Omaha, for instance, not only do we have too many vacant hospital beds, but we have--each of the major hospitals through the years has developed its own cardiac care unit, for instance.

In my statement, which I would ask to have made part of the record, I show that we now have seven open-heart cardiac surgery units in Omaha.

REPRESENTATIVE STARK. Seven. And how many in the state?

MR. HOAGLAND. I can't answer that. Probably not many more in the state.

REPRESENTATIVE STARK. How many people in the Omaha area?

MR. HOAGLAND. About 550,000 or 600,000 people.

REPRESENTATIVE STARK. I thought California was bad. I think we have 120 in California. And many of which do, you know, do ten procedures a year and others that do 1,000 procedures or more.

MR. HOAGLAND. It really makes no sense. I know the hospitals would like to be relieved of the burden of having to compete.

In Omaha, we have two medical schools. We have two teaching hospitals. And there is duplication inherent in that.

The cost of a hospital bed nationally, of course, is $686 now, and Nebraska and Omaha are not far behind. It is $674. We are a regional--quite a regional medical center in Omaha, and we serve people from many of the surrounding rural areas. But, nonetheless, there are a lot of economies that could be realized with a bill such as my bill and/or Mr. Slattery's bill.

We have a number of distinguished witnesses following Mr. Slattery and me, and I don't want to take a whole lot of time.

Let me just make a couple of additional comments.

Let me first describe what the bill does.

H.R. 5244 does two things: First, it authorizes the Department of HHS to conduct up to 20 demonstration projects across the country to facilitate cooperation among two or more providers to share capital intensive medical technology and also to demonstrate the extent to which those agreements reduce costs without impairing care. Twenty such programs and the bill authorizes $2.5 million to fund those.

Now, the second portion of the bill would be to authorize the Attorney General to grant a certificate of review for facilities wishing to enter into a sharing arrangement for expensive capital intensive medical technology. So, two or more hospitals in Omaha could enter into an arrangement to jointly support one kidney dialysis unit, one cardiac surgery unit and so forth.

I think the economies to be realized from all of this are really quite obvious, and I would suggest that we consider making either or both bills' amendment to whatever package that, as refined by the Committee, we ultimately vote on this year.

Let me make two final comments: First, the antitrust law in this area is somewhat murky. We have a CRS report, which you probably have seen, prepared by Janice Rubin, entitled "Antitrust Law and Joint Activity by Hospitals," which is helpful and thorough and on point. I should note that Janice Rubin gave us assistance in drafting this bill. Her expertise is part of what went into this legislation. I think, if you review her CRS report, you will see that she is quite knowledgeable about these issues.

Point two. The problem is one of perception. Nobody is really quite sure what the current state of antitrust law is. It would appear to exempt these things in any event, but hospital administrators don't necessarily perceive that as being the case. Understandably, nobody wants to be prosecuted civilly or criminally.

REPRESENTATIVE STARK. They ought not to run for Congress then.

MR. HOAGLAND. As long as they don't open a checking account anywhere, they will be all right.

Over 44 percent of hospital CEOs in one survey indicated that antitrust concerns prohibited their collaborative efforts. And their lawyers say the same thing. Making it clear in the antitrust statutes that these things are permitted would be helpful.

I will be happy to answer any questions.

[The prepared statement of The Honorable Mr. Hoagland follows:]

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PREPARED STATEMENT OF THE HONORABLE PETER HOAGLAND

I appreciate the opportunity to come before you today to discuss the antitrust problems faced by health care providers. My interest in this subject stems from my deep concerns about the unrestrained, unrelenting, double-digit increases in health care costs Americans have faced in recent years.

The high cost of health care is of concern to all of us. The cost of one day in the hospital nationally is $686.83; in Omaha, Nebraska, it is $674.73. The charge for a two-pound baby in neonatal intensive care is roughly $1,500 per day. These are costs that make health care unavailable to many people and costs that eat into the standard of living of all Americans. These are expenses that add costs to employers and to consumer products [$500 of every automobile can be attributed to the cost of health care of employees]. And escalating health care costs are creating unprecedented strains on governments at all levels. In Nebraska, for example, our state legislature has had to find an additional $13 million for the Medicaid program for 1992-1993.

I have introduced H.R. 5244, a bill that begins to address one aspect of health care inflation. Some say that we are in a "medical arms race," with many hospitals and other providers appearing to compete to offer the latest high tech equipment and services. There is no question that we have made many impressive advances in medicine, that this country offers treatments that most other countries in the world only dream about. Premature babies that only a decade ago would live only a few short days now survive. Magnetic resonance imagers catch illnesses long before traditional X-ray machines or other techniques do, prolonging life and preventing death. Lithotriptors can pulverize kidney stones without expensive and painful surgery. Few dispute the benefits of these advances.

But they come at a cost. MRIs have a price tag of $1 to $2 million; lithotriptors can cost $2 million. The problem is that in one area several hospitals may purchase the equipment and duplicate services already provided in the area. According to the Omaha World Herald, Omaha has seven open-heart cardiac surgery units. This adds costs to those paying for health care.

We used to have a health planning process, supported in part, by federal funds. But Congress, prior to my arrival, went along with former President Reagan's request that it be repealed. It was designed to help local communities work together and avoid duplication in services. But only vestiges of that process remain in most states.

The time has come to encourage hospitals and other health care providers to share some of the expensive, high-tech technologies, particularly when sharing. would not inconvenience patients. But the problem is that hospitals considering cooperative or joint sharing arrangements perceive that they might violate our antitrust laws, well-intentioned laws designed to prevent monopolies and other anti-competitive behavior. They fear that if they enter into cooperative agreements, they will violate prohibitions against price-fixing, anti-competitive collusion, or restraint of trade through monopolies. In the words of one hospital official considering sharing arrangements, "You always feel like you're walking on land mines."

My conclusion is that our current laws and policies are sending a mixed message: the Department of Health and Human Services urges constraint in health care costs; the Department of Justice and the Federal Trade Commission promote competition. And these two worthy goals can conflict severely in the health care arena. This is why

I have introduced H.R. 5244, a bill offering two approaches. It would authorize the Department of Health and Human Services to conduct up to 20 demonstration projects across the country to facilitate collaboration among two or more providers to share capital-intensive medical technology and demonstrate the extent to which such agreements reduce costs without impairing care. Further, the bill would grant antitrust immunity for these demonstrations until the projects' completion. The second approach of the bill would authorize the Attorney General to create a certificate of review process for facilities wishing to enter into a sharing arrangement for expensive, capital-intensive medical technology or other high resource-intensive services and grant limited protection from antitrust violations.

Competition is a worthy goal in most economic pursuits, but in the provision of health care, it may be a notion worth reconsidering. "Selling" an appendectomy is not like selling automobiles, where the shopper tries to get the best quality at the best price in a broad, competitive, diverse market. Health care purchasers--be they individuals, physicians, insurance companies--do not shop for bargains. In addition, providers have less control over their revenues. One-half of hospital revenues Medicare and Medicaid--for example, are fixed or controlled. The hospital as the "seller" cannot change or control the price charged to reflect changes in the cost-of-doing business.

In terms of antitrust policy, there are two points. In antitrust terms, the more highly concentrated the market the fewer the hospitals--the greater the antitrust risk. Yet health care traditionally has been a community-based service and most communities can only support a few hospitals. Hospital care by its very nature can be highly concentrated in a given community, especially in small towns. Second, antitrust law assumes that all forms of competition always benefit the consumer. However, in health care, competition among hospitals does not necessarily result in lower prices. Hospitals compete very little. Consumers do not "comparison shop." Thus, we have to ask, is competition, in the antitrust sense, really relevant here?

Whether provider cooperative agreements would violate antitrust prohibitions would, of course, depend on the specific case. But a big problem today, as documented by several authorities, is the *perception* of possible antitrust violations if joint sharing agreements are developed and the uncertainty about potential antitrust violations creates a "chilling" effect. Over 44% of hospital CEO's in one survey indicated that antitrust concerns slowed or inhibited their collaborative efforts. Hospitals are reluctant, for example, to jointly plan centers of excellence, to agree that one will purchase an MRI and another a lithotriptor, that one will have a cardiac intensive care unit and another a neonatal intensive care unit. Some hospital administrators are skittish about even talking to their counterpart across town! In the words of one attorney who practices in this area, "The perception is the reality. It's the uncertainty that creates the problem."

Federal policy may be in conflict. HHS encourages efficient delivery and cost control. But antitrust policy may collide with these goals when providers try to coordinate the purchase of equipment and avoid duplication. (Such an agreement could be considered to be, in antitrust jargon, "market division.") The Department of Justice's merger guidelines address mergers in general for all industries, not mergers in the health care field. And they only address mergers. Among health care providers, there are many

areas of sharing or joint, planning far short of mergers that could come under antitrust scrutiny by the federal government.

I believe it is time for Congress to closely examine our federal antitrust policies as they apply to health care. It is time to question whether the free-market model of unchecked competition is really the right policy during this age of double-digit health care inflation. It does seem to me that in many communities across this country health care providers are willing to work together to provide a comprehensive array of affordable health care services that would make health care available to more Americans while also enhancing the position of the providers in the "marketplace."

I am not suggesting that my bill is the final answer, but it is a start. I commend you for examining this area of federal policy and I look forward to working with you.

REPRESENTATIVE STARK. Jim, welcome.

STATEMENT OF THE HONORABLE JIM SLATTERY, REPRESENTATIVE FROM KANSAS

REPRESENTATIVE SLATTERY. Thank you, Mr. Chairman. I thank you and the Subcommittee for allowing us to testify today about an issue that I think is one that should be addressed by the Congress before we adjourn this year.

As Chair of the House Rural Health Care Coalition Task Force on Hospitals, I share your concern in this area and, like I said, I appreciate the opportunity to testify today.

I would like, if I could, to spend just a couple minutes talking about a bill that I have introduced, H.R. 2406, which would provide that certain hospitals be exempted from standard review under the relevant antitrust acts if they meet three criteria:

One, eligible hospitals must be located in cities with a population of 125,000 or less;

Two, the eligible hospitals must rely on government resources for at least 40 percent of their revenues; and,

Three, the eligible hospitals would be required to demonstrate to HCFA that government expenditures would be reduced and consumer cost would not increase if their merger was permitted.

I would just point out, Mr. Chairman——

REPRESENTATIVE STARK. When you say 40 percent government—40 percent federal or 40 percent government, including state and local?

REPRESENTATIVE SLATTERY. It would be 40 percent government resources. That would include both Medicare and Medicaid reimbursements.

REPRESENTATIVE STARK. Including the state portion?

REPRESENTATIVE SLATTERY. That is my intention. That is correct. If you need clarification in the language, I would be happy to do that. But the bottom line is that if we are interested in cost containment it seems to me that we need to encourage hospitals, and especially our smaller communities, to merge, to consolidate, and to do joint ventures in an effort to contain costs.

I happen to represent a number of small communities that—Topeka, Leavenworth, Manhattan, to name three—in fact, do have more than one hospital serving a community of this size. It seems to me that we right now—whether it is real or just perceived, it is working as though it were real—and that is a situation where the hospitals are frightened, and they are afraid to even talk to another hospital that may be operating across the street about some opportunity to do a joint venture for fear that they may be in violation of antitrust laws.

For some people that don't think this is a real problem, I would point out the recent Carillon Hospital in Roanoke, Virginia. This case that was

being litigated has cost some $2.6 million in various fees to litigate, and it is the kind of thing that I don't think hospitals can afford. It is the kind of thing the health care consumers in this country can no longer afford either.

REPRESENTATIVE STARK. We should have mandatory arbitration and keep the lawyers out of this mess.

REPRESENTATIVE SLATTERY. That is perhaps another option. I think, bottom line, we need to clarify and indeed encourage hospitals in these areas to come together and make decisions. If one hospital decides that they are going to be the hospital in that community that is going to provide the OB/GYN care, perhaps another hospital will say that they will do the cardiovascular surgery, or whatever tradeoffs they make. Bottom line is, I think this kind of cooperation will lead to significant savings around the country.

There are examples after examples where hospitals have engaged in what some have referred to as the medical arms race, and the bottom line is that the health care consumers in this country end up paying for both hospital facilities, both of which may be underutilized. There is little if no evidence to indicate that this kind of situation does, in fact, improve quality or does, in fact, reduce cost.

The old idea of competition just doesn't work in the health care delivery system, especially with regard to this kind of situation.

REPRESENTATIVE STARK. Have you talked to our friends Stenholm, Cooper and Company that this idea doesn't work?

REPRESENTATIVE SLATTERY. I have shared this idea with them.

REPRESENTATIVE STARK. What is the highest altitude in Kansas, above sea level?

REPRESENTATIVE SLATTERY. Not having qualified as a flyer in Kansas, I want you to know I never studied those areas.

REPRESENTATIVE STARK. You don't have any areas like Jackson, Wyoming, where the oxygen gets real thin, do you?

REPRESENTATIVE SLATTERY. Mr. Chairman, I came today prepared to answer a number of questions, but I didn't come prepared to answer those questions, however.

REPRESENTATIVE STARK. Well, both of you gentlemen have hit on a problem, and, indeed, the very reason for these hearings. I concur with you.

I gather, Peter, you are just dealing with basically high technology equipment and the sharing of resources, like laboratories or MRI equipment and that sort of thing.

MR. HOAGLAND. That is correct.

REPRESENTATIVE STARK. Yours is broader, Jim!

REPRESENTATIVE SLATTERY. Mine is broader. The extent of what I am saying is that we should tell hospitals—especially communities of 125,000 or less—I would like to see you increase it, frankly, to a quarter of a million. In those communities where there is more than one hospital

serving a community, we should encourage joint ventures once it is demonstrated that they are, in fact, receiving 40 percent or more of their resources from the government, and once they demonstrate to HCFA that they can actually reduce costs and consumers would not see an increase in rates.

REPRESENTATIVE STARK. I would go further. There may be some areas where we should not only allow them, but we should encourage them.

What is your occupancy statewide in Nebraska?

MR. HOAGLAND. I can't answer that, Pete, but it can't be over 75 percent.

REPRESENTATIVE STARK. In California, it is a good day when we hit 60 percent. And we could ship some hospitals to Nebraska or Kansas.

REPRESENTATIVE SLATTERY. I have a better idea for you, Mr. Chairman. Until recently, for someone to have a triple bypass surgery performed in Los Angeles, it would cost about $7,500 for the surgeon's fee. In Topeka, you could come and operate with the same equipment, and the same medical malpractice insurance coverage. The doctor in Topeka was paid $3,500.

REPRESENTATIVE STARK. I have long argued, if we did a joint venture with not just doctors and hospitals but with United Airlines, we could move people to lower-priced communities where arguably the medical treatment is every bit as good. California is a very nice place to be, but if you want to spot me $3,500 to stay in a hospital there as opposed to Topeka, I will split the difference with you.

I do want to get to a couple of things: I would exempt hospitals from the antitrust procedures, one, because I don't understand them; and, two, they were designed for A&P and salt companies, things like that. On the other hand, I am not willing to turn this over to the hospital administrators. Because, while indeed they would contend that mostly they are nonprofit, I don't think any of them are above putting one of the guys in town out of business. I think they have all the instincts of property people and could gang up on the poor little sisters of something, and say we will get together and take all their business from the third person. And we cannot put the fox in the hen house.

Are you both suggesting that HCFA play some role?

REPRESENTATIVE SLATTERY. That is correct. Basically, what my legislation would do is just move the forum, you might say, from the FTC to HCFA.

REPRESENTATIVE STARK. My question to both of you is: Is there any need to protect other institutions? Everybody is talking here about getting two or more together to share or merge. Shouldn't we make sure that for somebody who is cranking along with a small but reasonable quality hospital that has fairly good utilization that we make sure we don't disadvantage them in the process? I guess that is what I am saying.

Take a city with three hospitals, one small one that runs at 80 percent occupancy and cranks along, and two big ones that run at 60 percent

occupancy. I can give you a scenario where the two big ones merge and break the small one. It takes all its customers away, and we would say, gee, what a good job we did for the two big ones. All the time, the small one loses its population, and we haven't gained a hell of a lot.

I guess my question is: Do you both see the government in that role? I gather you are both saying that HCFA is the one who ought to do it, assuming there is enough federal interest there.

REPRESENTATIVE SLATTERY. Let me clarify, Mr. Chairman. H.R. 2406—the legislation I introduced—is more carefully targeted on communities with a population of 125,000 or less. I already conceded I would like to see that increased.

REPRESENTATIVE STARK. Same problem. We just had one in San Francisco.

REPRESENTATIVE SLATTERY. I am not as familiar with the problem in big cities as I am with the cities that I have described. I think, if you move into the bigger cities, it is a different environment, arguably. But that is something I would certainly be willing to consider. It is just that I am not as knowledgeable about that.

REPRESENTATIVE STARK. Are you comfortable with HCFA being the watchdog?

REPRESENTATIVE SLATTERY. I am comfortable with HCFA being the watchdog when we talk about the antitrust exemption as I am describing it. If you move beyond that and talk about it generally being applied to all cities in this country, that is a different proposition. I would like to think about that.

Certainly, with the communities and the conditions that I am describing, the hospitals involved, both of them have to demonstrate that, in fact, 40 percent of their money is coming from the government.

I would observe that with many of the communities I described that the reality is probably 60 percent of their revenue typically is Medicare revenue or Medicaid revenue. There are instances where it is even higher than that. When you have the requirement that they have to show that at least 40 percent of the money is coming from the government, and that they have to demonstrate to HCFA that they can reduce costs by doing this, and that the consumers will not see an increase in costs, once those thresholds have been passed, common sense then dictates that you allow these mergers and joint ventures to take place.

Again, Mr. Chairman, I am not knowledgeable enough with respect to how this would affect hospitals in larger cities at this point to say that I think the FTC should be totally removed from it.

REPRESENTATIVE STARK. They do it in Maryland, for instance. I would commend both of you to take a look and talk with our colleague Ben Cardin, where they have state control of hospital rates. What they do is, in effect, offer bonuses to encourage mergers, sometimes on a case-by-case basis, but they have basically a state board that will recognize

situations such as the one you suggest and actually use the rate structure to encourage merges. It seems to work all right.

I don't care how it is done. It seems that all three of us would agree that we have some mismatching of facilities. Neither of you wants to go so far as to suggest going back to the certificate-of-need program.

MR. HOAGLAND. There is some similarity in the second program that is set up in my bill where a certificate of review is considered by the Attorney General to allow hospitals to get together to form joint facilities. One of the criteria that the Attorney General is to apply is found on page 11. He must also find that the application will not constitute unfair methods of competition against competitors engaged in providing the services under the class of the agreement. That language is there.

There is an enforcement problem. The smaller hospital with 80 percent occupancy—how will the Attorney General watch things in Dayton, Ohio?

REPRESENTATIVE STARK. Aren't we right back in the same box with another group of lawyers reviewing this, and each hospital in the trade area will have to hire a lawyer? We are right back in the same soup.

MR. HOAGLAND. On the demonstration project, the first section of the bill, it might be worth considering requiring all hospitals in an area to participate in the demonstration.

There is also some language in there about how, in evaluating a demonstration and in allowing it, HCFA has to take a look at the availability of health services in the entire area and how it affects other competitors.

REPRESENTATIVE STARK. I am trying to figure out what you mean by a demonstration project. You conjure up ideas of different treatment methods and follow along to see how well people perform. I really suspect that what you are suggesting is that the demonstration is the process of merging or setting up this cooperative entity, and that pretty much ends the project, right?

MR. HOAGLAND. It has a three-year duration, and it is to be evaluated according to what savings——

REPRESENTATIVE STARK. If it doesn't work, you set them asunder? You divorce them?

MR. HOAGLAND. I wouldn't think so.

REPRESENTATIVE STARK. You might accomplish the same thing by saying, okay, anybody who chooses could apply to merge or combine under either one of your bills, and let's see how it works for a couple projects, and if the parties to it—the hospitals, the government, the community—feels it seems to work better, we will try it.

That makes good sense. Otherwise, we sit around politically. We have to have a demonstration in Nebraska, one in Kansas, and one in California, and the devil take the hindmost. This way you offer it as an alternative to those people who want to try it.

REPRESENTATIVE SLATTERY. It seems to me, Mr. Chairman, as we approach this health care debate, we should encourage states and

communities to be creative and to use their own initiative to try and develop new ideas to contain costs. I see cost containment as the key to this whole debate.

I think you asked about the certificate-of-need question earlier. I envision that we ought to establish health care at the state level and give them broad authority to play key roles in monitoring health care within their borders.

REPRESENTATIVE STARK. I will do anything you want as long as we don't call it certificate-of-need.

MR. HOAGLAND. We have two proposals. We have seven quite distinguished panelists coming and would be interested in seeing which they think is the most workable.

REPRESENTATIVE SLATTERY. I summarized my statement. I would like for my statement to be——

REPRESENTATIVE STARK. Without objection, both of your statements and any supporting documents that you like will be in the record in their entirety, and I look forward to getting all the help we can on cost containment, a battle we are going to be fighting, if not for months, for the next couple of years.

[The prepared statement of The Honorable Mr. Slattery follows:]

PREPARED STATEMENT OF THE HONORABLE JIM SLATTERY

Mr. Chairman, I want to thank you for holding hearings on such an important topic regarding our health care delivery system. As Chair of the House Rural Health Care Coalition (Coalition) Task Force on Hospitals, I share your concern in this area and appreciate having the opportunity to testify before your committee this morning.

A problem which has been brought to the attention of the Coalition involves hospitals in small communities, and especially in rural areas, which attempt to either merge, consolidate or enter a contract for an agreement of services. These attempts by hospitals have been made in order to adjust to changing economic circumstances and to avoid excessive and duplicative services—trying to keep health care costs down and at the same time, not jeopardize access to vital health care services in these communities. Such attempts, however, have been challenged and attacked by the Federal Trade Commission (FTC) and the Department of Justice (DOJ) as being in violation of Antitrust laws (Section 7 of the Clayton Act and Section 1 of the Sherman Act).

Reports and studies have shown that the threat of actions by the FTC and DOJ have had a chilling effect on such collaborative efforts, which many hospitals, particularly in rural areas, view as an essential tool for financial survival.

I find it troubling that federal policies on health care and antitrust send mixed signals to providers; many hospitals find themselves in a double bind. Current Medicare and Medicaid payment policies have put hospitals under increasing financial pressures to consolidate their operations. At the same time, the FTC and DOJ appear to be intensifying their scrutiny of hospital mergers and joint ventures.

I am specifically concerned that the federal antitrust laws are unduly hindering some hospitals from undertaking joint activities—including the sharing of technology or expensive medical equipment—which they believe are necessary in order to maximize the efficiency of their operations. Many hospital administrators are afraid that if they even talk with each other, much less undertake joint programs, they will automatically violate antitrust laws.

The perception among many hospitals, both rural and urban, that much of the joint activity they wish to undertake for efficiency reasons would violate antitrust laws may be largely mistaken. But even if there is no real or no great antitrust problem, if a misperception is standing in the way of beneficial activity, then that misperception is itself a problem to be addressed. The fact is that the costs are real in any merger challenge. Merging hospitals have learned that you can fight city hall, but it's not cheap.

In one of the more recent and visible cases where the merging hospitals challenged the Justice Department, the hospitals have spent $2.6 million on various fees. I am referring to the Carillon case out of Roanoke, Virgina which began in 1987. The expenses fell into six categories: attorney's fees, consulting fees, economists' fees, public relations, court reporters' fees and market research.

Nearly 60 percent of the total expenditures have been for attorney's fees paid to two law firms. But the $2.6 million doesn't include the costs of complying with the government's request for documents before the suit. In the Carillon case, to comply with two government requests, the hospitals handed over 150,000 pages of utilization and financial records. It is estimated that the hospitals spent at least $1 per page retrieving, reviewing, copying and submitting the documents.

I do not happen to believe that there is merely a misperception problem. Mr. Chairman, in my testimony today I would like to make the case that the current antitrust review of hospital mergers and joint ventures is inherently flawed. My premise is a simple one: Traditional antitrust principles do not apply to health care.

Antitrust policy and law enforcement must be evaluated in the context of hospital market realities. Hospital markets are decidedly different from more traditional markets for goods and services.

Market concentration. Enforcement agencies (FTC and DOJ) assume that the greater the number of hospitals in a market, the better health care consumers will fare. In antitrust terms, the more "highly concentrated the market"—the fewer the hospitals —the greater the antitrust risk.

Health care is a community-based service; most communities can only support a small number of hospitals. However, the governments application of its market concentration standards makes it difficult for any consolidation in a community with 6 or fewer hospitals to pass government scrutiny. Yet, many communities with 5 (or fewer) hospitals exist with no adverse effect on consumers.

In fact, under traditional antitrust analysis, the most highly concentrated market—the one hospital town (a "monopoly," in antitrust terms)—theoretically would have the highest health care costs and prices. This is simply not the case, particularly in rural areas.

Competition. Enforcement agencies assume that all forms of competition always benefit consumers; however, competition among hospitals does not necessarily result in lower prices. Hospitals do not compete, and patients do not "comparison shop," based upon price.

Most patients are not directly affected by differences in hospital prices due to the prevalence of third-party insurance coverage. Instead of competing on price, hospitals compete on quality and services. The "medical arms race" generates costly duplication of services and equipment, not lower prices for consumers.

In any event, the price of health care is largely dictated by the federal government and sophisticated third-party payors. According to the American Hospital Association, approximately two-thirds of the typical hospital's revenues comes from these sources.

In the past, Congress has acted to clarify related areas of antitrust laws. I have introduced legislation, H.R. 2406, the Hospital Antitrust Act, which would address this issue. H.R. 2406 would revise the government's current selection criteria, urging a rejection of blind reliance on market share data and more consideration of non-statistical factors like cost savings and access.

Specifically, H.R. 2406 would provide that certain hospitals be exempted from standard review under the relevant antitrust acts, if they meet three criteria:

1. Eligble hospitals must be located in cities with a population of less than 125,000;

2. Eligible hospitals must rely on government resources (i.e., Medicare and Medicaid reimbursements) for at least 40 percent of their total revenues; and

3. Eligible hospitals must demonstrate to the Health Care Financing Administration that government expenditures would be reduced and consumer costs would not increase by consolidation of services.

I know that our colleague from Nebraska, at the table with me today, Rep. Peter Hoagland, will share with you another alternative in this area regarding state demonstration programs.

The point is that we must focus attention on hospital antitrust issues this year. In the course of the debate on overhauling our entire health care system, we must not lose sight of the important gains and savings that can be achieved by changing hospital antitrust policies.

The hard truth is that we may not achieve comprehensive health care reform this year, but this may be an area where we can find consensus for reform and build upon it in the next Congress.

Mr. Chairman, I applaud your efforts to tackle this complicated yet important issue and I look forward to working with you in order to resolve tough problems in our health care system. I hope you will join me in supporting legislation in this area as a result of your findings from this series of hearings.

REPRESENTATIVE STARK. Thank you both for taking your time to enlighten us. I appreciate it very much.

Our first panel is comprised of a group of experts in the hospital industry, including David P. Kaplan, President of Capital Economics; Rita Ricardo-Campbell, Senior Fellow at the Hoover Institution; D. Kirk Oglesby, Jr., Chairman, Board of Trustees of the American Hospital Association; and Don Ammon, Chairman, Board of Directors, Ukiah Valley Medical Center.

We welcome these members as a panel to the Subcommittee, ask them to use the Chair as a bad example, and limit their own opening statements to no more than five minutes so that we can engage in a little more informal discussion when you are done, submitting your prepared statements that will appear in the record in their entirety in the hearing record.

So, if you would care to enlighten me or expand on your written testimony in any manner you are comfortable, we will start with Mr. Kaplan.

STATEMENT OF DAVID P. KAPLAN, PRESIDENT, CAPITAL ECONOMICS

MR. KAPLAN. Thank you, Mr. Chairman, for the opportunity to address the Subcommittee this morning.

I am president of a consulting firm here in Washington that specializes in antitrusts, including mergers and acquisitions.

REPRESENTATIVE STARK. For everybody or just for hospitals?

MR. KAPLAN. For everyone. The Nation's hospital industry, representing 40 percent of health-care costs in this country, are encountering ever-escalating costs, including the costs of goods and services purchased by hospitals, payroll expenses, and the ever-increasing need for new and more expensive equipment.

At the same time as costs increase, hospitals face dramatically declining revenue for a number of reasons. First, declining admissions. Admissions have declined 14 percent in the last decade despite an increase in U.S. population of some 10 percent.

Second, declining occupancy rates, standing today at less than 70 percent nationally—the lowest level since World War II.

Third, the implementation of the prospective payment system that, as we all well know, constrains revenues for some 35 to 40 percent of the average hospital's revenue.

Fourth, increasing competition from numerous alternative medical facilities.

And, finally, revenues are constrained by the so-called buying power of large managed-care systems which purchase increasing amounts of health care at lower costs.

These two factors—increasing costs and declining revenues—have forced many hospitals to close and many others to experience serious

financial hardship. According to recently released data, 1,500 hospitals, or some 25 percent of all hospitals in this country, reported negative total margins in 1990. Many hospitals, in an attempt to control these escalating costs, have engaged in mergers and joint ventures to reduce duplicative high-cost facilities, decrease input costs and better manage capital costs. This trend towards consolidation has been repeatedly encouraged by U.S. health care officials.

On the other hand, U.S. Government antitrust authorities, concerned about the impact on competition of increased joint activity between hospitals, have raised many obstacles to the completion of certain mergers and joint ventures. These obstacles have included numerous time-consuming and expensive investigations of planned mergers and the successful litigation of certain attempted acquisitions—acquisitions stopped by the government in Federal court.

Obtaining antitrust approval for a merger between two hospitals can be quite a difficult task. Government merger enforcement standards are outlined in merger guidelines that are published jointly by the Department of Justice and the Federal Trade Commission.

Review of these guidelines and court cases brought by the agencies over the last 12 years teaches us a few lessons about antitrust enforcement related to hospitals. The lessons tell us how difficult it is for mergers to get approval.

First, the government will define the market in which they review the hospital merger or joint venture very narrowly: Acute care inpatient hospital services in a highly localized area. The government will give little credit to alternative care facilities—doctors' offices, clinics, etc.

Once the market is so narrowly defined—acute care inpatient services in a local area—the merger between two local hospitals out of a total of typically four or five will substantially violate the structural thresholds that are based on market concentration established by the merger guidelines.

The violations of these thresholds, based on government enforcement policy and practice, cast many hospital mergers as seemingly anticompetitive. While it is true that the merger guidelines point out concentration data based on so-called HHI, are the starting points for competitive analysis, the practical implications of high concentration data is significant because it places a much higher factual burden on the parties to overcome the negative competitive inferences created in the government's view by the high concentration levels.

Having lived through this, Mr. Chairman, repeatedly, I can tell you that those high numbers do change the burden substantially for the proponents of the acquisition.

One final point about government merger review. The government is generally very skeptical of arguments that the merger or joint venture will generate any cost efficiencies.

Indeed, in the most recent hospital merger case stopped by the government—University Health—the FTC argued to the court that the law recognizes "no efficiency defense in any form."

Recently, an FTC official stated in a speech:

> Most efficiency arguments presented to the agency concerning hospitals are speculation and entitled to little weight in merger review.

REPRESENTATIVE STARK. Do you agree with that?

MR. KAPLAN. No, I don't agree with that. Before integration, it is difficult to precisely determine all of the cost savings associated with a combination of firms. I think the problem is that because those cost savings are based on estimates contained in documents created by the parties, the government is quite skeptical of those estimates and, in my opinion, give too little weight to those particular points.

I am not surprised, given this environment, that hospital administrators find themselves confused. U.S. Government health-care officials repeatedly encouraging them to consolidate, merge and engage in joint ventures to lower costs.

On the other hand, the antitrust officials have raised serious obstacles to these activities. These mixed signals are not helpful to a business community in need of clarity.

I am not suggesting, Mr. Chairman, by my remarks that antitrust enforcement should play no role in the review of hospital mergers. However, I do believe that antitrust authorities must pay special attention when applying general merger standards to the highly complex, highly dynamic health care industry. Some of these include the buying power of managed-care third-party payers, government restraint of revenues through the PPS system, the declining financial position of many hospitals, the nonprofit status of certain hospitals, and the real cost savings associated with many hospital mergers.

One last comment. One of the most troubling aspects of merger enforcement in this country is that the merger guidelines and enforcement policy of the FTC and the Department of Justice are predicated on the assumption that a smaller number of hospitals in a local geographic area will result in higher prices, less nonprice competition, or a lower quality of care. However, the research available in the public domain suggests quite the opposite conclusion. A smaller number of hospitals are actually associated with lower prices.

However, there are some who criticize these results as misleading or incomplete. In fact, Judge Posner, in a case from the Seventh Circuit, commented on this literature and expressed dissatisfaction with there not being a full development of this particular issue.

Given that enforcement policy at the agency is predicated on this one particular assumption, I think it would be prudent for all parties to pay more attention to this particular issue.

[The prepared statement of Mr. Kaplan follows:]

PREPARED STATEMENT OF DAVID P. KAPLAN

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EXECUTIVE SUMMARY

The changing structure of the hospital industry is a critical factor as our country struggles to control increasing healthcare costs. It is imperative, at this time of dynamic change, that U.S. government policy be clear, consistent, and be designed to improve the quality of healthcare to all Americans at the lowest possible cost.

- Many hospitals have closed or are experiencing serious financial hardship, limiting their ability to effectively serve the public.
- Encouraged by U.S. healthcare officials, many hospitals, in an attempt to control escalating costs, have engaged in mergers and joint ventures to increase occupancy rates, eliminate duplicative (high cost) facilities, decrease input costs, and better manage capital costs.
- U.S. antitrust enforcement officials, however, have aggressively pursued a program of carefully reviewing many proposed hospital combinations and, in certain highly publicized court cases, prevented certain hospital mergers. In the most recent court case brought by U.S. antitrust authorities, in response to arguments by the merging hospitals that the combination would substantially lower costs and improve efficiencies, the enforcement agency argued that the "law" does not recognize any "efficiency" defense in a hospital merger.
- The community of health providers have expressed dismay and confusion at the apparent mixed signals they are receiving from different representatives of the United States government. As recently admitted by Dr. Wilensky, it is "not helpful to have different branches of government working in opposing directions."
- Positive steps need to be taken to coordinate the government's position on hospital mergers and joint ventures, including better and enhanced coordination between healthcare and antitrust authorities. In addition, meaningful empirical research should be conducted on critical issues associated with hospital mergers,

including the extent of cost savings associated with hospital combinations and the actual relationship between hospital consolidation and prices.

I. INTRODUCTION

Healthcare costs in the United States are rising at an alarming rate. Hospitals are an important part of the total picture representing approximately 40 percent of total healthcare costs. Over the last ten years in particular, hospitals have seen admissions fall, occupancy rates decline, competition increase dramatically from alternative care facilities, experienced the imposition of prospective payment systems limiting revenues, and encountered significant increases in the costs of doing business (including payroll, the costs of goods and services, and the capital cost of increasingly sophisticated equipment). In the face of these dramatic changes, many hospitals have actually closed or are experiencing serious financial hardship, limiting their ability to serve the public.

Many hospitals, in an attempt to control costs and survive, have increasingly engaged in mergers and joint ventures in an attempt to increase occupancy rates, eliminate duplicative (high-cost) facilities, reduce input costs, and control capital costs. Much of this merger-related activity has taken place with the approval of government healthcare officials which have urged the hospital industry to find ways to economize, to eliminate waste, and reduce the level of duplication. This government policy had included encouraging hospitals to merge and engage in other joint activity designed to reduce cost.

At the same time, however, antitrust authorities, including those at the Federal Trade Commission and the Department of Justice, concerned about the impact of increased joint activity between hospitals on competition, have raised certain obstacles to the completion of many planned collaborations. These obstacles have included numerous time-consuming and expensive investigations of planned mergers and the successful litigation of certain attempted acquisitions. The highly publicized nature of the action of U.S. antitrust authorities has also clearly increased the uncertainty and related risk of hospitals engaging in joint activity, thereby mitigating the willingness of many hospitals to engage in any attempt at possible cost-saving activity.

The apparent conflict between government healthcare officials and antitrust enforcers was highlighted in the most recent case litigated by U.S. antitrust authorities. Federal Trade Commission v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991) rev'g 1991-1 Trade Cas. § 69,400 (S.D. Ga. 1991) ("University Health"). In this case, the Federal Trade Commission successfully blocked a planned merger of two hospitals in Augusta, Georgia. The Commission claimed that a reduction in the number of hospitals from four to three in the Augusta area (creating a hospital with 43 percent of the market) was anticompetitive. The Commission, in response to arguments by the merging hospitals that the combination would substantially lower costs and improve efficiencies, argued to the Eleventh Circuit that "the law" does not recognize any "efficiency defense in any form."[1] In other words, the FTC argued in this case that the main driving force motivating many hospital mergers and combinations -- lower costs and improved efficiencies -- is simply not relevant to a competitive review of the proposed acquisition.

Quite obviously, the positions of government healthcare officials and U.S. antitrust authorities likely create a good deal of confusion among hospital administrators. This

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[1] University Health, at 1222.

paper discusses this issue and suggests certain steps that could be taken to provide better guidance to the business community.

II. THE PROBLEM: COST CONTROL

The cost of healthcare in the United States approximates $800 billion and represents over 13 percent of our Gross National Product ("GNP").[2] In other words, it costs each American, on average, $3,057 for his or her health care.[3] Since 1960, total health spending, before adjusting for population changes and general inflation, has increased an average of roughly 11 percent a year.[4] After adjusting for population and general inflation, the increase in real per capita health spending has been 4.75 percent per year over the last 30 years.[5]

The increasing cost of healthcare has generated a great deal of heated debate concerning the primary causes of this alarming trend. The debate has centered around certain factors that may facilitate higher health care costs, including fee-for-service medicine coupled with third-party payment, cost-based hospital reimbursement, tax exemption of employer-provided health benefits, the malpractice liability system (arguably providing incentives to providers to over-provide), and some argue, the tendency of certain patients to "overconsume" healthcare (because many patients are insulated from the actual costs of their healthcare purchasing decisions). We have also seen numerous proposals all designed to ultimately control healthcare costs.

The nation's hospital industry, which represents approximately 40 percent of total healthcare costs in the United States, has been buffeted by a number of factors limiting available revenues and, therefore, increasing the importance of controlling the cost of providing healthcare services. The institution of a Prospective Payment System ("PPS") utilizing DRG-based rates for Medicare patients, which compensates hospitals an amount fixed according to each patient's particular medical problem, has limited the revenue hospitals can generate with respect to such patients. These revenue constraints, affecting approximately 35-40 percent of the average hospital's revenue, provide strong incentives to hospitals to control the cost of providing these services (or shift these costs to other users).[6] Similarly, hospitals have encountered intense and increasing competition from numerous alternative medical facilities providing an ever-increasing portfolio of outpatient services. This competition further reduces hospital revenues again providing an added incentive for cost control. The "buying power" of third-party payer's, through use of coordinated care systems and prepaid health plans, has also emphasized cost control as health groups shop for the least expensive combination of healthcare services.

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[2] G. Wilensky, Administrator of the Health Care Financing Administration, U.S. Department of Health and Human Services, "Talking Points," Presented before American Nurses Association (January 13, 1992), at 4.

[3] Id.

[4] R. Darman, Director, Office of Management and Budget, "Comprehensive Health Reform: Observations About the Problem and Alternative Approaches to Solution," Presented to The House Committee on Ways and Means (October 10, 1991) ("Darman"), at 14.

[5] Darman, at 14-16.

[6] This issue, of course, has created a great deal of debate concerning cost shifting. See, for example, "Sullivan's Reform Suggestions Need to Be Based On Facts," Modern Healthcare (August 27, 1990), at 26.

Certain factors have made it difficult, however, for hospitals to effectively minimize healthcare costs despite declining revenues. Since the institution of PPS, hospitals have suffered falling admission rates and declining occupancy rates.[7] These declines, in addition to changes in case-mix, the increasing cost of the goods and services purchased by hospitals, and ever-increasing demand for new and more expensive technology has exacerbated the need for cost control within the hospital system:[8]

> Because of falling admission rates, total Medicare operating costs are being spread over fewer cases, resulting in a dramatic growth in costs per case. Other factors causing higher costs per case include (a) increased input prices; (b) new technology and changes in medical practice; and (c) changes in case-mix, as patients with less severe illness receive services as out-patients.[9]

Initially, hospitals were able to partially compensate for these changes by reducing length of stay and furnishing services in less costly settings. Over time, however, these "quick fixes" have not been able to offset increasing pressures on cost structures.

Many attempts by individual hospitals at cost containment have been hindered because of the high "fixed costs" associated with operating a hospital. The existence of high fixed-cost assets places added emphasis on hospitals to increase levels of occupancy which, as discussed above, has been an ever-increasing problem. Indeed, previous cost-based reimbursement policies of the federal government may well have facilitated an overbuilding of hospital capacity, capacity which now sits idle.

Cost containment has also been hindered because, hospitals, in order to attract physicians (and their patients), have experienced enhanced incentives to purchase the best (and highest cost) equipment, facilities, and amenities. Once these high-cost facilities are in place, there is added pressure to utilize these assets in order to justify the initial capital investment.[10]

Within a particular geographic area, high levels of unused beds and the presence of high-cost equipment may well make it difficult for individual hospitals to generate sufficient cash flow to cover operating costs or justify continued capital investments.

III. A PARTIAL SOLUTION: MERGERS AND JOINT VENTURES

Implementation of prospective payment and increased competition in the healthcare sector have forced providers, particularly hospitals, to seek strategies that increase productive efficiencies and reduce costs. One such strategy is to integrate business functions through affiliation arrangements, joint ventures, and mergers among competing hospitals. Such activities are designed to increase occupancy rates, eliminate duplicative facilities, and generally increase the efficient operation of expensive facilities. In 1961, only five hospitals merged.[11] Since 1980, between 40 and 60 mergers have occurred annually and the trend is apparently increasing.[12]

[7] Statistics highlighting declining admissions and occupancy rates are contained in Exhibit 1.

[8] Statistics highlighting increasing hospital expenses are contained in Exhibit 2.

[9] R. Leibenluft, "Development in Medicare Reimbursement for Hospital Services," Health Law Handbook, 1989, A. Gosfield, ed. (Clark Boardman Company: New York, 1989), at 29. Statistics highlighting the increase in outpatient visits is included in Exhibit 3.

[10] It has also been argued that capital pass-through reimbursement policies associated with PPS may well have facilitated the purchase of high-cost equipment.

[11] E. Blackstone and J. Fuhr, "Hospital Mergers and Antitrust: An Economic Analysis," Journal of Health Politics, Policy and Law, Vol. 14, No. 2, (Summer, 1989), at 383.

[12] D. Ettinger, "Mergers," Presented before the National Health Lawyers Association, Antitrust In The Healthcare Field (January, 1992)("Ettinger"), at 1.

A merger between competing hospitals may well increase productive efficiency by permitting the generation of the same or greater output with fewer resources. The ability to consolidate hospital operations and gain the economies of joint operation are fostered by geographic proximity. This is particularly accurate of clinical service consolidations. In addition, hospitals in the same community frequently have overlapping medical staffs. These overlaps facilitate interest in consolidation and contribute to the probability that services actually can be joined and costs reduced.[13]

IV. A POTENTIAL CONFLICT: HEALTHCARE V. ANTITRUST

Much of the merger and joint activity between hospitals has been encouraged by U.S. government healthcare representatives. Health and Human Services Secretary, Louis Sullivan, M.D., has stated that hospitals must "find ways to economize and to eliminate waste."[14] Former Administrator of the Health Care Financing Administration ("HCFA"), Dr. Gail R. Wilensky, recently stated that "we've got to find sensible ways to reduce [the] level of duplication. Sharing facilities and equipment is certainly one reasonable strategy."[15]

The combination of competing hospitals raise certain issues, however, related to the level of competition that will prevail in a particular geographic area subsequent to the merger (or joint venture). The competitive concern focuses on whether the elimination of a previously independent competitor is likely to result in higher prices, less non-price competition, and less quality.

The Federal Trade Commission ("FTC") and Department of Justice ("DOJ"), which jointly share responsibility for U.S. government merger enforcement, have, since 1980, substantially increased their review of the competitive effects associated with hospital mergers.[16] There have been numerous government investigations of hospital mergers in cities such as San Francisco, Knoxville, St. Augustine, and Manitowoc, among many other areas.[17] The FTC and DOJ have also challenged in court or in administrative hearings a large number of hospital mergers. Many of these challenges have been successful, i.e., they prevented hospitals from combining facilities.[18]

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[13] The new Medicare PPS system, which replaced the cost-based reimbursement program, was designed, in part, to facilitate efficient hospital operations and eliminate duplicative facilities. The Senate report stated that the PPS system was "intended to reform the financial incentives hospitals face, promoting efficiency in the provision of services by rewarding cost-effective hospital practices." S. Rep. No. 23, 98th Cong., 1st Sess. (1983).

[14] "Sullivan Seeks Tighter Cost Controls, Less Cost Shifting In Any Reform Package," Modern Healthcare (August 20, 1990), at 3.

[15] "Collaboration: Hospitals Find That Working Together Is Tough, Rewarding and Vital," Hospitals (December 5, 1991) ("Collaboration"), at 25.

[16] An action to challenge a merger could also be brought under state law. In 1987, the National Association of Attorneys General ("NAAG") prepared a set of merger guidelines which purportedly embodied the enforcement procedures of its member states. (4 Trade Reg. Rep. CCH 13,405). Most enforcement activity in the hospital area, however, has taken place at the federal level. Ettinger, at 47. See, however, North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc., 722 F.2d 59 (4th Cir. 1983), cert. denied, 471 U.S. 1003 (1985) (the Attorney General of North Carolina brought suit alleging that the acquisition of a private psychiatric hospital by a hospital system, which would result in the system's ownership of all private psychiatric hospitals within the area served by the Western North Carolina Health Systems Agency, violated federal and state antitrust laws.)

[17] T. Singer, "Mergers After University Health," Presented before the National Health Lawyers Association, Antitrust In The Healthcare Field (January, 1992), at 9.

Many have complained that highly aggressive U.S. antitrust policy--challenging the combination of hospitals which may reduce costs by increasing capacity utilization and eliminating duplicative facilities--is inconsistent with the stated policy of U.S. health-care officials. These officials have aggressively encouraged hospitals to explore every avenue to reduce costs, including mergers, consolidations, and joint ventures.[19]

The apparent conflict between the messages being delivered by different branches of the United States government is not productive. Dr. Wilensky, previous Administrator of HCFA, recently stated that it is "not helpful to have different branches of government working in opposing directions."[20] The need for hospitals to reduce costs and the potential advantages associated with hospital mergers is straightforward. The competitive concerns of antitrust enforcers, however, may be less obvious and are discussed in the next section.

V. ANTITRUST OVERVIEW OF HOSPITAL MERGERS AND JOINT VENTURES

The most significant federal antitrust statute applying to mergers and acquisitions is section 7 of the Clayton Act.[21] Section 7 prohibits mergers and acquisitions of stock or assets where "in any line of commerce in any section of the country the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly."[22] Prior notification to the Federal Trade Commission and the Antitrust Division of a wide variety of merger and acquisition transactions, including certain joint ventures, is required by section 7A of the Clayton Act.[23] No "covered transaction" may be consummated without compliance with section 7A and the implementing regulations issued by the Federal Trade Commission,[24] including the filing of a Notification and Report Form and the expiration of a prescribed preacquisition waiting period, which may be extended or shortened by the Commission or the Antitrust Division.[25]

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[18] These cases are identified in Exhibit 4.

[19] Some have complained that the federal government's enforcement policy with respect to hospital mergers has been internally inconsistent, not challenging, for example, the merger of the only two hospitals in St. Augustine, Florida while successfully challenging the merger of two hospitals in Augusta, Georgia despite the existence of three other local hospitals. See Modern Healthcare (November 11, 1991) at 34. This issue is discussed in more detail in Section V.

[20] Collaboration, at 25.

[21] Mergers also may be challenged under section 1 of the Sherman Act (agreements which unreasonably restrain trade) and in certain circumstances under section 2 of the Sherman Act (monopolization, attempted monopolization, or conspiracy to monopolize). See, United States v. Rockford Memorial Corp., 898 F.2d 1279 (7th Cir. 1990) cert. den. 111 S. Ct. 295 (1990). Mergers may also be challenged under section 5 of the FTC Act if they constitute an "unfair method of competition." 15 U.S.C.§ 45 (1982).

[22] 15 U.S.C. § 18(1982). A great deal of debate has centered around the issue of whether section 7 of the Clayton Act has application to the combination of nonprofit hospitals. For a discussion of this issue, see Ettinger, at 3-5; and W. Kopit and R. McCann, "Toward a Definitive Antitrust Standard for Nonprofit Hospital Mergers," Journal of Health Politics, Policy and Law, Vol. 13, No. 4, (Winter 1988) ("Kopit and McCann"), at 647-654.

[23] Hart-Scott-Rodino Antitrust Improvements Act of 1976, Pub. L. No. 94-435, § 201, 90 Stat. 1390 (codified as amended at 15 U.S.C. § 18a (1982). Failure to report when required can result in civil penalties of not more than $10,000 per day.

[24] 16 C.F.R. §§ 801.1-803.90 (1983).

[25] The firms must wait thirty days after the notification is filed before consummating the acquisition. If, within that period, one of the agencies issues a "second request letter" asking for more in-

The Justice Department has stated its enforcement policies in Merger Guidelines, first issued by the Department of Justice in 1968 and replaced by another set in 1982, and another in 1984.[26] Also in 1982, the Federal Trade Commission issued a Statement Concerning Horizontal Mergers to "highlight the principal considerations that will guide its horizontal merger enforcement."[27] The Commission, in its Statement, indicated that it would give "considerable weight" to the Department of Justice Merger Guidelines.

On April 2, 1992, the Department of Justice and Federal Trade Commission issued, for the first time, joint Horizontal Merger Guidelines (hereafter referred to as the Merger Guidelines). These revised Merger Guidelines generally codify existing enforcement policy and more clearly explain how, in the view of the enforcement agencies, mergers may lead to adverse competitive effects.

The "unifying theme" of the Merger Guidelines is that a "merger should not be permitted to create or enhance market power or to facilitate its exercise."[28] Market power is defined in the Merger Guidelines as the ability of a seller to profitably "maintain prices above competitive levels for a significant period of time."[29] Put simply, the enforcement agencies are concerned that the loss of one competing hospital through merger may lead to higher prices, less non-price competition, and a lower quality of care.

The Merger Guidelines define markets, measure concentration, review entry conditions, analyze other factors that characterize the market, assesses alleged efficiency gains, and the possibility that but for the merger, either party to the transaction would be likely to exit the market. A brief overview of how these factors are applied with regard to hospital mergers is discussed below.[30]

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formation about the acquisition, it cannot be consummated for twenty days after the additional information is provided. Actual reviews may well last 120 to 180 days, if not longer. For a further discussion of these issues, see W. Miller, III, "What To Do When The Government Investigates," Presented before the National Health Lawyers Association, Antitrust In The Healthcare Field (January, 1992).

[26] 2 Trade Reg. Rep. (CCH) § 4510 (1968); 47 Fed. Reg. 28493 (1982); and 4 Trade Reg. Rep. (CCH) § 13,103 (1984).

[27] Trade Reg. Rep. (CCH) § 73 (extra ed. No. 546, June 16, 1982).

[28] Merger Guidelines, at 4.

[29] Id.

[30] This discussion is presented in the context of merger review. Joint ventures among healthcare providers may involve differing degrees of integration and control. If control is sufficiently organized such that the participants could behave as a single economic actor, the transaction would be analyzed using standard merger analysis. "Antitrust In The Healthcare Field," Remarks of Charles A. James, Deputy Assistant Attorney General, Antitrust Division, United States Department of Justice, Before the National Health Lawyers Association, Antitrust In The Healthcare Field (January 31, 1992) ("James Statement"), at 9. (Mr. James is presenting Acting Assistant Attorney General.) Conversely, if cooperative arrangements are less structured and meaningfully independent activity is possible, "collusion would require coordinated actions beyond those provided for under the venture, and thus the venture itself might not affect materially the likelihood of anticompetitive behavior." Id., at 10.

It should also be noted, however, that "legitimate joint ventures" must "share economic risks," "integrate operations" or "produce new products." Id., at 5. Arrangements that have no purpose other than to accumulate the "economic leverage of individual providers" may be prosecuted as price-fixing agreements or market allocation schemes. Id., at 6. A discussion of this issue is beyond the scope of this paper.

Before moving ahead, it should be noted that both the Department and the Commission have emphasized that the analysis of hospital mergers is no different than the analysis of mergers in other industries.[31]

A. Product Market

The first step in merger analysis is the definition of the relevant market. The relevant product market basically represents the products or services offered by the merging firms, as well as the products or services that buyers view as good substitutes at prevailing prices, and products or services to which buyers would switch to if the merging firms and their competitors raised prices above competitive levels. As a practical matter, in defining the relevant product market in hospital merger cases, the DOJ/FTC focus is upon the activities that comprise acute-care inpatient hospital services.

Hospitals provide a broad array of health-related services, including X-rays, clinical tests, and nursing care, among many others. Many of these services are also available on an outpatient basis from other providers, such as doctors' offices, clinics, urgent care centers, medical laboratories, and ambulatory surgery centers. Such competition may well suggest that defining a product market that excludes healthcare providers other than hospitals is too narrow. This is precisely the position adopted by the district court in United States v. Carilion Heath System, 707 F. Supp. 840 (W.D. Va. 1989), aff'd without opinion, 892 F.2d 1042 (4th Cir. 1989) ("Carilion"):

> Providers of outpatient services compete with providers of inpatient services for the same patients in a significant number of cases, [and] the court concludes that the relevant service market for this case includes not only other inpatient hospitals but also various outpatient clinics that treat medical problems for which patients might otherwise have sought treatment in an inpatient hospital setting.[32]

The enforcement agencies, however, have rejected this view. The more narrow view of market definition in hospital merger cases is best expressed by Judge Posner in United States v. Rockford Memorial Corp., 898 F.2d 1278 (7th Cir. 1990) cert. denied. 111 S.Ct. 295 (1990) ("Rockford"):

> For many services provided by acute-care hospitals, there is no competition from other sorts of provider. If you need a kidney transplant, or a mastectomy, or if you have a stroke, heart attack or a gunshot wound, you will go (or be taken) to an acute-care hospital for inpatient treatment. The fact that for other services you have a choice between inpatient care at such hospital and outpatient care elsewhere places no check on the prices of the services we have listed, for their prices are not linked to the prices of services that are not substitutes or complements.[33]

Robert E. Block, Chief, Professions and Intellectual Property Section at the Department of Justice, concluded in a 1991 speech that in the "context of hospital mergers, the pertinent inquiry is whether an attempted price increase resulting from an exercise of

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[31] "A New Concern In Health Care Antitrust Enforcement: Acquisition and Exercise of Market Power By Physician Ancillary Joint Ventures," Prepared Remarks of Kevin S. Arquit, Director, Bureau of Competition, Federal Trade Commission, Before the National Health Lawyers Association, Antitrust in the Healthcare Field (January 30, 1992); and James Statement, at 7-9.

[32] Carilion, at 847. In its unpublished opinion affirming the district court, the Fourth Circuit in Carilion held that "hospitals consist of a cluster of product markets, each with a different degree of substitutability between inpatient and outpatient services. Thus, the answer to the question of whether outpatient services should be included in the product market will vary with each type of health care service at issue." Carilion, 1989-2, Trade Cas. (CCH) ¶ 62,515. Judging the effect of the merger as a whole, outpatient care must be considered, said the Fourth Circuit, because it was "significant relative to the entire hospital." Id.

[33] Rockford, at 1284.

market power by hospitals in an area, would cause enough of their inpatients to substitute out-patient care to defeat the price increase."[34] He added:

> Hospitalization is substantially more expensive than outpatient care, and because it is, third-party payers will not pay for inpatient care unless it is truly needed. Therefore, it is clear today that patients are hospitalized only when their doctors conclude that their conditions cannot be treated safely and effectively on an outpatient basis. Given this fact, patients whose conditions require hospitalization for treatment could not use outpatient services as a substitute, in response to a significant increase in the price of inpatient care and, as a result, acute inpatient hospital care is a relevant product market for antitrust analysis.[35]

Although it may be possible to convince a court that acute-care inpatient services do not constitute a proper product market in which to evaluate the likely competitive effects of a merger, this argument will likely fall upon deaf ears at the FTC or DOJ.[36]

B. Geographic Market

The next step in the process is to define the relevant geographic market. The relevant geographic market will generally include those firms, acting jointly, who could raise price above competitive levels without losing such a large number of patients that the price increase would prove unprofitable. Important data in this analysis includes patient origin and destination statistics and how these patient flows might be altered if local hospitals, subsequent to a merger, raised prices (or decreased quality) above competitive levels. Other relevant factors include the location of hospitals in which physicians have privileges and the available alternatives open to managed care operators, among other factors.

The basic purpose of defining the geographic market is to identify the competitors who could individually or collectively constrain the merging firms from exercising market power. As explained by Charles Rule, former Assistant Attorney General for Antitrust at the Department of Justice, "if in response to a price increase at a rural hospital enough consumers in the rural area would travel to a nearby city for healthcare so as to render the increase unprofitable for that hospital, hospitals in the nearby city would be included in the relevant geographic market."[37]

The ultimate conclusions reached by DOJ/FTC when defining geographic markets related to hospital mergers is more difficult to define precisely than their position in defining a relevant product market. Nevertheless, the DOJ/FTC position would tend to appear to support more narrow--as opposed to broad--geographic markets. In Rockford, consistent with Department arguments, the Seventh Circuit included within the

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[34] "Antitrust Enforcement In The Healthcare Field: A Report From The Department of Justice," Remarks by Robert E. Block, Chief, Professions and Intellectual Property Section, Before the Fourteenth Annual National Health Lawyers Association (February 15, 1991) ("Block Statement"), at 15-16.

[35] Id., at 16.

[36] Other courts, however, have basically adopted the same position as articulated by Judge Posner in Rockford. See, for example University Health, at 1210-1211. Moreover, it is possible that DOJ/FTC may actually define even smaller service areas as separate markets. See, for example, United States v. Hospital Affiliates International, Inc., 1980-81 Trade Cas. (CCH) § 63,721 (E.D. La. 1980), consent decree entered, 1982-1 Trade Cas. (CCH) § 64,696 (E.D. La. 1982).

[37] "Antitrust Enforcement and Hospital Mergers: Safeguarding Emerging Price Competition," Remarks of Charles F. Rule, Former Assistant Attorney General, Antitrust Division, U.S. Department of Justice, Before the National Health Lawyers Association's Eleventh Annual Seminar on Antitrust in the Healthcare Field (January 21, 1988) ("Rule Statement") at 9.

market only the hospitals to which Rockford area residents, as a practical matter, would be likely to turn if the prices charged by the merging hospitals rose above competitive levels.[38] In Carilion, on the other hand, the Fourth Circuit approved a broadly defined market consisting of 16 counties, three independent cities of Virginia and three counties of West Virginia (as opposed to one county and parts of four others in Rockford).[39] This definition was based on that area from which one of the merging hospitals drew at least 100 patients a year.[40]

The DOJ, quite obviously, disagreed with this conclusion. Mr. Block concluded that the Carilion test was "unrealistically broad" and ignored the "critical question" i.e., "in the face of a price increase by the hospitals in the market" would enough patients "switch to the outlying community hospitals in sufficient numbers to defeat the price increase."[41] The DOJ/FTC position on geographic markets was best summarized by Mr. Rule:

> In most cases, the geographic market will be highly localized. This conclusion reflects the strong needs and preferences of both patients and their physicians for convenience, for prompt service in time of emergency, and for accessibility to relatives and others in the community during a hospital stay.[42]

There may well be fact patterns, however, that would support a broader geographic market in the view of DOJ/FTC officials. For example, as noted earlier, the FTC did not challenge the merger of the only two hospitals located in St. Augustine, Florida. According to certain press reports, the parties to that transaction argued that convincing evidence (patient origin data, supported affidavits, etc.) demonstrated that the hospitals in Jacksonville, roughly 30 miles away, competed in the same geographic market with those in St. Augustine. The FTC may well have agreed with this position, and this conclusion would explain why--despite apparent conflicts with previous decisions--the FTC decided not to challenge this acquisition.[43]

C. Market Concentration

Once the market is established, DOJ/FTC calculate industry concentration using the Herfindahl-Hirschman Index ("HHI"). The HHI is calculated by adding together the squares of the market shares of the firms in the market. The important HHI figures in merger analysis are the HHI after the merger (post-merger HHI) and the increase in the HHI caused by the merger. Using these two figures, the Merger Guidelines create thresholds for analyzing mergers based on the HHI.

Mergers in markets with post-merger HHI levels between 1000 and 1800 and an increase in the HHI of more than 100, as well as mergers in markets with post-merger

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[38] Rockford, at 1284-1285.

[39] Carilion, at 847-48.

[40] Id.

[41] Block Statement, at 17-18.

[42] Rule Statement, at 9. Indeed, Mr. Block suggests that in certain metropolitan areas, part of a city may well represent a separate geographic market. Block Statement, at 19-20.

[43] It should also be noted that a hospital may serve product markets of different geographic scope. In general, hospitals are likely to have a smaller drawing area for primary (basic acute-care) and secondary care (acute-care and other more difficult medical problems) and a larger drawing area, perhaps even national, for highly specialized tertiary care. Hospitals that provide tertiary care can generally attract patients from a very large geographic market for these specialized services, but may not compete with far-away hospitals for primary and secondary level acute inpatient care. See Rule Statement, at 10.

HHI levels above 1800 and a post-merger increase of between 50 and 100 points, will "raise significant competitive concerns" and will require a close analysis of competitive conditions in the market. Mergers in markets with post-merger HHI levels above 1800 and a HHI increase of more than 100 will face a rebuttable presumption that they will create or enhance market power or facilitate its exercise.[44]

Given the rather limited number of hospitals in many areas of the country, these structural thresholds create a substantial burden on parties advocating the merger of two competitive hospitals. Mr. Rule agreed:

> It is clear that many of the hospital markets in this country fall into the highly concentrated category -- that is, the HHI exceeds 1800. This is because towns and smaller cities simply can not support the minimum number of independent hospitals that must be in a market in order to keep the HHI level below 1800. For example, even if there were five equally large hospitals in a community, the pre-merger HHI would still be 2000 points. But many communities are just not that large, and it is not uncommon to find rather large communities with a need for only 500 beds and no more than 2 or 3 hospitals supplying those beds.
>
> Consequently, when we are faced with a merger in a town or small city, we find that the market has a post-merger HHI substantially above 1800, with a change of at least several hundred points. For example, even if a merger moved a market from 5 equally large hospitals to 4, the post-merger HHI would be 2800 and the increase would be 800.[45]

The heavy reliance of DOJ/FTC on concentration statistics is predicated on the theory that fewer numbers of hospitals will lead to higher prices, less non-price competition, or lower quality of service. However, the great majority of the literature which addresses this issue suggests the opposite conclusion: prices for hospital services are higher the larger the number of hospitals which exist in a given market.[46] In Carilion, for example, statistical evidence was presented demonstrating that "as a general rule hospital rates are lower, the fewer the number of hospitals in an area."[47] If this empirical evidence is meaningful, it would suggest that the reliance placed on concentration ratios by DOJ/FTC when attempting to predict the competitive impact of a merger of two hospitals is misplaced.[48]

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[44] Merger Guidelines, at 29-31. The pre-merger HHI level is established by adding the totals of the squares of the "market shares" of all the competitors. For example, in an industry with ten competitors who each have a 10 percent market share, the pre-merger HHI level would be 1000. [10 firms times 10 squared = 10 x 100 = 1000.] The increase in the post-merger HHI level is determined by doubling the product of the shares held by the acquirer and the target. Thus, if the two companies have respective market shares of 5 percent and 10 percent, the merger would increase the pre-merger HHI level by 100 points. [5 x 10 x 2 = 100]. This same figure can be obtained by subtracting the pre-merger HHI from the post-merger HHI.

[45] Rule Statement, at 12. This dilemma was also highlighted in a recent article concerning hospital mergers:

> To understand the significance of these standards, a postmerger HHI of 2,800 might result from a merger of two out of five hospitals in a market where each hospital had equal market share. In a three-hospital market, the smallest value the HHI could have after a merger is 5,001. Generally, a market would have to have more than six hospitals in order for a merger of any two to produce an HHI of less that 1,800. Obviously, only large communities have as many as six hospitals; indeed, federal and state health planning policies historically have discouraged the proliferation of hospital facilities.

W. Kopit and R. McCann, at 640.

[46] See Kopit and McCann, at 645-646 for a review of this literature.

[47] Carilion, at 846.

[48] Mr. Block, of the Justice Department, recently stated that a significant concern associated with

It has been suggested, however, that the available empirical data is, at the present time, not sufficiently robust to support firm conclusions. In Rockford, Judge Posner observed: "It is regrettable that antitrust cases are decided on the basis of theoretical guesses as to what particular market-structure characteristics portend for competition ... We would like to see more effort put into studying the actual effect of concentration on price in the hospital as in other industries. If the government is right in these cases, then, other things being equal, hospital prices should be higher in markets with fewer hospitals. This is a studiable hypotheses, by modern methods of multivariate statistical analysis, and some studies have been conducted correlating prices and concentration in the hospital industry . . . . Unfortunately, this literature is at an early and inconclusive state."[49]

Therefore, it would appear prudent for all concerned parties to increase the level of research in this critical area. Nevertheless, at the present time, hospital markets typically are relatively concentrated and, as a result, many mergers may be viewed as highly suspect under the Merger Guidelines based on concentration data alone. Judge Posner argued that the "government is not required to await the maturation of the relevant scholarship in order to establish a prima facie case."[50]

D. Entry

Market share and concentration data, however, are only the first step in merger analysis. An examination of many other relevant economic factors may well support the conclusion that a particular merger or joint venture is no threat to competition. Entry is one such factor. Indeed, modern antitrust analysis puts the conditions of entry in an industry on a virtually even footing with characteristics of market structure such as concentration. In fact, in some respects, conditions of entry take precedence over structure in that ease of entry can promote competition irrespective of underlying concentration statistics.[51]

The enforcement agencies have generally reacted negatively to the prospect of new entry foiling or disciplining any anticompetitive price increase facilitated by a merger of two hospitals. DOJ/FTC officials generally point to state certificate of need regulation, as well as the significance of economies of scale, as generally making entry by new hospitals into many markets unlikely (in addition to the existence of substantial unused capacity at the present time). It should be noted, however, that certain states never had

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hospital mergers is whether, after the merger, remaining hospitals continue to provide discounts to third-party payers. Block Statement, at 12. This is, of course, a legitimate concern but, again, it would appear reasonable that the relationship between numbers of hospitals and levels of discounts could be tested empirically. (In this regard, one should view cautiously any alleged studies concerning the relationship between levels of discounts and numbers of hospitals which do not control for the many other relevant factors that could impact this relationship.)

[49] Rockford, at 1286.

[50] Rockford, at 1286.

[51] Rather than focusing on "barriers to entry," the proper focus is on analyzing ease of entry or the likelihood of entry in response to noncompetitive pricing. Analyzing entry in terms of barriers can be misleading in that many so-called barriers are often nothing more than requirements for entry that entrants with varying degrees of ability can meet. Requirements that may reduce the probability of entry are those with significant (relative to the scale of the business) fixed costs that cannot be substantially recovered through resale in the event of exit. Highly specialized and costly production equipment for which there is no resale market is an example; delivery trucks would not be a good example because they can be readily used in a number of different businesses.

certificate of need laws, others have eliminated these regulations, while still others have relaxed existing obstacles to expansions of capacity.

Moreover, entry or expansion -- each having the effect of disciplining attempts to raise prices above competitive levels -- can take other forms. For example, existing hospitals could expand output. In Carilion, the district court concluded that certain hospitals were using "substantially fewer beds than their licensed capacity and could expand to their full licensed quotas without obtaining state approval."[52] Other methods of expansion could include certain hospitals expanding the number of services offered, if not restricted by certificate of need laws, and thereby providing new competition in the marketplace. Similarly, somewhat distant hospitals could attempt to attract increased numbers of patients by more aggressively promoting their services in the relevant local area, among other possible means of entry and expansion.

E. Other Factors

Parties to a proposed merger could also point to other factors that may well suggest that a proposed acquisition or joint venture is not likely to be anticompetitive.[53] For example, there may be evidence that a particular hospital - not party to the merger - is a "maverick" competitor unlikely to participate in any anticompetitive activity. Parties could also emphasize that capacity is available to managed care providers--outside of the facilities controlled by the merging parties--providing these buyers with sufficient competitive alternatives to preserve existing discounts. Other relevant factors could include the increasing number of services provided by outpatient competitors, the complex and dynamic nature of the cluster of heterogeneous services offered by competing hospitals, and the general difficulties associated with attempts to raise prices above competitive levels in the face of DRG-based rates and large buyers such as significant managed care providers.[54] (It should be noted, that the views of buyers such as these concerning the likely competitive impact of a merger is quite important to the enforcement agencies because they may well be adversely affected by any anticompetitive conduct.)

F. Efficiencies

Most mergers or joint ventures between hospitals are motivated by the need and desire to lower costs and become more efficient. Cost savings or efficiencies can be generated by spreading fixed costs over higher occupancy rates. Mergers can also lower

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[52] Carilion, at 845.

[53] These factors are discussed in great detail in the Merger Guidelines under the general heading of "Competitive Effects." See Merger Guidelines, at 33-46.

[54] This argument was rejected in Hospital Corp. of America, 106 FTC 361 (1985), aff'd, 807 F.2d 1301 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987):

> But the role of the third-party payor is not quite that of a large buyer. The explicit contract between the insurance companies and their patients, and the statutory and regulatory obligations of government to Medicare and Medicaid recipients, require reimbursing patients for hospital services. Of course the insurer is not required to, and no insurer does, reimburse the insured for whatever services are consumed, regardless of price. But as a practical matter Blue Cross could not tell its subscribers in Chattanooga that it will not reimburse them for any hospital services there because prices are too high.

HCA, at 1391.

costs if duplicative services are consolidated or eliminated, particularly in situations where the hospitals have complementary strengths and weaknesses. For example, as discussed by Mr. Rule, two "merging hospitals can lower total costs if Hospital A transfers all of its obstetric and pediatric care to Hospital B and Hospital B transfers it psychiatric and substance abuse units to Hospital A."[55] Other possible savings may be generated by lowering input costs and reducing capital costs.

The Merger Guidelines recognize the relevance of efficiencies and DOJ/FTC will consider such claims when exercising its prosecutorial discretion.[56] However, there is some serious question as to how much weight these potential efficiencies will receive when presented to the enforcement agencies. First, DOJ/FTC will "reject claims for efficiencies if equivalent or comparable savings can reasonably be achieved by the parties through other means."[57] For example, as discussed by Mr. Rule, if hospitals can lower the cost associated with laundry and laboratory operations or with purchasing medical supplies by entering into third-party contracts or joint ventures, these same efficiencies generated by a merger will be given no credit.[58] As Mr. Arquit, Director of the Bureau of Competition at the Federal Trade Commission, stated in April, 1992: "Comparable cost reductions that could be achieved in other ways, such as through a merger or joint venture with a different firm, are not cognizable efficiencies."[59] Mr. Arquit also concluded that efficiencies not passed on to consumers would not be given any meaningful hearing.[60]

Moreover, Mr. Arquit argued, the FTC "seldom see a cogent efficiency justification argument, usually because these 'stories' are not backed by credible facts."[61] Many efficiency arguments, according to Mr. Arquit, are purely "speculation." Mr. Arquit provided the following example to support his position:

> The speculative nature of claimed efficiencies is revealed in a recent followup report on a certain hospital merger. Over the objection of the Justice Department, the district court allowed a merger of two hospitals to proceed in Roanoke, Virginia, [Carilion] in part because of claimed efficiencies. Now, nearly two years after the merger, an effort has been made to determine if the efficiencies have been achieved. So far, the answer appears to be no. According to a recent article, [in Modern Healthcare] prices rose after the merger and remain above premerger levels, although the extent to which the price increases result from the exercise of market power is unclear. While there remains hope that efficiencies will be achieved, the article reports that the premerger estimates of the costs and time necessary for accomplishing the efficiencies were substantially underestimated.[62]

Of course, at the time of merger, prior to actual integration, planned efficiencies must be based on estimates. They should not be discarded for this reason. Moreover, the fact that actual savings take time to materialize is not a reasonable basis for disqualification. Most disconcerting, however, is the apparent lack of actual empirical

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[55] Rule Statement, at 17.

[56] Merger Guidelines, at 55-56; and "Further Thoughts On The 1992 U.S. Government Horizontal Merger Guidelines," Prepared Remarks of Kevin S. Arquit, Director, Bureau of Competition, Federal Trade Commission, Before the State Bar of Texas (April 24, 1992) ("Arquit Texas Speech"), at 9-14.

[57] Merger Guidelines, at 56.

[58] Rule Statement, at 14-15.

[59] Arquit Texas Speech, at 10.

[60] Id., at 11.

[61] Id. at 11.

[62] Id., at 12-13, (footnotes deleted).

evidence to support the position that this particular hospital merger--or the many other combinations of hospitals over the last ten years--have not generated actual cost savings. The article cited by Mr. Arquit is devoid of any reliable statistical data concerning the performance of these hospitals.[63] As with the issue of the relationship between the number of hospitals and pricing, there would appear to be a need for serious empirical research concerning the issue of hospital mergers and cost savings.

The enforcement agencies' hostility to efficiency arguments in the hospital area manifested itself in University Health. In this matter, involving the proposed merger of hospitals in Augusta, Georgia, the FTC argued that the acquisition would reduce the number of competitors in the market from five to four and increase concentration unacceptably. The Eleventh Circuit granted an injunction to the FTC, reversing the lower court's ruling, and the parties abandoned the transaction. In this matter, in response to efficiency arguments advanced by the parties, the FTC argued to the Eleventh Circuit "that the law recognizes no such efficiency defense in any form."[64] Although the Eleventh Circuit rejected the FTC's argument, concluding that an efficiency defense is appropriate in certain circumstances, the FTC's position highlights an obvious hostility to the main driving force motivating hospital combinations. Similarly, the FTC claimed that the parties' apparent representation that duplicative facilities and resulting costs would be reduced by the merger--another apparent motive for certain hospital mergers--was anticompetitive because it evidenced an intent to reduce non-price competition.[65]

G. Failing Firm

Many merging hospitals also argue that absent the merger, one of the hospitals will exit the market. This so-called "failing firm" argument is also recognized as relevant to merger enforcement in the Merger Guidelines.[66] This argument, however, similar to the response to efficiency claims, is apparently not viewed in high regard by enforcement officials. Mr. Arquit recently observed:

> Evidence allowing us reasonably to predict the future effects of recent or ongoing changes in the market--such as a vital new technology that the firm lacks but its competitors possess--will be taken into account in interpreting market concentration data. Serious and sustained financial difficulties may be a symptom of a firm's more fundamental, structural disadvantages that undercut the firm's future competitiveness, and they will be relied upon as such. What is necessary under this section, however, is evidence of the actual structural disadvantages that in turn may prevent a company in financial difficulty from being a strong competitor in the future. It must be emphasized that the financial data, by itself, does not establish structural disadvantage.[67]

In order to successfully mount a failing firm defense, a party must demonstrate that (1) the allegedly failing firm would be unable to meet its financial obligations in the near future; (2) it would not be able to reorganize successfully under Chapter 11 of the

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[63] The article also points out that Carilion has embarked on a program to consolidate many services (including pediatric services, obstetrics, and gynecology services, among others), that the business community has not complained about the prices or service offered by the newly combined entity or that the most direct competitor of the merged entity complains bitterly about the enhanced competition from Carilion and, in response, has begun an open-heart surgery program, opened a surgical intensive-care unit, opened two operating-room suites, and expanded its inpatient oncology services.

[64] University Health, at 1222 (emphasis added).

[65] Id., at 1220.

[66] Merger Guidelines, at 56-58.

[67] Arquit Texas Speech, at 16.

Bankruptcy Act; (3) it has made unsuccessful good-faith efforts to elicit reasonable alternative offers of acquisition of the assets of the failing firm that would both keep its tangible and intangible assets in the relevant market and pose a less severe danger to competition than does the proposed merger; and (4) absent the acquisition, the assets of the failing firm would exit the relevant market.[68]

VI. POTENTIAL POSITIVE STEPS

Certain actions would help facilitate a rational and coordinated response to the difficulties now encountered by many hospital administrators as they try to respond to the increasing pressure to reduce cost through consolidation and elimination of duplicative facilities. These steps include:

1. Enhanced Coordination Between Government Healthcare Officials and Representatives of the DOJ and FTC. There would appear to be an apparent conflict in the positions articulated by agencies such as HCFA (encouraging mergers, sharing facilities, and eliminating duplicative facilities) and the DOJ/FTC rejection of these arguments as insufficient to overcome certain competitive concerns. This apparent conflict can be mitigated, in part, by improved communication between the respective agencies. Certain public reports suggest such cooperation is taking place and it should continue on a regular basis.[69]
2. Enhanced Communication Between Representatives of the Hospital Industry and DOJ/FTC Officials. An open exchange of ideas would reduce uncertainty between government and private officials concerning the relevant factors critical to hospital competition and survival and how the government views the importance of these various factors. Certain public reports suggest such meetings have taken place and they should continue on a regular basis.[70]
3. Pass Legislation Related to Production Joint Ventures. Acting Assistant Attorney General James recently urged the implementation of legislation proposed by the Administration related to production joint ventures. The legislation would clarify the fact that legitimate production ventures would receive rule of reason treatment under the antitrust laws. Mr. James commented that such legislation "would likely apply" to "arrangements among healthcare providers to jointly operate certain high-cost equipment, where it would make little economic sense for each provider to have its own."[71]
4. Consider Seriously S. 2277, the Hospital Cooperative Agreement Act. The purpose of this Act is to "encourage cooperation between hospitals in order to contain costs and achieve a more efficient healthcare delivery system through the elimination of unnecessary duplication and proliferation of expensive medical or high technology services or equipment." The Act would establish and award ten 5-year grants to "facilitate collaboration among two or more

[68] See also, University Health, at 1221 for a discussion of the failing firm defense.

[69] See Collaboration, at 25 (discussing meetings between representatives of HCFA and DOJ/FTC to discuss hospital merger policy).

[70] Id. (discussing meetings between representatives of the American Hospital Association and DOJ/FTC officials to address antitrust policy).

[71] James Statement, at 13.

hospitals" and to study how cooperative ventures "result in a reduction in costs, an increase in access to care, and improvement in the quality of care with respect to the hospitals involved."

5. Enhance Research Efforts of Actual Cost Savings Associated With Completed Hospital Mergers. As discussed previously, much of the debate concerning the importance of cost savings associated with hospital combinations apparently takes place without rigorous and systematic statistical evidence of actual experiences. Such evidence should be gathered and closely analyzed.
6. Enhance Research Into the Relationship Between the Number of Hospitals and the Level of Prices, Non-price Competition, and Quality of Service. As discussed previously, this important element of merger enforcement as it relates to hospitals requires more significant research efforts.

There have been other proposals that should be viewed cautiously. For example, certain legislation has been introduced, H.R. 2406, which would grant apparent antitrust immunity to mergers between hospitals meeting certain conditions. One such condition is that HCFA would grant a certificate specifying that "Federal expenditures would be reduced, and consumer costs would not increase." Such legislation may well create great debate as to which hospitals might qualify for the exemption, thereby creating greater uncertainty for some members of the business community. It also would apparently transfer some form of antitrust review from current enforcement agencies to HCFA. Neither outcome is necessarily desirable from a public policy standpoint.

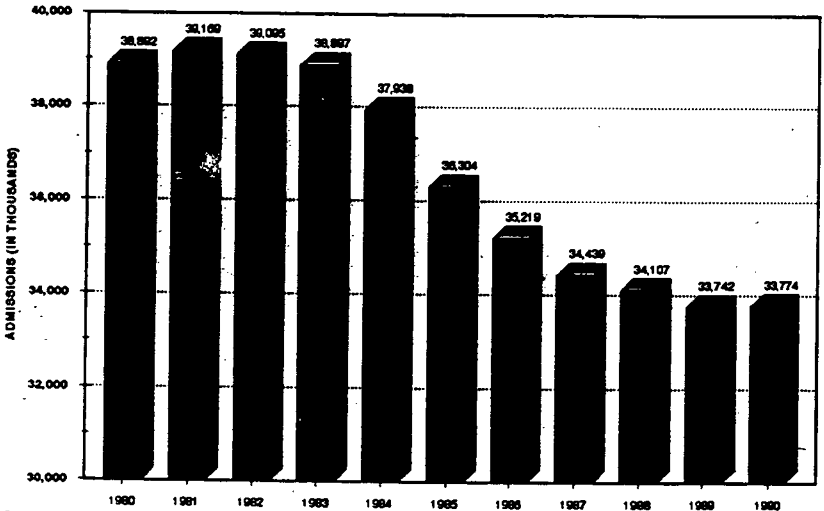
In a more general sense, there should be an increased emphasis on promoting proper incentives (linking costs and benefits) to relevant economic actors in the healthcare field, including the possible increased use of managed or coordinated care, for example. Similarly, restrictions on competition such as limitations on entry should be carefully reviewed to determine if elimination of such restraints would, again, provide for greater competition in the healthcare industry. All proposed changes should be directed at removing patients' insulation from the actual costs of their healthcare purchasing decisions.

VII. CONCLUSION

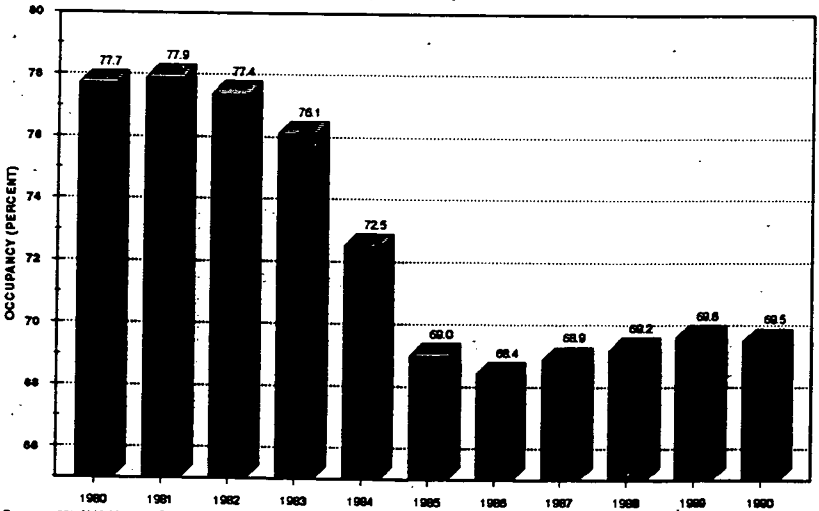
Rising healthcare costs in the United States represent a serious threat to our long-term economic viability. At current levels of growth, public and private healthcare spending would represent 16 percent of GNP in the year 2000 and 26 percent of GNP by 2030. Medicare (Parts A and B) presently represent 9 percent of the federal budget and is projected to exceed 27 percent by the year 2025. These trends, quite obviously, cannot continue.

It will take many individual actions to arrest this trend. One critically important action is to create an environment in which hospitals can merge, consolidate facilities, eliminate duplicative facilities, and jointly share equipment in a manner which both substantially lowers healthcare costs and does not meaningfully threaten a high level of effective competition between healthcare providers.

EXHIBIT 1



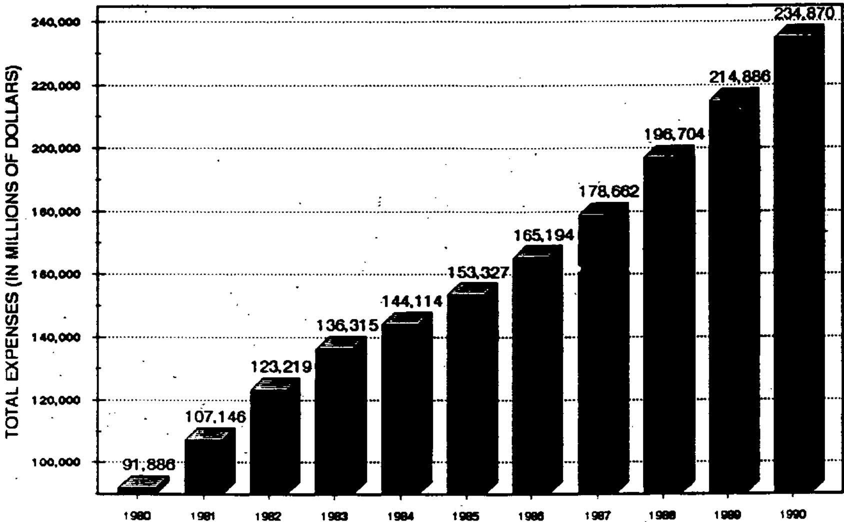
Source: 1991 AHA Hospital Statistics



Source: 1991 AHA Hospital Statistics

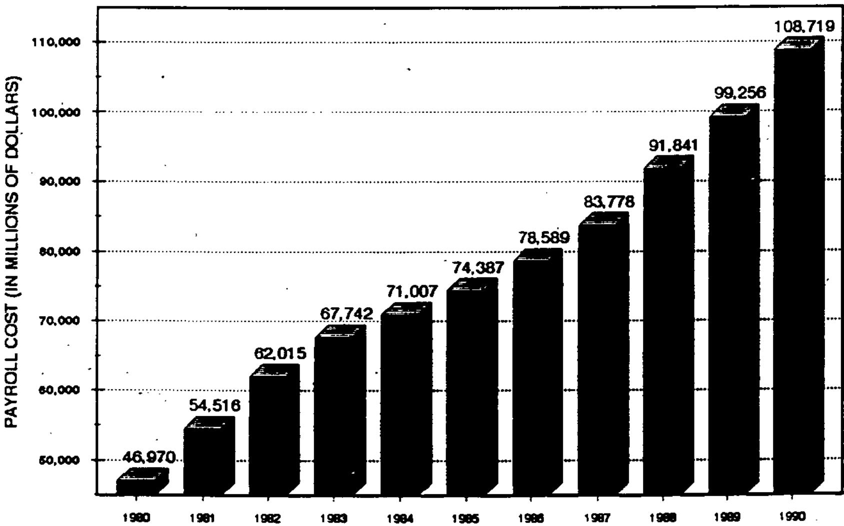
EXHIBIT 2

TOTAL EXPENSES AT U.S. HOSPITALS
1980 - 1990
(IN MILLIONS OF DOLLARS)



Source: 1991 AHA Hospital Statistics

PAYROLL COSTS AT U.S. HOSPITALS
1980 - 1990
(IN MILLIONS OF DOLLARS)



Source: 1991 AHA Hospital Statistics

EXHIBIT 3

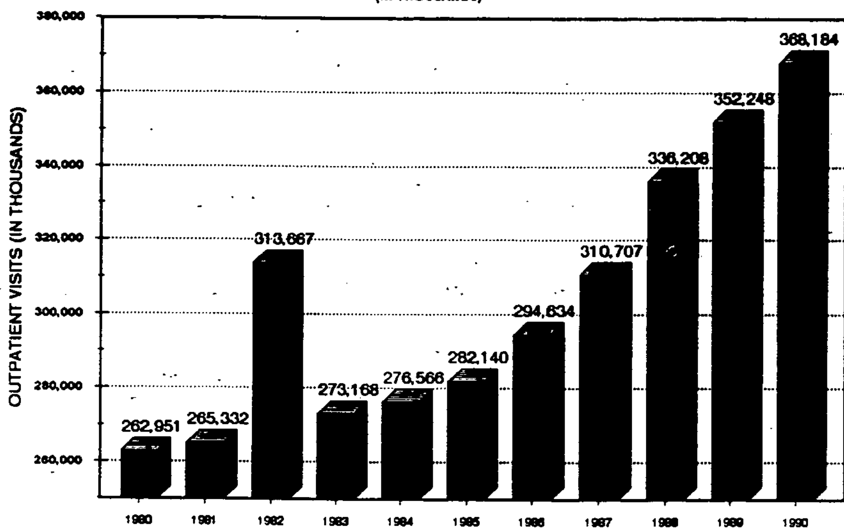


EXHIBIT 4

CHALLENGED HOSPITAL MERGER CASES: U.S. GOVERNMENT

1. 1980 [DOJ] — U.S. v. Hospital Affiliates Int'l, Inc., 1980 - 81 Trade Cas. (CCH) 63,721 (E.D. La. 1980), consent decree entered, 1982-1 Trade Cas. (CCH) § 64,696 (E.D. La. 1982)

   - attempted merger of two psychiatric hospitals
   - preliminary injunction enjoining merger

2. 1984 [FTC] — American Medical International, 104 FTC 1 (1984) (order modified 104 FTC 617 (1984) and 107 FTC 310 (1986))

   - FTC Administrative proceeding
   - Acquisition of French Hospital in city/county of San Luis Obispo, California
   - Consent order: divestiture of French Hospital

3. 1985 [FTC] — Hospital Corp of America, 106 FTC 361 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987).

   - FTC Administrative proceeding
   - Acquisition of several hospitals by proprietary hospital chain in Chattanooga, Tennessee
   - Consent order: divestiture of two hospitals, termination of management contract with third

4. 1985 [FTC] — Hospital Corporation of America, 106 FTC 298 (1985) (consent order modified 106 FTC 609 (1985))

   - Acquisition of Forum Group, Inc. hospitals
   - Consent order required divestiture of:
     2 psychiatric hospitals, Norfolk, VA
     1 acute care hospital, Midland/ Odessa, Texas

5\. 1987 [DOJ] U.S. v. National Medical Enters., 1987 - 1 Trade Cas. (CCH) 67,640 E.D. Cal. 1987) (consent decree)

- attempted merger in Modesto, CA

6\. 1989 [DOJ] U.S. v. Carilion Health, System. Inc. 707 F. Supp. 840 (W.D. Va. 1989), aff'd 892 F.2d 1042 (4th Cir., 1989)

- attempted merger of two hospitals in Roanoke, VA
- merger approved

7\. 1989 [FTC] Adventist Health System/West. 5 Trade Reg. Rep. (CCH) 22,761 (FTC complaint, Nov. 7, 1989)

- Acquisition of for-profit hospital by non-profit chain in Ukiah, California
- ALJ dismissed complaint, lack of jurisdiction
- reversed by Commission
- stay pending Court of Appeals ruling on jurisdiction

8\. 1990 [FTC] The Reading Hospital. C-3284 (FTC consent order issued April 20, 1990, 55 Fed. Reg. 15,290 (April 23, 1990))

- merger of two hospitals into a new corporation in Reading, PA
- Consent agreement: affiliation terminated

9\. 1990 [DOJ] U.S. v. Rockford Memorial Corp., 898 F.2d 1278 (7th Cir. 1990), cert. denied, 111 S.Ct. 295 (1990)

- attempted merger between two non-profit hospitals in Rockford, Illinois
- merger stopped (preliminary/permanent injunction)

10\. 1991 [FTC] FTC v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991), rev'g 1991-1 Trade Cas. 69,400 (S.D. Ga. 1991)

- attempted merger of two non-profit hospitals in Augusta, Georgia
- preliminary injunction denied by district court on merits, FTC jurisdiction upheld
- preliminary injunction issued; transaction abandoned

REPRESENTATIVE STARK. Ms. Ricardo-Campbell, please proceed.

STATEMENT OF RITA RICARDO-CAMPBELL, SENIOR FELLOW HOOVER INSTITUTION

Ms. RICARDO-CAMPBELL. Thank you. I am a senior fellow at the Hoover Institution at Stanford University. I used to work for the House Ways and Means Committee many, many years ago.

REPRESENTATIVE STARK. You certainly seem to have gotten over that without any noticeable side effects.

Ms. RICARDO-CAMPBELL. Thank you for inviting me.

I stress that I am not a lawyer. I am an economist. To me, a hospital organization is a business like any other business. Now, there may be some slight differences, but they are not noticeable to an economist—prominently noticeable—whether they are for profit or they are not for profit. Either way, I think the hospital is out to make money.

I point out, it is health care that is the expanding industry in the United States and also that it is fairly profitable, on average. If you look at your investment sheets, you will see that the operating margins on all hospitals averages 2.9 percent and in Kaiser, which is a nonprofit hospital, it was about 5 percent. All these figures——

REPRESENTATIVE STARK. Kaiser?

Ms. RICARDO-CAMPBELL. Kaiser.

REPRESENTATIVE STARK. They are not really a hospital.

Ms. RICARDO-CAMPBELL. They own their hospitals. That is how they make money.

Let me go into this a little bit at the end. That is a vertical merger.

I believe that the informed consumer can monitor the markets. I define the informed consumer as not only as you and myself and others but as the business firm that is paying the very large proportion of the bill. I brought along an item written by me called, "Business, Health Care Costs, and Competition," which I think people here might well read to get some information.

The big opposition to a merger are the people who feel that they will lose their job. That is always the opposition. It doesn't make any difference whether it is a business firm in the sense of making cars, airplanes, hospitals, or whatever they are doing.

I point out that I am for the idea of having more hospitals merge. Fifty-four percent of community hospitals and 60 percent of the hospital beds that are in hospitals are in chains or hospital systems. These have already been merged.

I am in agreement with people arguing that there should be some exemption in the hospital sector under antitrust. When I served on the Health Services Industry Committee in 1971 through 1974, it was very seriously discussed that if a hospital had less than a 50 percent occupancy rate that it should be forced to close.

REPRESENTATIVE STARK. Do you think that was a good idea?

Ms. RICARDO-CAMPBELL. Yes. I think it is usually a small hospital with low occupancy rate that can't make it. And that is the one big difference between a hospital and regular business. When you are not making it, you haven't got tax dollars to keep you in business.

The total number of hospitals that closed in 1991 was 45, and their average size was 73 beds.

REPRESENTATIVE STARK. Do you know why half of them closed, of those 45?

Ms. RICARDO-CAMPBELL. No, I don't.

REPRESENTATIVE STARK. The doctor died or moved out of town. And the other half merged or became a nursing home or something else.

Do you know how many hospitals there are? Six thousand. Does it sound like a death rate that would concern you?

Ms. RICARDO-CAMPBELL. That is what the problem is. Some of these hospitals should go out of business, in my opinion.

REPRESENTATIVE STARK. All right.

Ms. RICARDO-CAMPBELL. I believe that the geographic area from which hospitals are drawing their patients is greatly increasing, and that is due to the greater availability of medical information through the national news periodicals, through CNN television, faxes and personal computer searches. If you notice the *U.S. News and World Report* of June 15 of this year, it describes 16 top medical specialties and the top hospitals for these specialties in the United States.

REPRESENTATIVE STARK. Who was the champion of champions in that article, do you recall? The best of the best. Was it in *U.S. News*?

Ms. RICARDO-CAMPBELL. It was *U.S. News and World Report*.

REPRESENTATIVE STARK. It was Johns Hopkins. The best of the best was Johns Hopkins. We are going to talk about that later.

Ms. RICARDO-CAMPBELL. I computed the average number of beds; over 580 beds per hospital, and five were over 1,000-bed hospitals. These are the hospitals that make money because they are large enough that they can shift their costs from one class of payer to another class. That, I would be happy to answer questions on.

The increasing level of technology means that hospitals need more access to capital, and a small hospital doesn't have the access to capital to purchase the expensive MRI and usually cannot specialize.

REPRESENTATIVE STARK. Okay.

Ms. RICARDO-CAMPBELL. The material sent to me had a case of the Southern Illinois University Medical School, which had a prohibition on staff doctors admitting patients to competing hospitals. I can't understand why that is accepted. I think what we need is competition among hospitals, and if the information were out to consumers about——

REPRESENTATIVE STARK. What are the hospitals going to compete for?

Ms. RICARDO-CAMPBELL. The patients. They are competing for patient volume.

Representative Stark. How does the patient decide which hospital to go to?

Ms. Ricardo-Campbell. Referral, what his friends tell him, what he reads in the news, and what his physician tells him—the staff physician. But that is changing.

Representative Stark. You think so. Do you want to spend a weekend with me in Duluth, Minnesota, if they offered us a special suite? We wouldn't go to a hospital unless somebody told us to. You wouldn't.

Ms. Ricardo-Campbell. Basically, people read that—

Representative Stark. They read all about it. If it is a death trap, if it is Capitol Hill Hospital, or if it is Bethesda Naval Hospital, you say, wait a minute, doctor, isn't there someplace else?

Ms. Ricardo-Campbell. The business firms are concerned that their employees——

Representative Stark. We will let that part settle for a minute. Go ahead.

Ms. Ricardo-Campbell. I am getting a lot of calls from GAO on business firms, and basically they have been negotiating directly with hospitals for a form of DRG, covering both the hospital and physician.

I think that these charges are volume discounts, and hospitals just can't give everybody a volume discount and make any money. That is one of the biggest problems. You have Medicare and Medicaid. Every payer gets a volume discount.

I believe what is missing in the proposal, as you mentioned, are joint ventures. I have been on corporate boards—a source of income. A joint venture, which I am worried about, is that hospitals are competing by purchasing group practices. They are merging vertically.

Representative Stark. They are purchasing patients.

Ms. Ricardo-Campbell. That is purchasing patients, but I am worried about it.

Representative Stark. How do you feel about being traded around like a pork belly? Doesn't that bother you some?

Ms. Ricardo-Campbell. I think it is very interesting.

I come from California across the Bay on the other side. A year ago, El Camino Hospital in Los Altos was in the newspaper that it was merging with two other groups—Shoreline and some other group—and this was protested by the community. Under the California law a hospital district can apparently transfer all the assets for more, or some money, to the medical groups and/or the newly-formed foundation. I am concerned about foundations doing that.

This resurfaced just as I left.

Representative Stark. There are guys in Los Angeles who made a couple hundred million dollars in a recent deal that was so bad that it would make you throw up, under the guise of a nonprofit charitable operation. And that is troublesome.

Ms. RICARDO-CAMPBELL. I will just close with the Subcommittee's request to comment about merger policy of hospitals, depending upon what the national health policy might be. This is, to me, rather difficult except to state that uncertainty in business is a very bad feature. If you don't know if you are going to have price controls, if you don't know if you are going to be slapped with a legal suit, those are the things that interfere with running a hospital. I hope that Congress by the year 2000 has a new national health policy.

Thank you.

[The prepared statement of Ms. Ricardo-Campbell follows:]

PREPARED STATEMENT OF RITA RICARDO-CAMPBELL

First, let me state I am not a lawyer, but an economist. To me, and to most business people, a hospital is a business organization that may be a for-profit or non-profit institution. Either way, the hospital seeks to make money.

I was initially asked to focus on public perceptions of hospital mergers. In general, the great increase in the number of business mergers during the 1980s has made the public more accepting of mergers. Perceptions differ by demographics and by where one lives, as for example, whether in a semi-rural, two-hospital town or in a large metropolitan center as San Francisco with a much larger number of hospitals. As in all cases of mergers, the main opposition to a specific merger is by those individuals who anticipate losing their jobs as a result of the proposed merger. It is probably not perceived that the potential job loss when hospitals merge may be as great as when, say, banks merge and several branches are closed. For example, 382 branches of the Bank of America in its Security Pacific, 1992 consolidation[1] are expected to close. Each branch has, relative to hospitals, few employees. For comparison, in 1991 there were nationwide only 45 community hospital closures, each averaging only 73 beds. The total closed represent less than one percent of this hospital class.

Hospitals usually do not have branches or even draw on a broad patient geographic area that spreads across several states. However, some very prestigious hospitals that offer high-quality care and often in well-defined specialties, do draw patients from far away, and even patients from outside the United States.

With the greater availability of comparative medical information through national news, periodicals and personal computer searches, the geographic area from which many hospitals draw is increasing. The June 15, 1992, *U.S. News and World Report* details the best, in a quality sense (measured by interviews with 1600 top physicians randomly selected from 146,125 board certified specialists), U.S. hospitals by 16 medical specialties giving for each hospital the number of beds; daily rates of semi/private and intensive care; registered nurses per bed; interns and residents per bed, etc. The greater the impact a disease has on a person's functioning, the more likely that person will seek the best care within United States. This is, of course, more true for the well educated person who has either insurance or other ability to pay. For a competitive market to work it is only a small percent of consumers who need to be informed and exercise choices at the margin. Rethinking about the area of competitiveness among hospitals for such disease categories as cancer, neurological disorders, eye disorders, urology and cardiology is needed. In life-saving, true emergency situations, there is no opportunity to shop but over 80 percent of medical care does not have the time urgency of a true emergency.

Health and Human Services (HHS) published in 1987, for the first time, mortality outcomes of hospitals by diagnosis and geographical area and compared them to expected mortalities given patients' ages and medical histories. Although the data are criticized by some hospital administrators because it is claimed that they are not sufficiently corrected for the differences in severity of illness within the patient mix of a specific hospital, these now annual data do yield broad rankings of hospitals by quality

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[1] San Francisco Chronicle. May 28, 1992, p. C1.

within a community and among specialties. By providing information they make the market for hospital care more competitive.

A study published in the June 6, 1990, issue of the *Journal American Medical Association* (JAMA) analyzed 1983 data (that is before these specific outcome data were available) in three areas of California and found that although proximity is a major determinant of the patient's hospital choice that a "lay referral network" using quality played "an important role in choice of hospital" although distances and charges were somewhat more important.[2] The San Francisco competitive hospital market area was defined to include from Santa Rosa in the north to beyond San Jose in the south."[3] With about 70 hospitals in this 1983 San Francisco area the area seemed to be overbedded. Since then many mergers with accompanying specialization have occurred and more will. This is true nationally. Modern Healthcare of May 18, 1992, reports that there are "311 health care systems," which account for 54 percent of the nation's community hospitals and 60 percent of their staffed, acute-care beds in 1990. (p. 38) Small hospitals have lower occupancy rates and on average poorer outcomes because a specific operation is not performed enough times to maintain skills. Among the *U.S. News and World Report* article identifying 43 high-quality hospitals, the average bed size was 581.5 and this computation includes the two rehabilitation centers and one, eye clinic each with less than 100 beds. There were five hospitals with over 1000 beds. Small hospitals are less viable because expensive medical technology has become more important. As the information explosion spurred by computers and faxes, CNN television and weekly periodicals continues, the geographic area of competition among hospitals grows larger.

It is usually the smaller, less specialized hospitals that are being bought by hospital systems, and very few are closed down. The public perceives that small hospitals are less viable because on average they give poorer quality care. They do not have the latest expensive equipment and operations are performed less than the optimum number of times to maintain expertise. On the other hand, in sparsely populated rural areas the public may oppose a merger as in a two-hospital town, which will then have no in-town competition because other hospitals are perceived to be too far away.

Hospitals are experiencing rapid changes in their overall economic climate. More and more medical procedures are being done out of the hospital, many on an out-patient basis and the increasing level of technology requires access to large amounts of capital. Many hospitals are contracting directly with large employers, thus bypassing middlemen. Some hospitals are seeking to merge with other hospitals in order to deliver medical care more efficiently by specializing. All try to keep their hospital beds occupied. Linkages with highly specialized regional centers are increasing. For example, hospital helicopter flights to specialty burn units and other trauma care are viable. The occupancy rate of community hospital beds is still below 70 percent.

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[2] Harold S. Luft et al., "Does Quality Influence Choice of Hospital?" JAMA Vol 263, No. 21, p. 2905, June 6, 1990.

[3] Ibid, p. 2900.

Pricing. A hospital has at least six classes of customers: the federal government's Medicare patients, state governments' Medicaid patients, the non-compensated-for charity cases, various HMO subscribers where the HMO may have negotiated a discount, persons insured under various other preferred provider networks, persons insured by commercial plans and the very rare self-payer who is not insured. The hospital has different charges for each of these classes of customers, and this is unlike most other business in the United States. These different prices may be viewed as volume discounts and in an economist's sense, they result in "scooping out under the total revenue curve." This could be desirable. High sunk costs in building and equipment make pricing based on marginal costs viable. It, however, encourages cost shifting to primarily the business payer and self-payer.[4] But the June 1992 issue of Business and Health restating from Hospital Inpatient states that "The average national charge for heart bypass surgery paid by Blue Cross and private insurance patients is $29,875; Medicare's average payment is $35,220." (p. 20) Why is this so?

A few large hospitals are no longer providing the patient routinely with an itemized bill, but only with charges that their third-party payer refuses to cover in full.[5] How are these bills audited?

Discounts are the name of the game. But a hospital cannot afford to give every payer a discount unless the hospital unduly inflates the charge which it is discounting. The latter is apparently occurring. I believe that antitrust action might better concern itself with this area than with perceived prohibitive barriers to actions resulting in mergers or actions by hospital associations and consortia, which seek to improve the efficiency of hospitals as a business. It was no accident that the Massachusetts business coalition dominated by business devised a successful single payer, one-price charge system which until 1988 contained hospital costs in that state.

Antitrust law, as I understand it, is to promote competition by not permitting monopoly suppliers of product lines, such as an acute, general hospital bed day, or hospitals in a defined geographic market, to set or collude in setting prices. Competitive pricing is encouraged.

Hospital administrators seek to lower costs by making joint purchases of various support services, such as those mentioned in the proposed statute: laundry services and data processing, in order to increase their efficiency and thus reduce costs. This may promote lower prices and benefit consumers. As a citizen who lives in Silicon Valley, I have not sensed that the informed public or hospital administrators believe that the antitrust laws act as barriers to these kinds of efforts.

Additionally, I believe that those joint research activities among business firms, including hospitals, which are practiced by Sematech in the semiconductors chip industry, are also accepted by the general public.

It makes sense for smaller hospitals to merge or join systems or chains of hospitals and each part to specialize. That the geographical area of a hospital's market for patients is widening is in part due to some multi-locational business firms that seek to negotiate

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[4] Rita Ricardo-Campbell, "Business, Health Care Costs, and Competition" (Essays in public policy; no. 24) Hoover Institution, Stanford University, 1991, p. 7.

[5] "Stanford Hospital patients pleased at being 'bill-less'" *Peninsula Times Tribune*, June 17, 1992, p B-2.

with high-quality and relatively lower-cost hospitals for the medical care of their employees. Some employers even encourage out-of-state purchase for a high-cost operation, such as a cardiovascular bypass. These also involve the physician in the total price package. Improved transportation and payment of travel and hotel charges of family members make this viable to the patient. To the degree that itemization has decreased, dependence on third-party payers to negotiate a good deal has increased.

It is possible that in passing the proposed revision of the antitrust statute that the federal government would publicize desirable joint activities of hospitals which might increase their efficiency, such as joint purchase of very expensive medical equipment needed for today's high-tech, specialized procedures. But this is expensive publicity. I assume that the aim of this legislative proposal is to encourage lower pricing of hospital care.

What is missing in the proposal is acknowledgment of the greater activity occurring in forming new umbrella organizations of hospitals and group practices, which are, I believe, vertical mergers. Some hospitals claim that they can no longer make money unless they vertically merge with medical group practices. In the area of horizontal mergers, my recommendation is that little, if any, action is needed.

I have also been asked to comment on how alternative proposals to reform medical care will affect the merger policy of hospitals. Concern over the current uncertainty about potential limits on hospital revenues now is affecting future merger policy. Health care is a growing profitable industry. Non-federal, nongovernmental hospital systems are doing well. Average operating margins are at 2.9 percent, a level below that prior to Diagnostic Related Groups (DRGs) when they ranged from 4 to 8 percent. Among the non-profits, Kaiser Permanente reported revenues rising to $9.8 billion, with net earnings of $486.6 million, or about a 5 percent margin. To me it is a futile exercise to analyze the probable impact of unknown actions beyond stating that rationally administered hospitals will try to maximize their surplus, whatever is passed. Mergers and more specialization will continue.

Appendix

I append from my book *The Economics and Politics of Health* (University of North Carolina) the first three and also number 8 of my "Ten Specific Recommendations," which I believe are as important today as in 1982, when the book was first published.

1. "The most important of the author's recommendations involves the education of consumers about what medical care can and cannot do, and about what individuals can do to improve their own health. More dissemination of information through advertising, directories of physicians by specialties, and of hospitals with representative charges, staffs, and tertiary care specialists is needed. Most public libraries purchase the national directories of physicians by specialties and the Physician's Desk Reference (PDR), which contains manufacturers' descriptions (FDA approved) of prescription drugs. But most persons apparently are not

aware that these informational sources exist. There is also a need for new compilations about HMOs, PPOs, hospitals, nursing homes, health insurance benefits, and alternative medical technologies written in language consumers can understand. Unless consumers are knowledgeable about what they buy, the market cannot approach a competitive market." (from p. 337)

2. "Certification should replace licensing of all allied health manpower jobs. The majority of any licensing board should not consist of either those persons who already hold that license or those practicing an occupation competitive with the one being licensed. Substitution for physicians and dentists by less expensively trained personnel should be encouraged through direct reimbursement of them by third party payers. Then those who wish to can work independently of an employer, and consumers who wish to purchase less expensive and possibly lesser quality care may do so. Reimbursement to these certified persons would be at a lesser rate than if the physician or dentist had performed the task. When group practices and hospitals submit charges for work done by lesser-trained persons, their accounts should indicate it and reimbursement should be made at the lower price." (from p. 338)

3. "Federal and state governments should encourage growth of new HMOs and PPOs both for-profit and non-profit. If prepayment per capita organizations are truly competitive, they should be able to obtain commercial loans for start-up capital costs. Quality controls within them remain a problem. They should be routinely audited on the same basis as other businesses are." (from p. 338)

8. "The federal government should limit the level of health insurance premiums that employers can continue to expense and which employees also do not count as income for tax purposes. This is an open-ended subsidy, which distorts consumer spending and allocation of resources." (from p. 339)

REPRESENTATIVE STARK. Before you start, Mr. Oglesby, I am going to ask you to pass a historical test. Who is the most famous citizen of Rock Hill, South Carolina?

MR. OGLESBY. Perhaps, the former Congressman Tom Gettys.

REPRESENTATIVE STARK. How did you guess? I sat literally at the feet of Tom Gettys in my first term. When you return, you tell him, if they haven't built that statue—we appropriated the money several times—there was supposed to be a statue at the end of the subway line. Do you have a subway?

MR. OGLESBY. No.

REPRESENTATIVE STARK. I am not sure what it got spent on.

STATEMENT OF D. KIRK OGLESBY, JR., CHAIRMAN BOARD OF TRUSTEES, AMERICAN HOSPITAL ASSOCIATION

MR. OGLESBY. Mr. Chairman, I am from Anderson, South Carolina, having grown up in Rock Hill. Mr. Gettys was the principal of the elementary school.

I am the President of Anderson Memorial Hospital and have the privilege this year of serving as the Chairman of the Board of Trustees of the American Hospital Association.

As all of us are aware, this Nation is currently engaged in the most serious debate in years over the future of the American health care system. You, Mr. Chairman, and many of your colleagues understand the critical need for leadership in this debate. Major changes in financing, cost containment and the government's role are on the agenda.

The AHA has a proposal that not only deals with these issues, we think, but also addresses fundamental and dramatic change in the basic way health care is delivered.

We believe incentives for the elimination of excess capacity, duplication of services, waste and fragmentation in the system must be put into place. We believe all citizens—every American—deserve access to a highly coordinated system of care that compels providers to work together to render the most efficient and effective service possible.

Most of all, we believe a reformed health system must put great emphasis on primary and preventive care, rather than illness or acute care alone.

It is with these goals in mind that we urge the Congress to recognize and act upon the role that the antitrust laws can play in creating this more efficient, cost-effective, high-quality health care system.

Little of substance can be accomplished unless health care providers can work together in the delivery of health services at the local level. Mr. Chairman, I suggest to you that this is where the action is in health care. Yet, many such efforts which would clearly benefit patients and the communities in which they live, and which would save a great deal of money,

are thwarted because of collision with antitrust enforcement or the fear of liability.

Health care is not simply another market to which antitrust laws apply. Health care is a unique and vital service in our society. As such, we believe that the role of antitrust in health care ought to be quite different than its role in, for example, the automobile industry.

Many activities make sense from a health care delivery standpoint, yet may create antitrust problems. For example, hospitals cannot necessarily merge to get rid of excess capacity or establish centers of excellence to improve quality of health services. Even joint ventures that eliminate duplication of existing services may be a problem. And agreements among institutions that one will provide one service and another will provide another service are forbidden.

But we don't believe that hospitals—and our activities related to mergers and joint ventures—ought to be exempt from antitrust laws. That is not our point. Rather, we maintain antitrust enforcement should be a referee in this battle to reform health care, to prevent behavior that is not in the public's and patient's interest. But, neither should antitrust enforcement prevent or stand in the way of behavior that is in their interest.

Congressman Hoagland mentioned a recent survey of national hospital leaders that showed that more than 40 percent of them had considered some kind of collaborative activity with another provider to benefit the community and save resources. But the initiatives never got off the ground because of the fear—either real or perceived—of antitrust violations.

Congressman Slattery emphasized this same point in his remarks.

Further, there are enormous gray areas in the interpretation and application of these laws in the realm of health care. Clearly, more specific federal guidance, focusing only on antitrust as it relates to health care, is desperately needed. That alone would go a long way toward encouraging efficient behavior and discouraging the kind of medical arms race attitude that results in the duplication, excess capacity, and out-of-control costs that concerns all. It would also wipe out much of the fear that prevents productive partnerships before they ever begin.

An expedited review process would be a shot in the arm to spurring hospital collaboration. A long and expensive process hampers cooperation and eats up scarce resources. And even if one chooses that long review process, a lawsuit can still occur which would frustrate the initiative indefinitely.

Finally, legislative action probably will be needed to address health-care-specific issues. A number of worthy proposals have been introduced. We heard about two of them this morning. All agree that the time has come to relook at antitrust as it applies to health care.

Even President Bush has said in his own health reform package that antitrust liability shouldn't put a damper on cooperative efforts and new approaches to providing efficient health care. Yet, the key agencies

involved in antitrust enforcement seem not to be in spirit with their own President.

Every member of this Subcommittee knows how difficult the struggle for health care reform is and will be in the years ahead. It is going on right now in both Houses of Congress. But giant steps can be taken that will help immensely to create a more efficient delivery system in the 21st century—where we started this conversation. Actions in the areas I have tried to outline could make antitrust a powerful and positive force, Mr. Chairman, in health reform, pushing—with proper oversight—for the kinds of linkages and efficiencies that will be better for patients, for providers, for payers, for the communities they live in, and for this Nation as a whole.

REPRESENTATIVE STARK. Thank you very much.

[The prepared statement of Mr. Oglesby, along with Q and A report, follows:]

PREPARED STATEMENT OF D. KIRK OGLESBY, JR.

SUMMARY

Hospitals are concerned about the future of health care in this country. Despite its strengths, the United States health care System is seriously flawed. Insufficient access, rising costs, and fragmentation of care have led to patient dissatisfaction with the current health care system and caused Americans to question the value they are receiving for their health care dollars.

The AHA has developed a plan for reforming the health care system. Our reform plan calls for universal coverage for a set of basic health care benefits. At the heart of our plan is the community care network, which would provide patients with integrated care at the community level. The networks also encourage providers to collaborate with one another to avoid duplication of services.

While the country contemplates comprehensive health reform, policymakers can take immediate steps to encourage collaboration among health care providers, thereby increasing access, improving quality, and controlling costs. The antitrust laws and their enforcement, however, create a range of obstacles to hospitals' cooperative efforts. Some joint activities that would be beneficial to patients and purchasers of health care are definitely prohibited. For many other arrangements the law is unclear. Even where the antitrust laws may not pose an actual threat, inadequate guidance from enforcement agencies, the potential for damages, the time and expense associated with a challenge, and misunderstanding of the law create a "chilling effect" on hospitals' efforts to work together. In order to remove these barriers to cooperation, we seek both better guidance from the government and possible changes in antitrust law and enforcement.

STATEMENT

Mr. Chairman, I am D. Kirk Oglesby, Jr., Chairman of the Board of Trustees of the American Hospital Association (AHA). On behalf of the AHA's nearly 5,400 member hospitals, I am pleased to testify on the role hospitals will play in the delivery of health care in the 21st century, and whether federal policy on hospital mergers and joint activity is consistent with that role.

Hospitals are concerned about the future of health care in this country. Our delivery system fails to reach many of those most in need of care and our financing system has created conflicting incentives for patients and providers. The challenge is to find an acceptable balance between providing greater access to health care services and conserving health care resources. We think we have several good ideas for meeting these goals. As a long term solution, AHA has developed a plan for reforming the U.S. health-system by changing our existing fragmented system into a network of care. To meet more immediate needs, AHA is looking to incremental steps for reform. Specifically, we are seeking to ensure that antitrust law and its enforcement do not create barriers to innovative ideas for delivering better and more efficient care.

THE NEED FOR CHANGE

The U.S. health care system is unique, both in its strengths and weaknesses. We have a wealth of health care facilities and highly trained personnel, and have long been recognized as a leader in the high quality of health care provided. Our health

system encourages clinical innovation and is known for state-of-the-art treatments and technologies.

Despite these strengths, the United States health care system is seriously flawed. Foremost among its problems is inadequate access to health care coverage. There are currently 36 million uninsured individuals in the U.S., 10 million of whom are children. Half of the uninsured live in families with incomes below the poverty threshold. Medicaid, a program originally designed to provide health insurance to the poor, now provides care to only about 40 percent of people living in poverty. As a result of strained federal and state finances, those who do qualify for Medicaid face limitations on the services they receive. Many state Medicaid programs, for example, do not pay for screening and preventive services. Coverage limitations are becoming more common even for the privately insured, as many insurers eliminate benefits in an attempt to control their rising costs.

Another major problem with the current system is the continued rapid growth in health care spending. National health expenditures are rising at an annual rate of over 10 percent and are expected to exceed $800 billion in 1992. Although the U.S. currently devotes more than 13 percent of the Gross National Product to health care spending, more than any other nation in the world, we still suffer significant deficits in health status. Among the western industrialized democratic nations, the United States ranks first in health care spending per capita, but 20th in infant mortality.

Faced with escalating health care costs, federal and state lawmakers have frequently opted to reduce payments to hospitals and physicians. But lowering payments does not lower the costs of providing care. In the aggregate, the Medicare program now reimburses hospitals for only 90 percent of the cost of treating Medicare patients. State Medicaid programs pay even less. While payment varies from state to state, in the aggregate Medicaid now pays for only 80 percent of the cost of treating Medicaid patients.

What about the remaining costs of care rendered to patients? To cope with payment shortfalls, health care providers are often forced to shift unfunded costs to privately insured patients by raising their prices. For these and other reasons, private insurance premiums have increased even faster than hospital costs.

Our capacity for providing care is excessive in some areas and inadequate in others. For example, some hospitals possess a costly over-abundance of high technology equipment, while others have trouble adequately filling their staffing needs. Under our current system, the delivery of care remains fragmented. Individuals generally receive care from a changing array of providers, and only after they have become ill. Patients are often left to patch together services in a variety of settings from unconnected providers.

Insufficient access, rising costs, and fragmentation of care have led to patient dissatisfaction with the current health care system. Americans question the value they are receiving for their health care dollars. The United States has the greatest health care available in the world, but our delivery system is in need of repair.

AHA' S REFORM PLAN

What will health care in the 21st century look like? The AHA's vision for reform calls for universal access to a basic health care benefits package. The set of basic

benefits would cover the full range of services from preventive care through long-term care. Universal access would be provided by means of a pluralistic system of financing—a combination of private workplace coverage and a new public program consolidating and expanding Medicare and Medicaid. Employers would be first encouraged and ultimately required to provide coverage for their workers and dependents.

At the heart of the AHA's reform plan is the community care network, providers working together to provide patients with integrated care organized at the community level. Networks would be responsible for providing all the covered health care services for their enrolled population and would coordinate patient care over time and across various provider settings. Patients could turn to their network for everything from preventive care to acute care to long-term care services.

Community care networks would improve the quality of care because they hold the promise for true management of patient care. True managed care requires assessing patient health risks and needs, and planning, organizing, and delivering care so that problems are averted or treated early and all needed services are efficiently provided.

Community care networks, which would receive risk-adjusted capitated payments from purchasers of health care, would encourage providers to conserve health care resources by providing only appropriate and necessary care. Networks would also encourage providers to collaborate with one another to avoid duplication of services.

The AHA believes that its reform plan offers an attractive and viable solution to the problems afflicting the U.S. health system. Many other proposals for health care reform have been put forth as well. As the country contemplates comprehensive reform, policymakers can address some problems immediately by taking steps to encourage greater cooperation among providers.

COLLABORATION IS NEEDED NOW

The future development of community care networks will require flexibility under the antitrust laws. But collaboration is needed now—and steps towards reform can begin today.

The AHA is urging its member hospitals to collaborate with one another and with business, government, schools, community groups, add other health care providers to ensure that the health needs of communities are met. Greater provider cooperation will lead to expanded access, improved quality, and controlled costs. Provider joint efforts can contain high costs by reducing excess capacity and duplicative services. Provider cooperation can improve access to and quality of care by, for example, facilitating the establishment of centers of excellence and community-wide indigent care programs.

Hospitals, however, are receiving mixed messages from the federal government. The Department of Health and Human Services (HHS) encourages providers to increase efficiency, avoid duplication, and reduce costs—goals that can be achieved through greater provider collaboration. At the same time, the Department of Justice (DOJ) and Federal Trade Commission (FTC) indicate that activities designed to achieve these goals may be at risk under the federal antitrust laws. Many arrangements which common sense indicates are appropriate from a health care perspective may be prohibited by the antitrust laws.

ANTITRUST IS AN OBSTACLE TO COLLABORATION

The antitrust laws were not intended to prevent, or even inhibit, vital health care services from being provided to a community. Yet, the laws create obstacles to collaborative efforts. Intended to prevent anticompetitive behavior, the antitrust laws scrutinize joint conduct more closely than unilateral conduct. Therefore, activities a hospital could legitimately engage in independently may be subject to antitrust scrutiny if engaged in with others.

The antitrust laws and their enforcement pose a range of problems for hospitals. Some collaborative activities that would be beneficial to patients and purchasers of health care are clearly prohibited. Many other arrangements fall into a gray area, and it is unclear whether the antitrust laws would prevent their implementation. Finally, misunderstanding or misperception of the antitrust laws may deter some providers from engaging in joint activity that is in fact permissible.

The AHA is attempting to address hospitals' misperceptions of the antitrust laws by better educating its members. For example, last month the AHA published the first of a series of Q & A Report addressing the antitrust implications of collaborative activities. (Copy attached.) The AHA's educational efforts, however, cannot resolve the uncertainty inherent in the antitrust laws or change the laws' preference for competition, even where competition results in the wasteful use of resources.

Some examples of beneficial arrangements help illustrate the barriers hospitals face. Under current law, hospitals cannot agree to allocate services among themselves based on location or the type of services provided, even if the allocation is recognized as beneficial by consumers—including the business community, one of the largest purchasers of health care. Thus, two hospitals cannot agree that one will purchase an MRI and the other will purchase a lithotripter, instead of each purchasing both pieces of equipment. Such an agreement would be considered "market division," a per se violation of the antitrust laws.

Other examples of arrangements that risk antitrust liability include agreements to create health care "centers of excellence" and joint ventures to provide high technology services, even where such arrangements enhance the quality of care and eliminate the unnecessary duplication of services.

Even where the antitrust laws may not pose an actual threat, other factors create a "chilling effect" on hospitals' efforts to work together. Inadequate guidance from the federal government, the potential for treble damages and/or criminal prosecution, and the time and expense associated with challenges by enforcement agencies combine to inhibit hospital initiatives. In order to successfully cooperate and conserve costly resources, hospitals need to discuss and assess the needs of their communities. Yet, even these discussions may implicate the antitrust laws. A Hospitals magazine poll indicated that more than 44 percent of surveyed hospital CEOs agreed that antitrust concerns have slowed down or inhibited hospitals' collaborative efforts.

Current federal agency guidance fails to meet the needs of the health care community. Recently published merger guidelines do not specifically address health care considerations and apply only to mergers, not other joint activity. Existing administrative review processes, such as examinations resulting from notification under the Hart-Scott-Rodino Act and Business Review Letters, are of use only in limited circumstances and can be prohibitively expensive and time-consuming.

The AHA is encouraging its members to work together to deliver more efficient, high quality care to their communities. In order to remove barriers to such cooperation, we seek both better guidance from the enforcement agencies and possible changes in antitrust law and enforcement. While any relaxation of the federal antitrust laws may create the potential for abuse, the vast majority of the country's hospitals seek flexibility only in order to better and more efficiently provide health care.

THE NEED FOR CHANGE IS WIDELY RECOGNIZED

The AHA is not alone in recognizing the need for antitrust reform. In December, 1991 the Advisory Council on Social Security recommended that the Attorney General develop legislation that would permit more hospital mergers. 1991 Advisory Council on Social Security, pp. 126 (Dec. 1991). The Council also recommended that the Attorney General and the Secretary of HHS jointly develop legislation to permit two hospitals in the same community to joint venture to provide hospital and health-related services. Id. at 126-127.

Federal lawmakers also recognize the need to address the antitrust barriers to collaboration and several Members of Congress have introduced related legislation. Senator Bill Cohen (R-ME) and Representatives Tom Campbell (RCA), Peter Hoagland (D-NE), and Jim Slattery (D-KS) have pending proposals that, in varying ways, seek to address the growing interest in and need to facilitate cooperation among and between hospitals.

Representative Slattery's bill, H. R. 2406, would exempt from the antitrust laws joint activities of certain hospitals in rural areas or small cities. Senator Cohen's bill, S. 2277, establishes a demonstration program under which the Secretary of HHS would award ten 5-year grants to facilitate collaboration among two or more hospitals with respect to the provision of expensive, capital-intensive medical technology or other highly resource-intensive services. Representative Campbell introduced a companion bill to Senator Cohen's bill, H. R. 4472.

Representative Hoagland's recently introduced bill, H. R. 5244, is similar in part to Senator Cohen's proposal, although the proposed demonstration program would be jointly administered by the Secretary of HHS and the Attorney General. In addition, the bill would establish an expedited review process to be administered through the Department of Justice. This process would allow hospitals that enter into cooperative agreements for the provision of expensive, capital-intensive medical technology or other highly resource-intensive services to obtain a certificate of review from the Attorney General within 90 days of the request. Activities approved by the Attorney General could not form the basis of a civil or criminal antitrust action for the term of the certificate.

Yet another antitrust proposal is contained in H. R. 5325, the health care reform bill recently introduced by Minority Leader Bob Michel (R-IL). The antitrust provisions of this bill would encourage cooperation among providers by establishing a waiver process for hospitals that jointly provide expensive medical services or expensive high technology equipment. Providers that obtained waivers, which would be granted by the Secretary of HHS, would be exempt from the antitrust laws for a specified period of time.

The President's Comprehensive Health Reform Program also recognizes the need for antitrust reform. Although the recommendations are not as far-reaching as the above proposals, the plan acknowledges the need to ensure "that concerns of antitrust liability do not chill the evolution of a more organized and efficient delivery system." The President's Comprehensive Health Reform Program, p. 55 (Feb. 6, 1992).

The AHA is encouraged by the increasing interest in the antitrust laws' impact on hospitals and other health care providers. In the absence of concrete federal reform, however, state governments are actively seeking to foster cooperative arrangements among hospitals by exempting them from state antitrust laws and providing them with a defense against federal antitrust liability. Anticompetitive conduct that is undertaken in furtherance of clearly articulated and affirmatively expressed state policies and that is actively supervised by the state is protected by the "state action" doctrine, a court-created defense to the federal antitrust laws.

State statutes in Maine, Minnesota, and Wisconsin, to varying degrees, protect hospitals' cooperative arrangements from state antitrust laws and seek to provide "state action" protection from the federal antitrust laws. Other states are exploring this issue. This growing movement for antitrust reform at the state level confirms the strong sentiment for change.

CONCLUSION

Antitrust plays an important role in health policy. Faced with the growing problem of providing affordable health care to all Americans, we need to ensure that innovative ideas for delivering better and more efficient care are not thwarted. To that end, enforcement of the antitrust laws needs to consider and acknowledge the unique issues involved in health care.

ABA believes that specific guidance from the federal government concerning the application of antitrust law to health care is essential to allow beneficial collaborative efforts to move forward. An expedited review process for assessing cooperative activity would encourage joint activity as well, and legislation may be necessary to adequately address health care antitrust issues. Most importantly, the federal government is faced with the task of developing a clear and consistent policy on the role of antitrust in health care delivery as we move into the 21st century.

May 1992

Q&A REPORT

American Hospital Association's Office of The General Counsel • 840 North Lake Shore Drive, Chicago, Illinois 60611 • 312-280-6700

The American Hospital Association has been urging hospitals to cooperate with one another and with business, government, schools, community groups, and other health care providers to ensure that the health needs of communities are met. A recent *Hospitals* magazine poll indicated that more than 70 percent of hospitals surveyed are currently collaborating or planning to share services with another hospital.[1]

When hospitals collaborate with other hospitals or health care providers, however, there is a danger that the activity may violate the antitrust laws. Some activities are clearly prohibited by law, while others involve little or no risk. Even where the antitrust laws do not pose an actual threat, fear of antitrust enforcement may discourage hospitals from participating in cooperative activities that would benefit their communities. The same *Hospitals* poll indicated that more than 44 percent of surveyed hospital CEOs agreed that antitrust concerns have slowed down or inhibited hospitals' collaborative efforts.

1. **Why is antitrust a potential obstacle to collaboration?**

   The antitrust laws, which are intended to prevent anticompetitive behavior, scrutinize joint conduct more closely than unilateral conduct. They focus on joint activity because such activity is more likely to reduce competition. Therefore, activities a hospital could legitimately engage in independently may be subject to antitrust scrutiny if engaged in with others.

2. **Who enforces the antitrust laws?**

   Federal antitrust laws are enforced by the Antitrust Division of the Department of Justice (DOJ) and the Federal Trade Commission (FTC), as well as state attorneys general. The DOJ may institute criminal or civil proceedings, while the FTC is limited to civil enforcement. In addition, any person or entity injured by a violation of the federal antitrust laws may file a civil action in federal court seeking to enjoin the allegedly illegal activity and/or to recover treble damages. A state may also bring such an action on behalf of its injured citizens. States and private parties may institute proceedings under applicable state antitrust laws as well.

3. **How are collaborative arrangements evaluated under the antitrust laws?**

   The antitrust laws measure anticompetitive behavior by its impact on consumers. Conduct that is likely to benefit consumers is encouraged, or at least permitted. In contrast, conduct likely to harm consumers is proscribed. Therefore, hospitals pursuing collaborative efforts must distinguish between conduct that may benefit consumers by decreasing price, improving quality, or increasing output, and conduct that is likely to harm consumers by increasing price, lowering quality, or reducing output.

   Most collaborative arrangements will be evaluated under the so-called rule of reason. The key question under the rule of reason is whether the arrangement creates or enhances market

ANTITRUST: General Principles

Suggested Routing
Administration
Hospital Attorneys
Chief Financial Officer

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power. Market power exists when a party has sufficient power to be able to profitably increase price, decrease quality, or reduce output. Typically, enforcement agencies and the courts use market share as a rough surrogate for market power. Although market share can overstate or understate market power, depending on the particular circumstances, providers should be aware of the market share of their collaborative efforts in any relevant market.

Where no market power exists, antitrust liability is remote. Where market power does exist, the courts generally scrutinize the arrangement to determine whether injury to consumers--in the form of increased price or decreased output or quality--is a likely result of the arrangement.[2] Even where market power is created or enhanced, a collaborative arrangement may be permissible if other factors (such as the potential for new competitors or the creation of efficiencies) outweigh the threat to competition posed by the increased market power.

The major exception to this general rule involves so-called per se violations of the antitrust laws. Per se violations are limited to conduct that is so utterly devoid of potentially redeeming competitive consequences that the conduct is conclusively presumed to be unreasonable, i.e., harmful to consumers, without examination of its actual or potential market effects. In other words, all that need be shown is that the conduct existed. Such inherently anticompetitive agreements include price fixing and the division of markets.[3]

Group boycotts and tying contracts[4] also used to be viewed as per se illegal. Recently, however, courts have required market power before invalidating boycotts or tying contracts. Because the courts now consider actual or potential market effects in examining these arrangements, it can be argued that they are actually evaluated under the rule of reason rather than considered per se violations.

4. **What antitrust risks are involved if we engage in joint activity with a noncompetitor?**

Joint or concerted conduct between entities can involve significant antitrust risks, but only where the entities are actual, or at least potential, competitors. When agreements are not among competitors or potential competitors, they cannot create or enhance market power. Such agreements simply do not limit or constrain consumer behavior and, therefore, pose little antitrust risk.[5]

Because hospital markets are relatively local in nature, collaborative efforts between geographically distant hospitals are unlikely to create significant antitrust risks. Similarly, hospitals can be viewed as noncompetitors where there is little overlap or potential overlap in the types of goods or services provided. For example, hospitals in close geographic proximity that provide different services, such as an acute care hospital and a psychiatric facility, can collaborate with little antitrust risk.

Most agreements between hospitals and nonhospital organizations also fall into the low-risk category because they do not typically compete with each other. Hospitals may contract with insurance companies, managed care organizations, employers, or business coalitions to provide hospital services. Hospitals may also contract with so-called "downstream providers" such as home health agencies and durable medical equipment (DME) suppliers.

There is one significant circumstance in which noncompetitors may be exposed to antitrust liability: when a hospital has market power at the hospital level that it can use to limit

competition at some other level of distribution. *Key Enterprises of Delaware, Inc. v. Venice Hospital*[6] represents perhaps the best example of this concern. In *Key Enterprises*, the hospital formed a joint venture with a DME company. The hospital, the only hospital in Venice, FL, was found to have market power in the hospital market. The jury also found that the hospital used this market power to improperly restrain competition in the DME market by funneling hospital patients to the hospital-affiliated DME company.

The same concern would arise if a hospital with market power entered into an exclusive contract with an insurer or managed care plan. Such an arrangement would prevent competitors of the insurer or managed care plan from selling their product to consumers in the hospital's area. Under these circumstances, the vertical arrangement between the hospital and the insurer or managed care plan would create significant antitrust risk.[7] Again, however, such risks are the exception rather than the rule.

5. **What types of joint activities can we engage in without running afoul of the antitrust laws?**

The antitrust risks involved in joint ventures will vary depending on the nature of the venture. The risk will be lower if the joint venturers are noncompetitors, do not possess market power, or do not provide services directly to patients. For example, shared service arrangements[8] and joint purchasing agreements tend to pose little risk because they do not usually involve the provision of goods or services directly to patients. The purpose of these arrangements is generally to obtain the best possible prices for hospitals.[9]

Joint sales arrangements also should pass antitrust scrutiny where the arrangements do not involve a service or product the hospitals compete against each other to sell and the collaborating hospitals have no market power over the product or service sold. For example, if a group of hospitals--even competing hospitals--jointly sold hospital supplies to other hospitals (either inside or outside the area), or to nonhospital purchasers, the arrangement is unlikely to create a significant antitrust risk as long as the potential purchasers have a variety of other meaningful sources of supply.

In contrast, where joint ventures between hospitals are designed to provide services directly to patients, significant antitrust risks may be raised if the hospitals are competitors and have market power over the services rendered. Such arrangements may permit the participants to increase the price to consumers, or to reduce output or quality of services available. Nevertheless, where hospitals can prove that their joint ventures offer lower costs and prices, as well as higher quality and output, such ventures should pass antitrust scrutiny.

6. **When do mergers and acquisitions pose an antitrust risk?**

In situations where the merger or acquisition involves noncompeting hospitals--either because they are geographically distant from each other or because they provide different services--the potential for anticompetitive effects, and consequently the antitrust risk, is low. Even among competing hospitals, the potential for anticompetitive consequences is not significant in areas where there is a sufficient number of other competing hospitals.

Where there are few competing hospitals, however, as is the case in all but major metropolitan areas, mergers or acquisitions may enhance market power. The risk of antitrust challenge to

such mergers typically is high, unless one hospital is in immediate danger of failing or significant efficiencies clearly outweigh the potential for enhanced market power.

Notes

1. Based upon telephone interviews with 250 CEOs.
2. The focal point of analysis under the rule of reason is the actual or potential impact of the arrangement on competition, which may be influenced by the parties' motives.
3. Market division occurs when competitors agree to allocate business or customers among themselves, with the allocations based upon either geographic location or the nature of the goods or services sold.
4. A tying contract is an arrangement in which a purchaser is required to purchase another product or service in order to be allowed to purchase the product or service the purchaser seeks.
5. The mere fact that hospitals are not competitors, or even potential competitors, does not insulate from liability conduct that is per se illegal. For example, if a number of hospitals agree to fix prices, it is unlikely that they could successfully defend themselves by arguing that they are not competitors.
6. 919 F.2d 1550 (11th Cir. 1990), *petition for reh'g pending*. For a more complete discussion and analysis of *Key Enterprises*, see AHA's September 13, 1991, Advisory.
7. As a theoretical matter, precisely the same analysis would apply if the other entity involved in the collaborative effort with the hospital had market power in its market that it used to restrict competition at the hospital level. For example, if a drug with no substitutes was exclusively distributed through a single hospital, it could be argued that the manufacturer of the drug and the hospital were using the drug's market power to restrict competition at the level of the hospital market, at least for people requiring the drug.
8. Many of these arrangements, such as shared data processing services, are described in Section 501(e) of the Internal Revenue Code.
9. This discussion does not include analysis of possible liability under the Robinson-Patman Act. The Robinson-Patman Act, which addresses price discrimination in the sale of goods, but not services, involves distinct considerations that cannot be adequately addressed in this report.

If you have any questions or comments regarding the information contained in this *Q&A Report*, please contact either Jeffrey M. Teske, 312-280-6159, or Tracey L. Fletcher, 312-280-6674.

The information contained in this **Q&A Report** should not be considered legal advice regarding any specific transaction or activity. You should consult an attorney for such advice.

REPRESENTATIVE STARK. Fellow Californian, Mr. Ammon, please proceed.

STATEMENT OF DON AMMON, CHAIRMAN_ BOARD OF DIRECTORS, UKIAH VALLEY MEDICAL CENTER

MR. AMMON. My name is Donald Ammon. I am Chairman of the Board of Ukiah Valley Medical Center, a not-for-profit hospital located in Ukiah, California. Ukiah is a small, rural community of approximately 14,000 people, located in Mendocino County, approximately 100 miles from San Francisco on Highway 101. Today, Ukiah Valley is a 94-bed hospital.

I am here to tell you about our experience starting in August of 1988 when Ukiah Valley, which was then a 43-bed hospital, first announced its plan to acquire the assets of Ukiah General Hospital, a 51-bed hospital in Ukiah, California.

Prior to the consolidation of these hospitals, each hospital was operating at an average occupancy of approximately 26 patients per day.

It is very difficult to spread the fixed costs of a hospital and the costs for the necessary staffing of nurses and other personnel over such a small volume of patients. We were also concerned about our ability to deliver high quality services with so few patients. We decided that for both quality and efficiency reasons, it was important to combine these facilities.

We purchased the assets of Ukiah General for approximately $6 million. Despite what we perceived as a clear benefit of the transaction, the FTC decided to challenge the combined hospital.

From the moment the FTC advised Ukiah Valley on August 10, 1988, that it was going to conduct a preliminary investigation of the acquisition of the assets of Ukiah General, Ukiah Valley asked the FTC to consider two issues: First, we pointed out that because we were a not-for-profit hospital, they should recognize that they had no jurisdiction over this acquisition.

REPRESENTATIVE STARK. Good luck.

MR. AMMON. Thank you.

Second, we pointed out that, given the decreases in inpatient utilization reflected in the national trends and specifically in the economies of scale facing small hospitals, it was obvious that any combination of two small hospitals that resulted in a combined entity of less than 100 beds was clearly more beneficial than harmful in virtually any setting, but certainly in a rural area such as Ukiah.

Unfortunately, our efforts to persuade the FTC failed, and we have bounced back and forth through various levels of the FTC and the courts for almost four years. We have been through exhaustive discovery, and we are now set to start the case before the FTC starting July 13th.

Unlike transactions subject to the Hart-Scott-Rodino Act, we were not required to wait, and we went ahead and closed our transaction. Thus, we have operated on a consolidated basis for almost four years.

While many merger cases require enforcement agencies and courts to guess about what the effect on competition might be in the future, we are in the unique position of having an actual track record for almost four years. I challenge the FTC to identify for you any negative impact on competition that occurred because of this transaction.

Our written submission addresses the jurisdictional issue.

I will focus my observations on the competitive effects of this transaction, and how the FTC's challenge has affected our ability to deliver high-quality health care in our community.

Ukiah provides the classic example of how health care delivery trends are affecting medical care in rural America. Moreover, Ukiah demonstrates how antitrust policy is operating counter to sound health care policy.

The financial problems facing these tiny hospitals were similar to trends facing the health care industry in general. The combination of rising costs, reduced reimbursement and shift to outpatient facilities resulted in a dramatic decline in the ability of a small, rural hospital to serve its constituents.

Efficiency considerations were a key to Ukiah Adventist's decision to acquire Ukiah General. Studies indicate that economies of scale in hospitals are not achieved until a hospital has at least 200 beds.

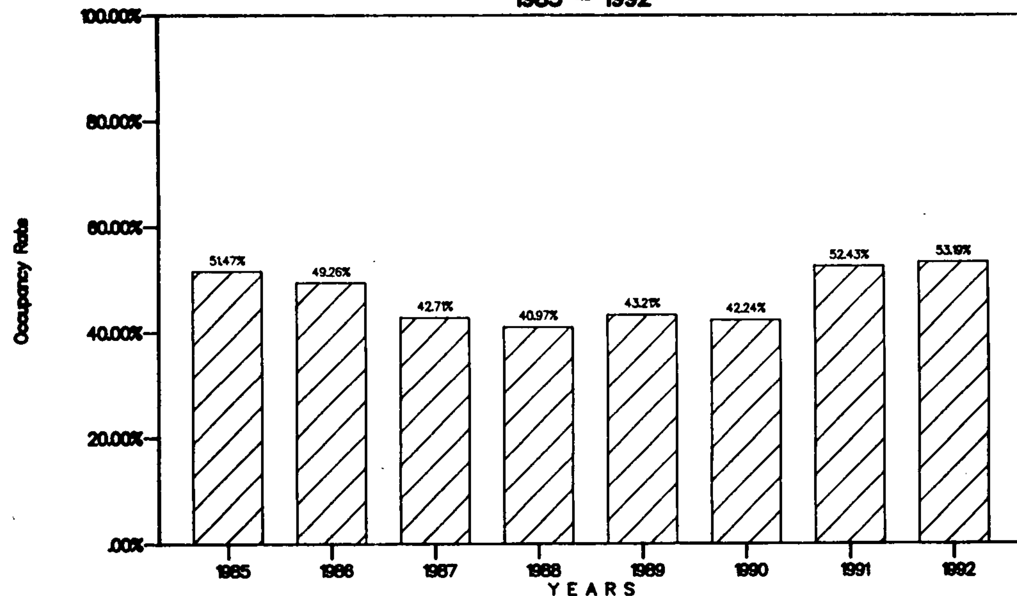
I have given to the staff some exhibits that further explain the decline in the census in Ukiah, which shows our patient days were declining from 1985 on through 1991. Also, I gave you data on Ukiah's census for last month. This chart shows a census of about 45, and it gets down to 30 to 35, in the last week before I came, as a matter of fact. The reason for this last point is to show you how small a transaction we are dealing with here in Ukiah.

[Exhibits for the record follows:]

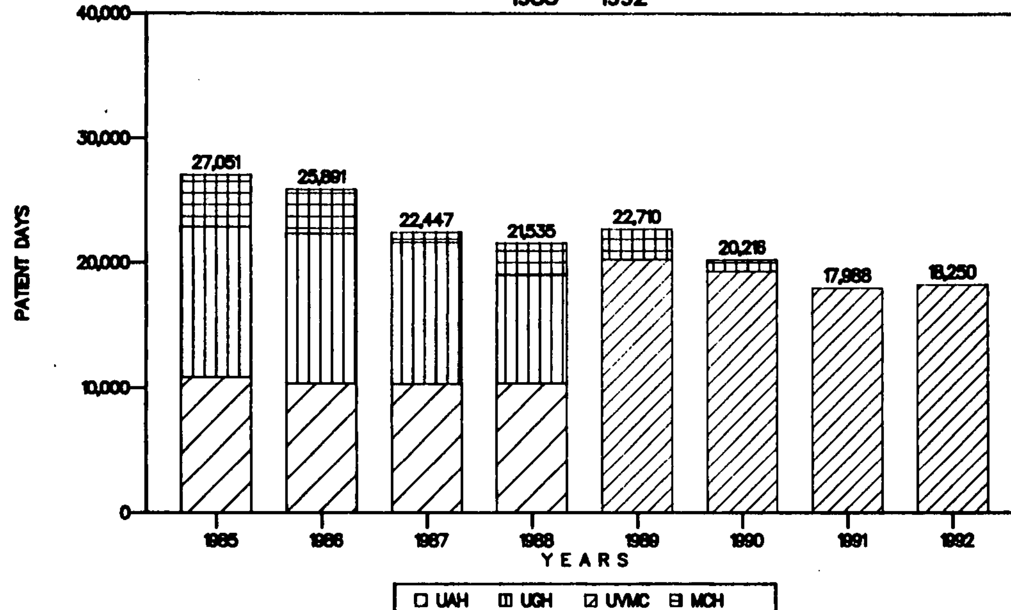
Exhibit 1

Hospitals in Ukiah

Total Occupancy
1985 – 1992*

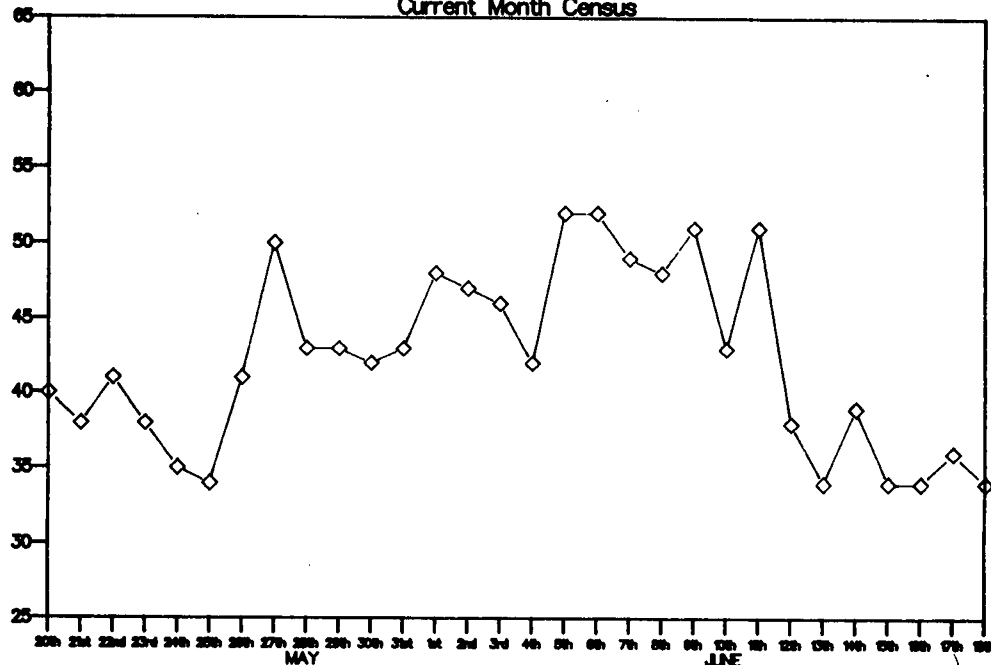


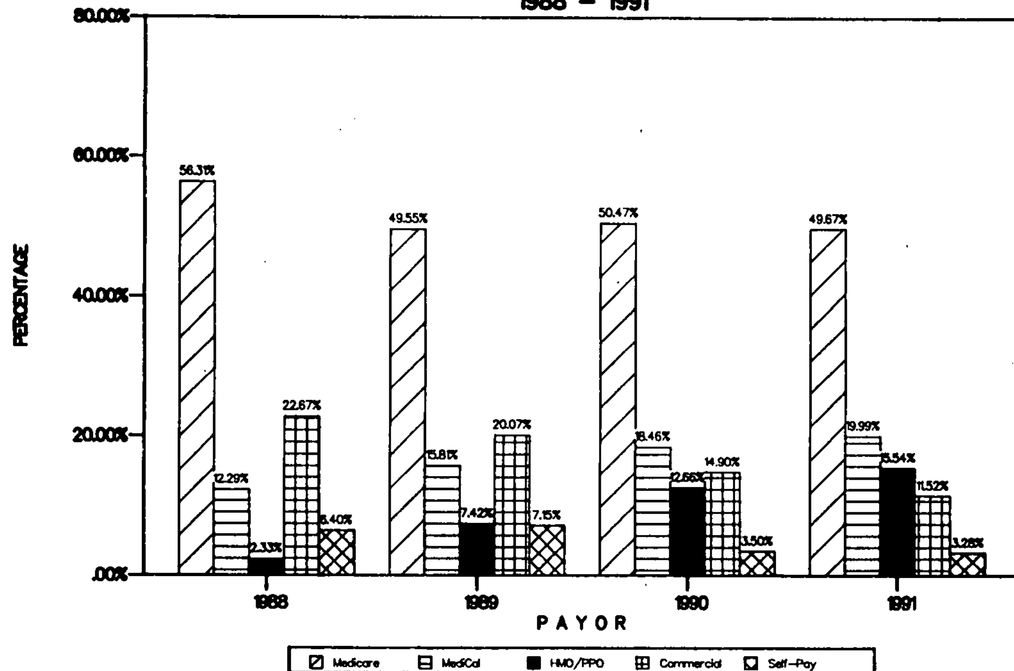
MCH Closed on 9/28/90
* 1992 Based on Projections as of 5/31/92
Filename: DA_UV619.CAL



60-211 0 - 93 - 9

Exhibit 3





UKIAH VALLEY MEDICAL CENTER
Percent of Total Inpatient By Payor
1988 – 1991
80.00%
60.00%
40.00%
20.00%
.00%
PERCENTAGE
56.31%
12.29%
2.33%
22.67%
6.40%
49.55%
15.81%
7.42%
20.07%
7.15%
50.47%
18.46%
12.66%
14.90%
3.50%
49.67%
19.99%
15.54%
11.52%
3.28%
1988
1989
1990
1991
PAYOR
Medicare
MediCal
HMO/PPO
Commercial
Self–Pay
Filename: DA_UV619.CAL

UKIAH VALLEY MEDICAL CENTER

LEGAL AND CONSULTING FEES PAID OUT FOR FTC PROCEEDINGS

FROM 8/88 TO 5/92

	FYE 12/31/88	FYE 12/31/89	FYE 12/31/90	FYE 12/31/91	1/1/92 thru 5/31/92	TOTAL
Total Fees Paid	173,626	237,754	284,383	86,291	340,392	1,122,445

UKIAH VALLEY MEDICAL CENTER

OPERATING RESULTS

	12/31/88	12/31/89	12/31/90	12/31/91	4/30/92	TOTAL
Net Gain	13,002	(2,491,860)	298,118	540,322	237,975	(1,402,423)

Mr. Ammon. Prior to the acquisition, we projected that we could eliminate the duplicative clinical services, administrative functions and related overhead expenses to achieve a cost savings of approximately $3 million annually. The elimination of duplicative obstetrical-related service was expected to save $500,000.

The most significant short-run savings opportunity resulting from the merger was from the elimination of $1.7 million in annual salary and benefit costs associated with staff efficiencies. In this day and age, that is very important because we have a shortage in nursing, pharmacy, physical therapy—those kinds of areas.

Also, there was a one-time $2.5 million capital savings because we were able to cancel plans to construct a new OB center at the Adventist hospital, and also we saved about $400,000 a year in duplicate equipment that we would be buying.

As it turns out, all of these savings that we projected were achieved, and, indeed, we surpassed that, exceeding our projections by about $400,000 a year. So, we feel that, in fact, we have achieved that successfully.

Some examples of the consolidation of emergency services—probably one of the best ones—were two services, 700 to 800 patients at each facility. We merged those into one at one site. We are now seeing close to 2,000 patients a month. We have full-time qualified physicians and nurses. Before the merger, they were taking virtually any physician they could get to come up for a day or two to fill a slot.

We have also added some services that we did not have before: A SPECT Nuclear Medicine Scanner, better in-house CT scanner, mobile lithotripter, mobile MRI and cardiac catheterization lab. Those are the kinds of services that we have been able to add to the community by the savings.

Despite the efficiencies and quality of care improvements that have occurred from this combination and the fact it was below the Hart-Scott-Rodino threshold, the FTC continues to apply antitrust principles that appear misguided when applied to small, rural hospitals. The FTC has constructed an unrealistic market, suggesting that we have a large market share that conveniently excludes all of the hospitals including Santa Rosa, which is 60 miles to the south. In actuality, about 25 to 30 percent of our patients in that service area go out of town for their services. We are suggesting that there is a larger market.

You will notice the payor mix in the graphs that I handed out. Eighty-five percent of our income at Ukiah Valley Medical Center comes from Medicare, Medical, HMO or PPO contracts. Those are all either fees imposed upon you or negotiated agreements. We have very little to say about the revenue stream.

To date, Ukiah valley has been forced to expend approximately $1.2 million defending this transaction and trying to fend off an attack that we feel serves no valid purpose.

The last exhibit you have is the one that shows the fees that we paid over this period of time by year, and the second line shows operating gain or loss.

REPRESENTATIVE STARK. It all went to the lawyers.

MR. AMMON. You can see how it matches. The point is that this process has been very expensive for a small hospital.

REPRESENTATIVE STARK. One other thing. It would appear from your exhibits that you put the Mendocino Community Hospital out of business. About the time of your merger it closed. Aside from the fact that I assume it was a public facility, had that been a private facility, you might have been in a suit. I don't know if that is coincidental, or if it was going to close anyway. Do you want to comment on how your merger affected the public hospital?

MR. AMMON. I don't believe our merger affected it at all. It was running three to five patients a day. You cannot successfully run a facility of any magnitude on that basis.

REPRESENTATIVE STARK. Unless you have your Member of Congress keep it alive.

MR. AMMON. It was inevitable. We put the numbers in there so that you would see the whole picture.

Mr. Chairman, we believe we have demonstrated the efficiencies and the savings and quality through there, and our appeal is that there be a difference in how the FTC and government intervention looks at some of these combinations, especially of small rural hospitals. And, frankly, the two bills that you talked about earlier on in the meeting today, I believe, are both helpful and would be helpful in this setting.

Thank you, Mr. Chairman.

REPRESENTATIVE STARK. Thank you.

[The prepared statement of Mr. Ammon follows:]

PREPARED STATEMENT OF DONALD R. AMMON

My name is Donald R. Ammon. I am Chairman of the Board of Directors of Ukiah Valley Medical enter, a not-for-profit hospital located in Ukiah, California. Ukiah is a small rural community of approximately 14,000 people located in Mendocino County, approximately 100 miles from San Francisco on Highway 101. Today, Ukiah Valley is a 94-bed hospital today.

I am here to tell you about our experience starting in August of 1988 when Ukiah Valley, which was then a 43-bed hospital, first announced its plan to acquire the assets of Ukiah General Hospital, a 51-bed hospital in Ukiah, California.

Anyone who has the slightest familiarity with the hospital industry knows that a 50-bed hospital is inherently inefficient. As the economists would say, it is on the wrong side of the cost curve. In the footnotes to this testimony is cited copious authority supporting the position that 50-bed hospitals are very inefficient and dangerous.

Prior to the consolidation of these hospitals, each hospital was operating at an average occupancy of about 26 patients per day. To have an average of twenty-five patients per day, on some days we had as few as six patients. It does not take a genius to recognize that it is very difficult to spread the fixed costs of a hospital and the costs for the necessary staffing of nurses and other personnel over such a small volume of patients.

We purchased the assets of Ukiah General for approximately $6 million. That amount is too small to require a Hart-Scott-Rodino filing. Thus, you can imagine how surprised we were when the FTC called us on the eve of the closing indicating they wanted to investigate this transaction.

From the moment the FTC first advised Ukiah Valley on August 10, 1988 that it was going to conduct a preliminary investigation of the acquisition of the assets of Ukiah General, Ukiah Valley asked that the FTC consider two issues: First we pointed out that because we were a not-for-profit hospital, they should recognize they had no jurisdiction over this acquisition. And, second, we pointed out that, given the decreases in inpatient utilization reflected in national trends and specifically the economies of scale facing small hospitals, that it was obvious that any combination of two small hospitals that resulted in a combined entity of less than 100 beds was clearly more beneficial than harmful in virtually any setting but certainly in a rural area such as Ukiah.

Unfortunately, our efforts to persuade the FTC to address these two issues forthrightly as a threshold matter failed and we have bounced back and forth through various levels of the FTC and the courts for almost four years. We have been through exhaustive discovery and are now set to try the case starting July 13, 1992. Worse, our effort to achieve the optimum benefits we anticipated from consolidation have been frustrated by the diversion of significant management attention from the task of providing quality health care to a new task of dealing with the FTC's attempt to thwart our efforts. This has hurt us and the Ukiah community we serve. I have no quarrel with the purposes of the antitrust laws, but it is hard to see how the public is served by challenging this small health care transaction.

Unlike transactions subject to the Hart-Scott-Rodino Act, we were not required to wait and went ahead with our closing as scheduled. Thus, we have operated on a consolidated basis for a]most four years. While many merger cases require enforcement agencies and courts to guess about what the effect on competition might be in the future, we are in the unique position of having an actual track record from almost 4 years

of operation. I challenge the FTC to identify for you any negative impact on competition that has occurred because of this transaction. What is particularly frustrating to a hospital management team of a small not-for-profit hospital is that an agency like the FTC gets so caught up in its own procedure that it cannot look at the reality of what has occurred. It cannot admit that our transaction was beneficial for the community because it preserved and improved health care in this community. There does not seem to be any way that the FTC can re-examine its premise after it gets going on a case and say, gee our prediction of negative consequences four years ago was off base. Apparently, when the FTC staff has misgivings about a case after discovery, it cannot effectively communicate that to the FTC commissioners to precipitate a reconsideration of the wisdom of pursuing the case.

Let me elaborate very briefly on these issues. First, the jurisdictional issue is probably best left for lawyers to debate. Let me just say that it has been unquestioned for at least forty years that the FTC does not have jurisdiction over not-for-profit corporations.[1] The FTC admits that its jurisdiction under sec. 4 of the FTC Act does not reach not-for-profits.[2] To challenge an acquisition of assets under sec. 7 of the Clayton Act, the FTC must first have jurisdiction under its own Act. This construction of sec. 7 is clear from the Supreme Courts decision in the Philadelphia National Bank case.[3]

However, to reach acquisition by not-for-profit hospitals the FTC has had to resort to a convoluted argument that another section of the Clayton Act is a separate grant of jurisdiction. This novel argument is contrary to the Supreme Court's interpretation of the Clayton Act and the FTC Act as expressly stated in Philadelphia National Bank. We pointed this out to the FTC but have found ourselves caught up in a crusade by the FTC to expand its jurisdiction so it can regulate not-for-profit hospitals. Footnoted below you will see the four-year chronicle of our trek to the Ninth Circuit, the ruling by Chief Administrative Law Judge Parker agreeing with us that the FTC has no jurisdiction, the reversal of that decision by the full commission and a pending appeal in the D.C. Circuit Court of Appeal.[4]

You are probably more interested in my observations about the competitive effects of this transaction and how the FTC's challenge has affected our ability to deliver high quality health care efficiently in our community.

As this panel is probably well aware, hospitals are closing at unprecedented rates due to rising costs,[5] changes in the form of government reimbursement from cost-based payments to fixed payments per service,[6] and difficulties hospitals confront in spreading their costs due to falling occupancy rates.[7] Ukiah provides the classic example of how these trends are affecting medical care in rural America. Moreover, Ukiah demonstrates how antitrust policy is operating counter to sound health care policy.

Prior to August 1988, Ukiah had three acute care general hospitals--Ukiah Adventist Hospital, Ukiah General Hospital, and Mendocino Community Hospital. Each of these hospitals was very small. Ukiah Adventist had only 43 beds, Ukiah General had only 51 beds and Mendocino Community Hospital had only 56 beds. In addition to the economies of scale problems facing these very small hospitals, they each suffered from extremely low occupancy rates. Both Ukiah Adventist and Ukiah General were operating at approximately 50 percent occupancy and many times had fewer than ten patients per day. Mendocino Community Hospital usually had only four to ten patients per day. What these figures suggest is that any of the hospitals in Ukiah could have been wiped

out by one Medicare outlier. (A Medicare outlier is a significant Medicare patient whose treatment greatly exceeds the DRG reimbursement schedule.)

Occupancy rates have continued to decrease as we become more efficient and as more procedures are conducted on an outpatient basis. Outpatient services are provided in physician offices and clinics as well as at the hospital. Thus, competition is very broad for these outpatient services.

The financial problems facing these tiny hospitals were similar to trends facing the health care industry generally.[8] The combination of rising costs, reduced reimbursement, and the shift to outpatient facilities[9] resulted in a dramatic decline in the ability of small rural hospitals to serve their constituents. The Ukiah hospitals, as well as an increasing number of rural and small hospitals, experienced severe financial difficulties.

Statistics prove that these trends have a disproportionate impact on small, rural hospitals. Between 1980 and 1988, of the 445 community hospitals closed, 206 were rural hospitals; and from 1986 to 1988, the number of rural hospital closures outnumbered urban hospital closures. In 1988 alone, 43 rural community hospitals closed, and 39 of these had fewer than 100 beds.[10]

These trends did not bode well for the survival of any small hospital in Ukiah. The financial situation of Ukiah General was particularly precarious at the time of the acquisition. Income declined steadily to a breakeven position in 1987 and to a substantial loss for the nine months ending June 30, 1988. At the time of acquisition, Ukiah General's balance sheet reflected negative net worth, a high debt burden, and substantial reliance on its parent organization, a for-profit corporation that was already heavily in debt. Given the trends in closures of small, rural hospitals, Ukiah General's closure was a distinct possibility.

However, we decided that rather than withdraw from Ukiah we would address our efficiency and quality concerns by combining with Ukiah General Hospital. To preserve medical services in Ukiah, on August 8, 1988, Ukiah Adventist Hospital acquired substantially all of the assets of Ukiah General Hospital. The combined facilities are now known as Ukiah Valley Medical Center.

Efficiency considerations were a key to Ukiah Adventist's decision to acquire Ukiah General. Studies indicate that economies of scale in hospitals are not achieved until a hospital has at least 200 beds.[11] Even members of the FTC's own Bureau of Economics recognize that general acute care hospitals under 100 beds in size are terribly inefficient.[12] The consolidation of Ukiah Adventist and Ukiah General, with 43 and 51 beds respectively, resulted in a 94-bed hospital which better approximated the size at which economies of scale could begin to be achieved. It is hard to understand the FTC's premise that our combination could be a threat to competition when we are struggling to meet minimum scale economies.

Prior to the acquisition, we projected that we could eliminate duplicative clinical services, administrative functions, and related overhead expenses to achieve a cost savings of approximately $3 million in annual, ongoing savings. The elimination of duplicative obstetrical related services alone was expected to effect a savings of $500,000. The most significant short-run savings opportunity resulting from the merger, however, was expected to be the elimination of over $1.7 million in overlapping and duplicative staffing costs. These are costs that would otherwise have to be paid by our patients.

A $2.5 million one-time cost savings was also anticipated. The largest one-time cost savings was the cancellation of plans to construct and equip a new Birthing Center at Ukiah Adventist that would have duplicated facilities at Ukiah General. We also anticipated $400,000 in savings from the sale of duplicative equipment.

Numerous Ukiah physicians, government officials, third party payors, and commercial executives endorsed the acquisition, realizing the enormous efficiencies which could be achieved.

As it turns out, all these savings were achieved. Indeed, the savings even surpassed those expectations. Ongoing annual cost savings exceeded original projections by almost $400,000. Moreover, expanded blood bank collection services reduced the per unit price of blood by approximately 10 percent, and the combined hospital realized significant savings in nursing personnel. Experience more than validated the efficiency expectations.

Economic efficiency has the added benefit of freeing revenues, facilitating the redirection of savings toward improving the quality of health care provided in Ukiah. By October 1989, Ukiah Valley achieved a substantial improvement in the quality of care offered to the citizens of Ukiah, and additional quality improvements have been made since then. The two emergency departments were consolidated on one site. This combined the staff, resources and backup in one department to serve 1,500 to 2,000 visits per month. This consolidation provided an improved operation and service over running of two departments with only 700 to 800 visits each. After the consolidation, all of the full-time emergency room physicians and nursing staff were board certified/qualified in emergency room medicine. Combined facilities permitted the expansion of blood banking and collection services, resulting in the provision of 75 percent of their needs in house; prior to the acquisition, this figure was only 25 percent. The hospital contracted for provision of nuclear medicine scanning, whereas neither hospital did so prior to the acquisition. C.T. scans were provided in-house rather than using a lower quality non-hospital unit.

Our experience is indicative of the experiences of other small hospital mergers. Studies constantly demonstrate a positive correlation between hospital size and quality of care. An increase in volume enhances staff proficiency.[13] The pooling of patient care volumes in the emergency room lend to improvements in staff proficiency. Avoiding duplicative birthing centers allows physicians to handle all procedures at one location and, concomitantly, to refine their skills.

Our advances in efficiency and quality of care in Ukiah continue to the present. Increased volume facilitates improvements in case management and related decreases in the average length of stay, resulting in medical cost savings for the Ukiah community. Because of the improvement of quality of the emergency physician staff, malpractice premiums decrease. The kitchen, cooking, accounting, admitting, linen and housekeeping, record keeping, data processing, and personnel departments report additional staff efficiencies. These cost savings enable Ukiah Valley to broaden the services provided to indigent patients, resulting in more complete provision of services to the community. Furthermore, prior to the consolidation, the hospital could not accommodate managed care contracts; now, Ukiah Valley serves several managed care contractors, including HMOs.

The FTC's prosecution is premised on an injury to competition. But we now have practically four years of operating history which demonstrates no such injury has occurred. Our price increases have been less than the average of other California hospitals. We now have more managed care contracts than before. Managed care providers and insurers have all told the FTC that they get competitive prices from us and that they recognize we have improved quality and efficiency.

Despite the efficiencies and quality of care improvements that have occurred from this combination and the fact that this transaction was well below the Hart-Scott-Rodino reporting threshold, the FTC continues to apply antitrust principles that appear misguided when applied to small, rural hospitals. The FTC has constructed an unrealistic market suggesting we have a large market share that conveniently excludes all the hospitals in Santa Rosa, a city 60 miles to the south along a major highway. Approximately 25 percent of the people living in our service area go to other hospitals, such as those in Santa Rose, regularly. It is ludicrous to suggest they are not direct competitors of ours. It was in part due to the exodus from Ukiah to Santa Rosa that made the consolidation critical. Anyone looking at Ukiah who is knowledgable in utilization patterns knows that Ukiah can only support one hospital.

Of course, what is particularly tragic is that investigations like this result in great expense not only for the hospital but also for the community it serves. The protracted hearing on the merits against a very small, not-for-profit hospital is causing grave harm. To date, Ukiah Valley has been forced to expend approximately $1 million defending this transaction and trying to fend off an attack which serves no valid public purpose. Beyond actual expenditures, a drawn out battle with the FTC forces Ukiah Valley to reserve scarce financial resources it might otherwise spend on staff salaries and health care services. Ukiah Valley's staff is paid less than other area hospitals, and Ukiah Valley has also had to defer making major necessary equipment purchases, such as diagnostic x-ray equipment, until after this matter is resolved. The uncertainty of this matter has also harmed Ukiah Valley's ability to secure financial support and its ability to recruit medical personnel.

At the same time, the trends in the health care industry that provided the original rationale for the acquisition show little signs of relenting. Although the rate of hospital closures slowed slightly during 1989 and 1990, community hospitals with fewer than 100 beds account for 74 percent of hospital closings in those years.[14] Closures of rural community hospitals continue to surpass closures of urban community hospitals,[15] and in 1990 California had the second largest number of community hospital closures in the country.[16] The AHA has just released statistics for 1991 showing 45 hospitals closed last year, two thirds of them in rural areas.[17]

While we might not have met all of our goals, the cost savings, increased efficiency, and enhancement of the quality of care that have resulted from the consolidation, provide a bright contrast to the rather bleak backdrop of the current state of the health care industry. Our achievements are especially remarkable given the financial burden and the accompanying constraints of the relentless FTC investigation.

Our experience clearly demonstrates the efficiencies, cost savings, and quality of care improvements that emanate from the merger of two small, rural hospitals. We are not asking Congress or the FTC to disregard antitrust policies whatsoever. What we are asking is for the FTC to differentiate and distinguish among situations before it applies

a blanket set of precepts. Given our experience, our recommendation would be for Congress and the FTC as a matter of policy to permit the combination of small hospitals, especially when such a combination results in a facility with 100 or fewer acute care beds. Such a step will allow higher quality health care for rural America. We also would recommend a policy encouraging joint ventures and other collaborative activities among hospitals even though such activities may result in market and information sharing.

[1] Community Blood Bank of the Kansas City Area, Inc. v. FTC, 405 F.2d 1011 (8th Cir. 1969).

[2] Hearings before the Subcommittee on Transportation and Hazardous Materials of the House of Representatives Committee on Energy and Commerce. 101st Cong., 1st Sess. (1989) (statement of William C. McLeod, Director of the FTC's Bureau of Consumer Protection); see also Charles A. James, Deputy Assistant Attorney General, Antitrust Division, United States Department of Justice, Remarks before the National Health Lawyers Association (Jan. 31, 1992).

[3] United States v. Philadelphia National Bank, 374 U.S. 321, 336 and 336 n.11 (1963).

[4] On August 29, 1988, the FTC wrote one of Ukiah Valley's attorneys, reiterating their request for extensive information without addressing the jurisdictional issue. We responded and again requested that the agency address jurisdiction as a threshold matter.

On September 16, 1988, the FTC claimed jurisdiction under Clayton Act Section 11. On September 30, 1988, our attorneys pointed out that the Section 11 argument had just been expressly rejected by the Supreme Court in United States v. Carilion Health System, which held that "The FTC lacks jurisdiction over the defendants because of their non-profit status (United States v. Carilion Health System, No. 88-0249-R (order granting motion to dismiss) (W.D. Va. Sept. 30, 1988); 707 F.Supp. 840 (W.D. Va. 1989), aff'd, 892 F.2d 1042 (4th Cir. 1989)).

On February 3, 1989, the FTC issued a subpoena duces tecum to AHS/West. This was authorized by a resolution of the full Commission.

In response we filed a petition to quash the subpoena based, in part on lack of jurisdiction under the Clayton Act.

On March 3, 1989, the Commission conducted a hearing on the Petition. And on March 15, 1989, Commissioner Calvani denied our petition (In re Adventist Health System/West, 5 Trade Reg. Rep. (CCH) ¶22,658 (March 15, 1989)).

The full Commission affirmed Commissioner Calvani's ruling on April 10, 1989, directing AHS/West to comply with the subpoena by April 21, 1989. We did not comply with the subpoena, because we intended to raise the jurisdictional defense in any federal action attempting to enforce the subpoena. The FTC chose not to try to enforce its subpoena in federal court.

Instead, in August of 1989, the FTC sent Ukiah Valley and AHS/West its draft administrative complaint and advised Ukiah Valley and AHS/West that we would be given an opportunity to be heard prior to the Commission voting on the complaint.

During the weeks of October 2, and October 9, 1989, I personally met separately with Chairman Steiger and each of the other then commissioners. At each meeting, I reiterated the jurisdictional objection and explained the benefits of the transaction.

Despite this effort, the FTC issued its complaint on November 7, 1989. Ukiah Valley initiated an action in federal court to enjoin the FTC (Ukiah Valley Medical Center v. FTC, 1990-1 Trade (as CCH ¶68,916 (N.D. Cal. 1990). The district court, however, ruled that the FTC should first decide the issue. This was appealed to the Ninth Circuit, which affirmed that decision (Ukiah Valley Medial Center v. FTC, 911 F.2d 261 (9th Cir. 1990)). We then filed a motion to dismiss the administrative complaint before the Administrative Law Judge based on the FTC's lack of jurisdiction over not-for-profits. Now chief administrative law judge, Lewis F. Parker, dismissed the FTC's complaint for lack of jurisdiction and ruled in favor of our position that the FTC lacked jurisdiction here (In re Adventist Health System/West, No. 92-34, Aug. 2, 1990). On appeal, on

August 2, 1991, the full Commission reversed the administrative law judge and remanded for a trial on the merits (In re Adventist Health System/West, No. 92-34, Aug. 2, 1991).

There are apparently one or two decisions, depending on how you count, that now support the FTC's view (FTC v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991); United States v. Rockford Memorial Corp., 717 F. Supp. 1251 (N.D. Ill. 1989), 898 F.2d 1278 (7th Cir.), cert. denied, 111 S.Ct. 295 (1990)), though at least one final decision, affirmed by the Fourth Circuit supporting ours (United States v. Carilion Health System, No. 88-0249-R (order granting motion to dismiss) (W.D. Va. Sept. 30, 1988); 707 F. Supp. 840 (W.D. Va. 1989), aff'd, 892 F.2d 1042 (4th Cir. 1989).

[5] See, e.g., Cole and Sizing, Cole Nurse Compensation Survey, Modern Healthcare, December 2, 1988, at 24; Wagner, Weighing the Cost of New Technology, Modern Healthcare, November 18, 1988, at 43.

[6] See Touche Ross, U.S. Hospitals: The Future of Health Care - A Survey of U.S. Hospital Executives and Presidents of Medical Staffs on the Challenges They Face in an Environment of Enormous Change, June 1988, at 4; See also McCarthy, DRGs - Five Years Later, The New Eng. J. of Med., June 23, 1988, at 1683-4.

[7] See Touche Ross, U.S. Hospitals: The Future of Health Care - A Survey of U.S. Hospital Executives and Presidents of Medical Staffs on the Challenges They Face in an Environment of Enormous Change, June 1988, at 4; See also Bureau of the Census, U.S. Dep't of Commerce, Statistical Abstract of the U.S. 1989, 1989, at 102.

[8] See Freudenheim, Rising Number of Hospitals Forced to Close, N.Y. Times, June 23, 1988, at A17, col. 1; Office of Evaluation and Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Services, Why Hospitals Close, Modern Healthcare, March 24, 1989, at 24.

[9] See American Hosp Ass'n, Hospital Statistics - Data from the American Hospital Association 1988 Annual Survey, 1988, at XXV; Prospective Payment Assessment Commission, Medicare Prospective Payment and the American Health Care System: Report to the Congress, 1990, at 52.

[10] Hospital Data Center, American Hospital Association, Hospital Closures 1980-1988: A Statistical Profile, 1989, at 5.

[11] Ira Moscovice & Roger A. Rosenblatt, A Prognosis for the Rural Hospital, J. of Rural Health, Part II, July 1985, at 13; Carr & Feldstein, The Relationship of Cost to Hospital Size. Inquiry, 1967, at 60.

[12] Vita, Langenfeld, Pautler, and Miller, Economic Analysis in Health Care Antitrust, 7 J. Contemp. Health L. & Policy 73, 97 (1991). (The authors are or then were economists at the FTC.)

[13] Hannan, O'Donnel, Kilburn, Bernard and Yazici, Investigation of the Relationship Between Volume and Mortality for Surgical Procedures Performed in New York State Hospitals, 262 J. Am. Med. Ass. 503 (July 28, 1989); Hughes, Hunt, Luft, Effects of Surgeon Volume and Hospital Volume on Quality of Care in Hospitals, 25 Med. Care 489 (June 1987); Harold S. Luft, The

Relation Between Surgical Volume and Mortality: An Exploration of Causal Factors and Alternative Models, 23 Med. Care 940 (Sept. 1980).

[14] Hospital Data Center, American Hosp. Ass'n, Hospital Closures 1980-1990: A Statistical Profile, February, 1991, at 11; Cleverly, Larger Urban Hospitals Increasingly on Closed List, Healthcare Financial Management, Sept. 1991, at 77.

[15] Hospital Data Center, American Hosp. Ass'n, Hospital Closures 1980-1990: A Statistical Profile, February, 1991, at 7.

[16] Hospital Data Center, American Hosp. Ass'n, Hospital Closures 1980-1990: A Statistical Profile, February, 1991, at 13.

[17] Modern Healthcare, June 15, 1992 at 2.

REPRESENTATIVE STARK. Let me push you all to destroy some preconceived notions that the Chair has.

I began to get into this with Ms. Ricardo-Campbell about the idea of the so-called informed consumers and their market responses to prices. I find that there is some difference between a commodities market or retail market for foodstuffs or sale of automobiles and the market for hospital service.

I am not sure that the economists, if they want to talk about elasticity and all those kind of things that you like to talk about, can tell me who the customers are. Who are the customers, Mr. Kaplan?

MR. KAPLAN. As you suggested before, I think the customers for hospitals are primarily physicians.

REPRESENTATIVE STARK. Okay. What do you think, Ms. Ricardo-Campbell?

MS. RICARDO-CAMPBELL. I think it is a joint decision. I think the *U.S. News and World Report* article made it quite clear. You need only a small percentage of consumers.

REPRESENTATIVE STARK. You are talking about informed consumers.

MS. RICARDO-CAMPBELL. Exercise choice.

REPRESENTATIVE STARK. Let's try this. You four ought to be as informed about medical services as any four people in the United States, right? I will toss my hat in, too, so there are five of us. Let's do the Stark test here.

Mr. Kaplan, how much comes out of your paycheck each month for your health insurance?

MR. KAPLAN. Approximately $500.

REPRESENTATIVE STARK. Not approximately. Let's get right down to it. You are an economist. You don't approximate things like that.

MR. KAPLAN. Being an economist, sir, does not preclude the option of having your wife pay the bills.

REPRESENTATIVE STARK. How much was it last year?

MR. KAPLAN. It was approximately $6,000.

REPRESENTATIVE STARK. Last year, too?

MR. KAPLAN. Yes, sir.

REPRESENTATIVE STARK. How much will it be next year?

MR. KAPLAN. I hesitate to project. Higher.

REPRESENTATIVE STARK. Ms. Campbell.

MS. RICARDO-CAMPBELL. Directly, it is only $125 a month because the employer pays the rest of it; $100 monthly is a pre-tax supplementary savings plan earmarked for Medical care. Additionally, my Medicare tax is $144.10 monthly.

RERESENTATIVE STARK. What was it last year?

MS. RICARDO-CAMPBELL. Last year, it was zero. The employer paid the whole bill.

REPRESENTATIVE STARK. MR. OGLESBY.

MR. OGLESBY. Our hospital provides health insurance.

REPRESENTATIVE STARK. Do you know what it costs per person?

MR. OGLESBY. Approximately $2,000.

REPRESENTATIVE STARK. Mr. Ammon.

MR. AMMON. Mr. Chairman, I don't pay anything because, like MR. OGLESBY, we have full coverage. In our case, it would run about $3,600 a year.

REPRESENTATIVE STARK. You could be off a hundred dollars or so?

MR. AMMON. Yes, and the deductibles.

REPRESENTATIVE STARK. Let's go back. What percentage of the hospital bill does your insurance pay?

MR. KAPLAN. I believe it is 80 percent.

REPRESENTATIVE STARK. You believe that?

MR. KAPLAN. Yes.

REPRESENTATIVE STARK. How about if you don't call first, pre-screen?

MR. KAPLAN. I do not know the answer to that.

REPRESENTATIVE STARK. How much of the doctor's bill does it pay?

MR. KAPLAN. I believe 80 percent.

REPRESENTATIVE STARK. For all procedures?

MR. KAPLAN. If I review the policies, I am sure that I could find exceptions.

REPRESENTATIVE STARK. How many days of mental health?

MR. KAPLAN. I have not had the opportunity to engage in that.

REPRESENTATIVE STARK. I don't want to drag this out, but I have the cream of America's medical health care consumers before me, and we are not sure. I can tell you that my Blue Cross option is around 80 some odd dollars an employee per month, and I know all of our costs are going to go up 20 percent next year no matter what happens.

If Congress does something, or doesn't do something, your insurance companies are going to kick your premiums up, on average, 20 percent next year. None of us really know. Unless we are sick, we don't know. If we have insurance, as consumers, basically, we are comfortable. We are a little uneasy that we may lose the insurance, but I am saying that this is not like shopping for a new Chevrolet or a pair of shoes, or a pound of potato chips. It ain't a market—go ahead.

MS. RICARDO-CAMPBELL. May I disagree, sir?

REPRESENTATIVE STARK. Yes.

MS. RICARDO-CAMPBELL. It is like shopping for a stereo, a high fidelity system, or shopping for a personal computer. These are highly complex products that people have learned to shop for, and medical care is highly complex. I think the market has widened.

REPRESENTATIVE STARK. Let's try the second test, to see whether in Mr. Ammon's and Mr. Oglesby's hospital—when you come in and you are faced with the candy striper or some stern-looking person behind the admissions desk who makes you feel about as welcome as the booking sergeant at a prison—first, they want your credit card, and then they want more information about you than you ever dreamed possible, and makes

applying for a mortgage loan look like an easy task. Do you ask them a question about why they are there? Do you say, who referred you, or whose patient are you, or where did you read about us? Did you find a coupon in the newspaper? Do you ask them?

MR. OGLESBY. No.

REPRESENTATIVE STARK. What do you assume?

MR. OGLESBY. I don't think we assume anything.

REPRESENTATIVE STARK. That a doctor sent them?

MR. OGLESBY. In the case of being admitted to a hospital, without a doctor, you couldn't be there. There has to be an admitting physician.

REPRESENTATIVE STARK. Unless you come to the emergency room.

MR. OGLESBY. That is right.

MR. AMMON. There are actually two drivers.

Mr. Chairman, in the part of the world I am involved with, it is highly managed care, and we do see blocks of patients moved from one group to another very directly.

REPRESENTATIVE STARK. By somebody other than the patient?

MR. AMMON. Absolutely. By somebody other than the patient and the physician, because even the physician at times is seeing their block of patients moved because of contract changes in PPO.

REPRESENTATIVE STARK. I didn't want to belabor the point, but what I am trying to suggest to both panels that—we will be talking with government witnesses later, again—this is not like A&P owning their own dairy or bakery and fixing the price by vertically integrating as it were and, therefore, jamming it to the customers, which was attempted on the part of the A&P long before any of you were studying economics.

All I am suggesting is that this is a different market. I am not suggesting for a minute that Mr. Oglesby or Mr. Ammon don't deal with very sophisticated purchasers, but they tend to be people who run preferred providers or corporations that can demand a discount because they are in Dearborn and they happen to be called Ford Motors and they have a lot of customers for you.

The individual patient, I submit, is pretty lost, much more lost than when they are going to Circuit City. There, at least, you can go and get *Consumer Reports*, if you are smart before you let that salesman talk you out of the last few dollars that you have in your jeans.

The same is true in automobiles. There is a big difference between a flatbed Ford in 1947 and that mess of computer chips you buy now. Somebody can read *Road and Track* or *Popular Photograph File*, if you buy a camera. But I don't believe the argument that we buy medical services that way. I am belaboring the point, but the real question still comes down to, if there is a different market, if we had a single payer or an all-payer system—let's say like Maryland—we really wouldn't have to worry about antitrust, would we?

Are you familiar with the Maryland system, Mr. Ammon?

MR. AMMON. A little bit.

REPRESENTATIVE STARK. Mr. Oglesby?

MR. OGLESBY. Yes, I am.

REPRESENTATIVE STARK. Your chief hired gun used to run it.

MR. OGLESBY. That is right.

REPRESENTATIVE STARK. Are you, Ms. Ricardo-Campbell, familiar with the Maryland system?

MS. RICARDO-CAMPBELL. Only somewhat. Is it a single price for each item?

REPRESENTATIVE STARK. For each hospital. Maryland is given a budget and basically they operate this way, and it is an all-payer system. Each hospital has a set of rates that it may and must charge every purchaser.

So, regardless of whether you are paying out of your own pocket or whether you belong to Blue Cross or a PPO, that particular hospital has one price for all comers, and it is adjusted each year. And there are incentives occasionally built in where the State board, if you are going to merge, say, look, merge, and for a while we will give you a higher price in this, and it is partly political, but it does away with the need for worrying basically about antitrust procedures, because arguably the rates are set by another party.

MR. KAPLAN. With all due respect with the quality of the Maryland regulators, Mr. Chairman, I am very hesitant, as a general rule, to place all pricing and quality decisions in a regulatory body. I think history has suggested to us many, many different——

REPRESENTATIVE STARK. That brings to us Johns Hopkins, the best of the best, where the administrator of Johns Hopkins, who initially fought this system, and will now sing its praises and not only say they live comfortably within it, but they have been able to expand and maintain their rank of, if not the leading, top teaching hospital institutions in the country.

They like it. It seems to work. You know, whether you put it together in pieces or not, it is tough to quarrel with success, and they come in under the average, which saves us money. It is hard to argue with success, but go ahead, try.

MR. KAPLAN. No. Obviously, I would have to look very carefully at the view of a hospital that claims that they benefit from the regulatory scheme. One could question their incentives there.

I am not questioning Johns Hopkins or their sanity. I am only suggesting that for every success story, we will find one that is not so successful, and successes today do not guarantee successes in the next century. And you know better than I, Mr. Chairman, the pressures that can be brought in regulatory bodies. As a general rule, I think markets are better allocators.

REPRESENTATIVE STARK. How have the markets done in the last 15 years?

MR. KAPLAN. In health care, sir, very poor, but it is not a free market.

REPRESENTATIVE STARK. As a scientist and as a person, what is there in that experience in the last 15 years that gives you any hope for the future?

MR. KAPLAN. We face troubled times, but to say that we have a well-functioning market, though, is incorrect. We have a market that is interfered with repeatedly in many different forms, with many different messages being sent. I do think that there need to be meaningful and dramatic reforms if we are going to——

REPRESENTATIVE STARK. What you are suggesting to me is deregulation, basically?

MR. KAPLAN. I am not suggesting deregulation. I am only responding to the question as to whether Maryland's policy is a good idea for the other 49 States, and I am not sure that it is.

REPRESENTATIVE STARK. I am not sure that it is, either. In general, what do you think about global budget, let's say? Do you think that this industry can get its inflation rate down anywhere near the growth of the economy of the country without some kind of discipline?

MR. KAPLAN. Again, I am quite cautious about top/down-imposed restraints put on market participants. I recognize that this is a special case. I spend a lot of time arguing that myself.

As a general rule, I think one ought to be quite cautious about doing that.

REPRESENTATIVE STARK. How would it work in Ukiah if you had a single rate? Would that——

MR. AMMON. A single rate would work in that setting, but I am not necessarily advocating that. It is just that we obviously, right now, as I mentioned earlier, when you take Medicare, Medicaid and the HMO, PPO contracting, everything is negotiated right now to a level that is quite different from the old days when you made a rate adjustment.

REPRESENTATIVE STARK. In terms of the idea that antitrust is to protect the consumer, the consumer is a pretty sophisticated, well-endowed purchaser, is it not?

MR. AMMON. In the California market, that is very true.

REPRESENTATIVE STARK. It is not some lone sheep out there in the pass about to be sheered by you wolves in the business.

MR. OGLESBY. Mr. Chairman, can I make a comment to follow up about the Maryland experience?

I would guess that a Johns Hopkins would be an outstanding performer for many reasons that have nothing to do with the all-payer system in that State. In talking to colleagues there, they do agree that in some ways it has performed very well. However, insurance rates have continued to go up in Maryland at approximately the same rate as any other state.

REPRESENTATIVE STARK. We will take care of the insurance companies later.

MR. OGLESBY. The other thing that the system has not done is change the way health care services are provided in terms of the delivery system. I personally believe, and the American Hospital Association believes, that if we are to get a handle on health care costs in the future, we have to deal with the process—the way health care is provided.

REPRESENTATIVE STARK. Here is the problem that I have politically. Every fiber of my intellect, both of them, would suggest to me that I would agree with the former Republican Administration, that the only way we are ever going to get this underway is capitation.

In Alameda County, California, half the people—500,000—belong to Kaiser Permanente. That is half of the people that are cared for in any system. You get in a fight at any bar in town as to whether Kaiser is better than not having a program system. But Kaiser provides the service, which is arguably as good as any, with a third of the number of doctors and a quarter the number of hospital rooms that the fee-for-service or the market does. Now, again, I am not sure what that tells me, except they are doing something more efficiently.

The problem is that I don't think you are going to force people, one, to join. My mother would go out and sleep on a grate and humiliate me before she joined Kaiser. She has her doctor and she wouldn't go.

Second, we can't do anything, in spite of the Administration's demonstration projects, until hell won't hold it, to keep the crooks out of the business. Kaiser has evolved over 50 years and has some kind of institutional conscious which makes it serve the community.

Let me show you those high flyers in Florida who have stolen $30 million of government money so fast it makes your head spin.

We are trying to force feed HMOs, and that doesn't work. You are not going to force the public in. Maybe, when insurance comes around, like it does for us federal employees, we will make that choice better. It always pushes us somehow toward control. Go ahead, Ms. Ricardo-Campbell.

MS. RICARDO-CAMPBELL. I would like to align with David Kaplan here.

REPRESENTATIVE STARK. That is why we had you sit next to him.

MS. RICARDO-CAMPBELL. Finding a fellow believer in the market.

I would like to make a couple of points. One of the major reasons that the costs are high is the licensure system that we have. One of the reasons that Kaiser can deliver with less physicians is that they have general nurse practitioners and physician assistants.

I think we need more of them. Primary care is meager within the physician group. We have too many specialists. Two-thirds of our physicians are specialists. In Canada, it is one-third. That is the major difference between the systems.

REPRESENTATIVE STARK. No question. What I am coming back to, in other words, is that medical care in this country is good. It really is. However, too many people don't get it, and in many cases the costs are high, inefficiencies being one of them, but you don't want politicians in.

You don't even want politicians working on rates, but for us to determine the process of medical care would be a disaster. God help you.

Ms. RICARDO-CAMPBELL. I got a good suggestion the other night from a physician seated next to me at a dinner at the National Building Museum. He said that he worked in Fairfax County Hospital. Maybe, that means something to people locally. Physicians are probably the only group in the United States that have increased their share of the gross domestic product sizably in the last 10 years or so—in fact, before that. His suggestion was that he would tax physicians that earned over a certain amount and give medical care to the poor. He would look at the nonprofit hospitals and see if they are giving charity care.

REPRESENTATIVE STARK. I was just in Chicago and suggested that they ought not to get profits on referrals, and I came close to having my hide nailed to the barn door. Good luck on taxing those guys.

Ms. RICARDO-CAMPBELL. I am just saying that there are other reasons besides the organization of hospitals and antitrust.

REPRESENTATIVE STARK. Well, having said that, it would seem to me that if some of us had our way and could set an all-payer system for you, we wouldn't have to worry about antitrust. On the off chance that our bill does not zoom through Congress and get signed by the President in the near future, we will try and see if we can make some sense out of this.

By the way, I don't think we can let you all decide this as hospital administrators without somebody protecting, or being party to negotiating or arbitrating between you and your competing hospitals. It seems to me that I don't want to have an open invitation for a couple of you to get together and say we can dump on the other guy.

MR. OGLESBY. We aren't suggesting that.

REPRESENTATIVE STARK. There has to be some kind of a mechanism for that, and I don't think the market can do that.

MR. KAPLAN. I agree that there is a role.

REPRESENTATIVE STARK. I don't know what it is. Hopefully, we will be able, with your help, to find a way that will at least allow, if not encourage—that is a fine line, allow or encourage or both—consolidations, cooperation, co-ops, and without all the savings going to the lawyers, which might not be exactly right.

The Chair has to go and vote, and so we will recess now, and I want to thank the panelists very much for their time and effort. I hope we can develop something that can take the form of legislation and make some changes that make life simpler for you.

Thank you very much.

REPRESENTATIVE STARK. We will recess for about 15 minutes.

[Recess.]

REPRESENTATIVE STARK. We will resume and I again thank the witnesses' indulgence. We will turn to a panel of administration witnesses, who I am sure will restore the public's faith in our government.

The panel is led by Mr. Charles James, Acting Assistant Attorney General, Antitrust Division of the Justice Department; MR. JAMES C. Egan, Jr., Director for Litigation, Bureau of Competition, Federal Trade Commission; and Mr. Robert Eaton, the Associate Administrator for Program Development from the Health Care Financing Administration, known as HCFA.

We welcome you gentlemen to the panel.

Your prepared statements will be in the record in their entirety. The Chair will ask you to not use many of those Latin legal words because we will have trouble understanding it.

Why don't you expand on your prepared testimony in any way you are comfortable. We will lead off with Mr. James.

STATEMENT OF CHARLES JAMES, ACTING ASSISTANT ATTORNEY GENERAL, ANTITRUST DIVISION, U.S. DEPARTMENT OF JUSTICE

MR. JAMES. Thank you, Mr. Chairman, for the opportunity to appear at today's hearing. I certainly was glad you invited us to hear the earlier witnesses.

I have to confess that I am a lawyer, but if I start speaking in Latin phrases, I will be speaking in tongues because I don't understand very many of them myself.

You asked us to address the question of whether there is an inherent conflict between antitrust laws and other policies for the creation of efficient health care markets. Inasmuch as the antitrust laws are designed to protect competition, the question thus becomes whether competition has an important role to play in shaping our health care markets for the future.

We strongly believe that it does, and from that perspective, we maintain that sound, effective antitrust enforcement provides an important form of market discipline in these markets. We think antitrust has an especially important role to play as health care markets move toward new modes of contracting and service delivery. In particular the greater reliance on managed care. We think that—

REPRESENTATIVE STARK. I didn't mean to interrupt, but I want to understand where you all are coming from. The Chair recognizes a difference of opinion between the Administration and many members on my side of the aisle, in terms of economics. While I understand that there may be some differences of opinion as to whether there are "competitive markets," if we can stipulate that there are conflicting opinions as to how best to solve the overall problem and address ourselves more or less to the idea that some hospital consolidations, mergers or joint ventures could be useful and accept that there is some difference—maybe not an absence of a market—between buying health care because of the complexities of professionals directing us and insurance companies buying

for us. I say I recognize that there may be some difference between various witnesses on the panel and the Chair because you heard me try and destroy that argument with the last panel. You guys have too much information on how this operation runs for us to spend a lot of time on that. Fair enough?

MR. JAMES. Well, certainly. The only point that I would make is that from our perspective, there are important forms of competition, and we think that the antitrust laws provide a very effective way of screening out—within the context of that competition—those transactions that are likely to harm competition from those transactions that are likely to increase efficiency and reduce costs. In enforcing the antitrust laws, we certainly recognize many mergers and joint ventures actually promote competition and thus the enforcement standards we employ, those standards being dictated by the courts, require us to employ market shares only as a starting point in our analysis.

They certainly require that we perform a detailed competitive effects analysis that includes an accounting for actual market conditions, and require us to balance competitive risks against any efficiency likely to be generated through transaction. Finally, they require us to take into account the possible failure of one of the merging firms.

We believe balanced antitrust enforcement is the best and least intrusive mechanism for screening out those combinations that are likely to be harmful. I think our track record in terms of enforcement demonstrates that fact.

Over the past two years, there have been at least 220 hospital mergers. Our agency has challenged only five. The Department of Justice hasn't challenged a merger since 1988.

The Department has not challenged a single merger involving a small hospital with less than a hundred beds, and hasn't challenged a single merger in a rural market with a population of less than 200,000. With respect to joint ventures, we haven't challenged a single joint venture among hospitals with respect to ancillary services, such as laundry services, ADP centers or costly equipment such as MRIs and helicopters, things of that nature.

In light of the actual enforcement record, there is absolutely no basis for asserting that the agency has been over-reaching or indiscriminate in challenging mergers and joint ventures among health care providers. Not withstanding that perspective, the Department is always looking for ways to improve our enforcement efficiency and to reduce the cost of compliance.

The Administration, for example, supports legislation to clarify the law with regard to production joint ventures. That legislation would make it absolutely clear that those transactions would be fair under the rule of reason test, and beyond that would limit private damages to actual damages with respect to such ventures.

We continue the process of attempting to educate the health care community through the publication of enforcement guidelines, like our merger guidelines. Indeed, just this coming Monday, I will be talking to the American Academy of Hospital Attorneys, trying to further their understanding of our policy.

We continue to work with proponents of individual transactions through our business review procedure, and we are always happy to work with cooperating firms in merger investigations to resolve these issues quickly by initially focusing on the difficult positive issues and limiting our requests to the issues that will be determinative in the matter.

Finally, we are always looking at ways to improve the quality of analysis, and we are trying to work more closely with experts and other agencies in the department. I am happy to announce today that the Department of Justice, HHS and the Federal Trade Commission have agreed to form a staff working group to work together and make sure that we are understanding the factual issues and economic trends of the health care industry.

We recognize there is a prevailing difference of opinion with the hospital industries with respect to the need for antitrust enforcement in this business. I would say to you, Mr. Chairman, that I can't think of a single industry in this country that doesn't want an antitrust exemption if they can get one.

I think our enforcement record is very clear. The vast majority of hospital mergers and joint ventures are permitted to proceed without any interference from federal enforcement agencies. Nevertheless, when competitive problems do arise, when mergers actually threaten harm to the consumers, we take appropriate action.

Representative Stark. Did you say harm to consumers?

Mr. James. Harm to consumers.

Through this process, we promote the types of innovation and efficiency that exists in the market.

With that, I rest on my prepared remarks.

[The prepared statement of Mr. James follows:]

PREPARED STATEMENT OF CHARLES A. JAMES

I am pleased to appear before the Subcommittee today to present the views of the U.S. Department of Justice on the subject that is the focus of this series of hearings: the structure of the hospital industry in the 21st century. It is certainly our hope that the hospital industry of the future will be one that is characterized by accessible, cost-effective, high quality care. We believe that increased reliance on market competition, supported by sound antitrust enforcement, will promote the emergence of such an industry.

Today's hearing seeks to determine whether there is an inherent conflict between federal antitrust policy and the types of mergers and joint ventures that may be necessary to create the efficient and effective health care delivery systems of the future. The answer to that question is an unequivocal no. Indeed, it is our view that the relaxation of antitrust discipline through immunities or regulation actually will retard the process of necessary reform of our health care markets.

The U.S. antitrust laws are designed to protect competition through the elimination of anticompetitive conduct that fosters monopolies and cartels. Our antitrust laws, however, are sensitive to the fact that many mergers and joint ventures actually may promote competition. Thus, both our laws, and our policies to enforce them, provide plenty of room for health care providers to undertake transactions that increase output, enhance quality, spur innovation and otherwise promote economic efficiency. Through sound enforcement of the antitrust laws, we ensure that health care consumers and providers alike get the full benefit of the competitive process.

It has been suggested that the specter of antitrust enforcement has an inhibitory effect on health care providers. Those holding this view argue that antitrust prevents mergers needed to correct imbalances in capacity utilization in local markets or that antitrust prohibits joint purchases of costly capital equipment. The actual enforcement record, however, reflects just the opposite. As I will discuss in some detail later in my testimony, during a period of unprecedented merger activity, the agencies have challenged only a few hospital mergers and have not yet challenged a single joint venture among hospitals to operate an ancillary service or to purchase expensive capital equipment. We welcome the opportunity to set the record straight on these points, so that we can begin to discuss the future structure of our health care markets from the premise that competition will promote, not hinder, necessary reform.

THE CRITICAL ROLE OF COMPETITION IN HEALTH CARE REFORM

Cost-containment and access are two of the most important issues facing health care policy makers today. Many who have studied the performance of U.S. health care markets regard greater reliance on innovative contracting mechanisms and alternative delivery systems, managed care in particular, as a key to resolving some of these issues. Enrollment competition between managed care systems, for instance, encourages innovation, enhanced quality, and efficiency in the delivery of health care services. Similarly, greater use of selective contracting and bidding competition would generate efficiencies and improve quality, as competing providers vie to demonstrate the value and dependability of their services relative to those of their rivals. Unlike individuals who have "first dollar" insurance coverage, who are somewhat removed from the cost consequences of their health care purchasing decisions, managed care providers have

strong incentives to control costs and promote quality. Lower costs, of course, increase access.

Whatever the eventual structure of the health care industry of the future, hospitals and health care professionals will continue to provide the services that are the key inputs for our overall health care delivery system. Prices charged for these inputs must be determined by market competition if the movement to greater reliance on managed care delivery is to produce any of its expected benefits. No amount of structural reform will succeed if health care providers are organized into tightly knit cartels that reduce output, increase prices, stifle innovation or restrict entry. Balanced antitrust enforcement is the best available mechanism for screening-out those combinations among health care providers that are likely to have adverse competitive effects, from those combinations that promote efficiency and reduce costs.

ANTITRUST ANALYSIS OF MERGERS AND JOINT VENTURES

The Department analyzes mergers and joint ventures under two primary statutes -- Section 1 of the Sherman Act and Section 7 of the Clayton Act. Section 1 of the Sherman Act prohibits contracts, combinations and conspiracies in restraint of trade. Section 7 of the Clayton Act prohibits mergers, acquisitions and certain joint ventures, the likely effect of which may be substantially to lessen competitition or tend to create a monopoly. In analyzing mergers and joint ventures among health care providers, we seek to determine the likely effects of such transactions on all consumers of health care services, including managed care systems and other third-party payors.

Merger Standards

The Department recognizes that health care providers must be able to undertake consolidations and other transactions to achieve necessary economies of scale and scope in the provision of health care services. Our enforcement policies with respect to hospital mergers, therefore, are flexible and comprehensible enough to permit such transactions to proceed. However, when we conclude hospital mergers threaten to harm consumers, we take action.

The basic analytical approach for the evaluation of mergers under Section 7 is the Horizontal Merger Guidelines. Those Guidelines, revisions of which were just issued jointly by the Department and the FTC on April 2, set forth in considerable detail the specific market factors and decisional standards the agencies consider in reviewing a transaction. The 1992 Horizontal Merger Guidelines represent the next logical step in the evolution of merger enforcement policy. They reflect further movement away from wooden, concentration-based standards for evaluating competitive harm, and toward a more dynamic analysis that takes proper account of real-life business conditions in the affected markets, together with any efficiencies likely to be generated through the merger.

Without attempting to explain all facets of the Merger Guidelines, the basic approach can be summarized as a sequence of analytical steps that are each necessary and together sufficient to determine whether a merger will create market power or facilitate its exercise. We begin by defining the relevant market -- the group of products or services and the geographic area -- affected by the transaction. We then measure concentration in that market to determine whether the transaction will result in a concentrated or

highly concentrated market. Consistent with the view that concentration is only the starting point for merger analysis, we then proceed to a detailed analysis of likely anticompetitive effects. We next consider whether possible anticompetitive effects will be deterred or counteracted by new entry. We then consider whether efficiency gains likely to be generated by the transaction will counter-balance any identified anticompetitive effects. In cases where the acquired firm faces imminent financial failure, we also consider whether its productive assets would exit the market absent the transaction.

Joint Venture Standards

The term "joint venture" is routinely applied to a broad range of collaborative activity in the business community. Depending upon the nature of the collaboration, and especially the extent to which the parties are integrating their operations, joint ventures can be considered under the conduct prohibitions of Section 1 of the Sherman Act or the more transactional screen of Section 7 of the Clayton Act. In either event, the essence of the analysis is essentially the same -- to determine the joint venture's competitive effects.

Legitimate joint ventures -- i.e., those that involve some integration, but not so much as to be a complete merger of operations -- are evaluated under the Sherman Act's "rule of reason." That means that we consider the extent to which the venture is likely to create market power or facilitate its exercise. Just as we do in merger analysis under the Clayton Act, we must balance likely anticompetitive effects against efficiencies to be generated through the venture.

The critical distinction in the joint venture context is that joint venturers often retain some degree of economic autonomy, and that retained autonomy may be relevant to the firms' incentives to engage in anticompetitive conduct through the venture. Thus, there are often situations in which a limited joint venture among competitors might be lawful, whereas a complete merger among those firms would not. In each case, we look to the specific circumstances, including the extent to which the venturers will continue to interact as competitors.

ANTITRUST ENFORCEMENT IN THE HOSPITAL INDUSTRY

At this point, I would like to address certain specific misconceptions about our application of the antitrust laws to the hospital industry.

Hospital Mergers

Perhaps the greatest misconception about our enforcement program is that we have been overly aggressive in challenging hospital mergers or that we have challenged an inordinate number of these transactions. Nothing could be further from the truth. Over the last five years, there has been unprecedented consolidation in the hospital industry. Data concerning the actual number of mergers are subject to varying interpretations. By our account, however, there were at least 229 hospital mergers during the period 1987 to 1991. During that period, the Department and the FTC opened formal investigations into only 27 transactions. Of those 27 investigations, only five resulted in challenges. Given the large number of transactions, this is hardly a record of over-aggressive enforcement.

Similarly, it has been suggested that we have been overly aggressive in attacking transactions among small or rural hospitals, where demographic conditions would not necessarily support competing hospitals. Once again, the actual record belies this notion. Between 1987 and 1991, the Department did not challenge a single merger between small hospitals (under 100 beds) or a single merger in a community with a population under 200,000.

Turning to the merits of merger analysis under the antitrust laws, we often hear the criticism that our concentration standards are too low for an industry where some markets are too small to support a large number of competitors. The simple fact is that concentration is merely the starting point in merger analysis. In each case, we conduct a detailed analysis of competitive effects and likely efficiencies to reach a balanced evaluation of the proposed merger. In a number of instances, the agencies have approved transactions well exceeding the stated concentration standards, based upon evidence that the transaction was not likely to harm consumers.

Another frequently voiced criticism is that the antitrust laws prohibit or "chill" hospital mergers necessary to address over-capacity or under-utilization problems in particular markets. The Department, however, is always sensitive to the possible capacity utilization problems confronting the parties to a transaction. We recognize the rationalizations of capacity can reduce operating costs in ways that will benefit consumers through lower prices and more efficient services. To be sure, we look closely at each efficiency claim to ensure that it is well founded. But when the evidence indicates that efficiencies are both likely and substantial, we are unlikely to challenge a merger.

The Department is proud of its merger enforcement program both generally and in the hospital industry. We employ flexible and comprehensible standards to separate the good transactions from those that legitimately should be of concern. We have devoted considerable resources to understanding how hospital markets function, and we apply that expertise to ensure that health care providers and the consumers they serve get the full benefits of competition.

Joint Ventures

With respect to joint ventures, the absence of any inhibitory effect from antitrust enforcement is even clearer. We often hear that hospitals need to collaborate on ancillary services and equipment to ensure proper utilization. It is said that an inability to collaborate results in "arms races" in which individual hospitals each invest in costly equipment -- e.g., MRIs, helicopters, laundry services, etc. -- only to have those investments go severely underutilized. Antitrust is not a barrier to such collaborations. Generally speaking, joint ventures to purchase and operate ancillary services and equipment raise few real antitrust concerns. Indeed, as far as we have been able to tell, the Department has not yet challenged a single joint venture of that type.

Moreover, the Department is quite willing to work with health care providers, both informally and through our formal business review process, so that they can know, in advance, whether we perceive antitrust problems in the ventures they are considering. Over the years, both agencies have reviewed a number of collaborative arrangements among health industry firms, most of them resulting in clearance of the activity. Depending upon the level of cooperation we receive, this can be a relatively quick, low-

cost mechanism for determining agency enforcement intentions with regard to a proposed course of conduct.

MOVING TOWARD THE FUTURE

One useful purpose of these hearings is to consider what can be done to ensure that there are no unnecessary barriers to useful collaborations among hospitals. As I've explained, existing antitrust laws and enforcement policies serve their proper function -- prohibiting anticompetitive mergers and joint ventures, while permitting most transactions to proceed. We believe that any relaxation of antitrust enforcement, through legislation or otherwise, could have the harmful effect of retarding the process of market oriented reform that has already begun. Just as in any other market, competition among health care providers will encourage cost-containment, innovation and efficiency, and the sound enforcement of existing antitrust laws will protect that competition.

That is not to say, however, that there are no positive steps that can be taken. To that end, the Department supports legislation that would clarify the law with respect to the treatment of joint ventures. Pending legislation, including an Administration proposal, would extend the National Cooperative Research Act to production joint ventures. The thrust of this legislation is to confirm that legitimate production joint ventures must be evaluated under the rule of reason and to provide for a limitation on damages in the case of production joint ventures prenotified to the government.[1]

Another important step is to continue the process of educating the health care community concerning the true reach of the antitrust laws. Notwithstanding the fact that the agencies have challenged only a few hospital mergers and no hospital equipment or service joint ventures, the health care industry has a different impression of our enforcement policies and intentions.

We are somewhat puzzled by the fact that there is not broader understanding of our enforcement policy, despite the fact that no single industry presents more conferences, seminars and educational programs focused on antitrust issues. During the last four years, our health care experts have given over 35 speeches addressing a broad range of antitrust topics of special interest to the health care industry. Indeed, next week I will be speaking before the American Academy of Hospital Attorneys, which is sponsoring an antitrust conference as part of its annual meeting. I know that the FTC also has been quite active in speaking on health care issues. We will continue our efforts to explain clearly our enforcement priorities.

A third step relates to coordination between agencies involved in health care regulatory policy and the two federal antitrust enforcement agencies. As the health care industry continues to evolve, it is important that the antitrust agencies remain current on trends and factual developments that are relevant to our competitive analyses. At the same time, it is also important that the health care and antitrust agencies work to develop a common view of those trends and developments. Accordingly, the Department, the FTC and HHS are working on ways to review industry trends and developments as they affect competition among health care providers. The industry can only benefit from better information flows between us.

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[1] The Administration has supported a variety of health care reforms designed to contain costs for consumers of health care, and increase certainty for providers of health care. For example, the Administration has supported health care liability reform.

Finally, it is important for those setting policy for the health care industry -- be it at the local, state or federal level -- to recognize the important role competition can play in curbing costs and increasing access. Regulatory policies that discourage innovation, entry and efficient expansion must be reconsidered, and any new regulatory schemes must leave room for the maximum level of competitive interaction among firms at all levels of the industry. Market-oriented solutions should be considered wherever possible.

CONCLUSION

In sum, it is our firm belief that sound, effective antitrust enforcement has a positive effect on the health care industry. Antitrust enforcement, and the competition it fosters, advance the goals of cost-containment and efficiency by ensuring that market forces, not private cartel agreements, dictate the performance of our health care markets. This will be as important in the future as it is today.

This concludes my prepared remarks. I would be pleased to respond to any questions you might have.

REPRESENTATIVE STARK. Mr. Egan, please proceed.

STATEMENT OF JAMES C. EGAN, JR. DIRECTOR FOR LITIGATION, BUREAU OF COMPETITION, FEDERAL TRADE COMMISSION

MR. EGAN. I, too, am grateful for the opportunity to testify here today. I do have prepared remarks and those remarks do represent the views of the Federal Trade Commission. I do have to give the normal caveat that any other remarks are my own and are not necessarily those of the Commission or any individual Commissioner.

As you will see in the prepared remarks, the position of FTC is generally consistent with the position of Department of Justice, and if I were to fully summarize my remarks, I would be repeating much of what Mr. James has just said. I will try to avoid that to the degree that I can.

I will quickly make some points, however, in way of summarizing the remarks.

We agree that competition does matter in health care markets. That does not mean that competition meets the textbook model.

I think everyone agrees that it does not in health care markets, but markets can adjust to perceived problems within them, and antitrust allows that to happen, in large part. I would give as an example the role that the FTC played in allowing managed care to develop in health care markets.

It was not until the FTC brought a case against the American Medical Association in 1975, challenging ethical restrictions which limited the ability of managed care to develop, that managed care was able to really blossom, and today is becoming much more important.

[The prepared statement of Mr. Egan follows:]

PREPARED STATEMENT OF JAMES C. EGAN, JR.

Good morning. I am James C. Egan, Jr., Director for Litigation at the Federal Trade Commission's Bureau of Competition. My responsibilities include the supervision of the Bureau's antitrust enforcement activities relating to health care services, and in particular the Bureau's work relating to mergers and joint ventures in the hospital industry.

I would like to thank the Committee for the opportunity to testify today in these hearings regarding "The Structure of the Hospital Industry in the 21st Century." The Commission has been active in recent years enforcing the antitrust laws in that industry. The Commission has pursued a vigorous but careful effort to promote an industry structure conducive to the hospital competition needed to help make America's health care system work now and in the future. The Commission's testimony today will focus on the role of antitrust enforcement when the market attempts to overcome inefficiencies in the health care system, and to preserve options for future reforms to make the system work better.

This written statement represents the views of the Federal Trade Commission. However, my responses to this Subcommittee's questions are my own, and do not necessarily reflect the views of the Commission or of any individual Commissioner.

Antitrust's Historical Role in Promoting Health Care Reform

Those who pay for and use health care services increasingly have relied upon innovative methods of health care financing and delivery to overcome inefficiencies in America's health care markets. But those efforts were greatly facilitated by the relatively recent introduction of antitrust enforcement into the health care sector, which eliminated some of the obstacles to reform and promoted the competitive market forces needed to make reform work.

The premise of the antitrust laws is that a competitive marketplace normally will supply the full range of goods and services that consumers want, at the lowest possible prices. The purpose of the Commission's health care antitrust enforcement program, including its hospital merger enforcement efforts, is to preserve the most opportunities for consumers.

Of course, health care markets differ in many respects from the textbook model of the competitive market. In particular, the relative lack of information available to patients, the resulting fiduciary responsibilities of providers to their patients, and the presence of health care insurance which blunts the impact of price on patients' purchasing decisions, have been cited as factors that may impede normal competitive processes in health care markets. Certainly, these factors, and others, may mean that market responses to changing conditions are more complicated and take longer to develop in health care markets than in some others. But they do not mean that market forces do not play a valuable role in health care markets. Furthermore, such unique features do not mean that consumers will necessarily benefit if providers are permitted more control over price, output, and quality of services.

Indeed, the growing demand of patients and payers for more cost effective care and for more information about quality have led to market responses intended to overcome the inefficiencies of health care markets. These responses include the development of a large variety of "managed care" plans. These managed care plans, which have grown

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tremendously in recent years and continue to capture an increasing share of the market, are intended to address directly the special features of health care markets, particularly by making purchasing decisions more sensitive to costs. The Commission does not endorse any particular type of health plan, including managed care plans, to improve health care in this country, but instead encourages a competitive environment so that consumers may select among a range of options.

The antitrust laws are intended to help ensure that the market can provide the most choices at the lowest prices. But those laws have been applied to the health care field only relatively recently, beginning in the mid-1970s. Precursors of today's managed care plans developed many years ago, but for a long time were stymied by the organized opposition of physicians. Employer-provider health care services developed in some areas of the country in the mid-nineteenth century, and by the early twentieth century lay-controlled hospital associations were operating in a way similar to today's HMOs. These programs were attacked as unethical by medical societies, in large part because the programs promoted price competition among providers. Later, medical organizations established provider-controlled insurance programs that eventually developed into Blue Shield plans, and for a time were the dominant providers of health insurance in many areas of the country. For a long time these plans were closely linked to local medical societies, maintained physician control over reimbursement matters, and were open to any medical society member no matter how ineffective he or she was in controlling costs.[1]

Organized medicine opposed the development of prepaid group medical practice for many years. Physicians associated with such groups were often expelled from membership in their local medical societies and deprived of hospital privileges.[2] In 1943, the Supreme Court upheld a criminal conviction of the American Medical Association and the Medical Society of the District of Columbia for conspiring to obstruct the operation of Group Health Association, a prepaid group practice.[3] Among the challenged activities were disciplinary actions against physicians who were on the staff of Group Health, sanctions against non-employee doctors who consulted with Group Health doctors, and actions against hospitals that permitted Group Health doctors to practice there. Nonetheless, AMA and other medical organizations continued to adhere to ethical prohibitions on members' association with prepaid group plans until FTC enforcement actions were undertaken in the 1970's.

In 1975, the Commission issued an administrative complaint challenging a number of AMA's ethical standards, including those that prohibited physicians from providing services to patients under a salaried contract with a "lay" hospital or HMO, "underbidding" for a contract or agreeing to accept compensation that was "inadequate" in light of the usual fees in the community, or entering into an arrangement under which patients were denied a "reasonable" degree of choice among physicians. The Commission found that these restrictions restrained competition among physicians and impeded the

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[1] A brief history of the development of contract medical practice and physician-controlled prepayment plans is found in Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans, Staff Report to the Federal Trade Commission, at 54-62 (1979).

[2] See Feldstein, Health Associations and the Demand for Medical Care 40-44 (1977).

[3] American Medical Ass'n v. U.S., 317 U.S. 519 (1943).

development of alternatives to the traditional fee-for-service method of delivering health care services. The Commission's order prohibiting the AMA from imposing these restrictions on its members was upheld on appeal.[4]

The Commission has also issued orders prohibiting other forms of concerted medical opposition to health maintenance organizations, such as denying participation in a Blue Shield plan to doctors who worked for an HMO,[5] obstructing the grant of hospital privileges to HMO doctors,[6] or boycotting hospitals that planned to open an HMO facility.[7] These actions have cleared the way for the recent development of many types of managed care plans in response to federal legislation encouraging HMOs[8] and payer demands for cost containment.

Organized provider opposition to innovative methods of providing health care services continues to this day. For example, the Commission recently issued consent orders prohibiting concerted physician efforts in Broward County, Florida to prevent the entry of the Cleveland Clinic (which offered patients "package prices" set in advance for the various services needed in connection with particular types of surgery or medical procedures), and which competes with local physicians practicing traditional fee-for-service medicine.[9]

Antitrust's Current and Future Role in Promoting Competitive Hospital Markets and Opportunities for Reform

At this point, I would like to address the subject of what role competition and antitrust will and should have in the hospital industry in the 21st century. I will discuss in particular how the Commission's antitrust enforcement activities concerning hospital mergers and joint ventures attempt to maintain the competitive market forces needed to make the current health care system work, and provide opportunities for improvements in the system to make it work better.

The Commission is not in a position to make broad predictions or recommendations about what the hospital industry will or should look like in the next century. The Commission's involvement in the health care field is limited to the enforcement of certain antitrust and consumer protection statutes. While that role is important, the Commission's experience with and expertise in health care is limited and specialized, as compared to agencies such as the Department of Health and Human Services, whose

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[4] American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982). The Commission also challenged restraints on salaried practice and non-fee-for-service compensation imposed by the American Society of Anesthesiologists. American Society of Anesthesiologists, 93 F.T.C. 101 (1979) (consent order).

[5] Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976) (consent order).

[6] Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979) (consent order).

[7] Medical Staff of Doctors' Hospital of Prince George's County, 110 F.T.C. 476 (1988) (consent order).

[8] The Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e et. seq.

[9] Medical Staff of Holy Cross Hospital, C-3345 (consent order issued September 10, 1991, 56 Fed Reg. 49,184 (September 27, 1991)); Medical Staff of Broward General Medical Center, C-3344 (consent order issued September 10, 1991, 56 Fed Reg. 49,184 (September 27, 1991)).

regulatory responsibilities are much broader and more extensive and which is also responsible for the formulation of general health care policy.

However, the Commission does believe that competition significantly improves the performance of hospitals within the existing health care system. Competition will continue to play such a role in foreseeable circumstances. Under the present health care system, competitive market forces help make hospitals work well, and antitrust enforcement is needed to ensure that those market forces are unimpeded by anticompetitive agreements or practices.

The clearest benefit to consumers of competition in the hospital industry is the ability of third party payers, such as health maintenance organizations and preferred provider plans, to contain costs. Under various forms of managed care, health plans use their ability to selectively contract with hospitals, and their extensive knowledge of hospitals' prices and quality of care, to direct their beneficiaries to the hospitals offering the most cost-effective and highest-quality alternatives reasonably available to them. This strategy encourages hospitals to provide economical, high-quality care, by rewarding hospitals providing such care with additional patients, or at least by steering patients away from high-cost institutions.

Managed care competition for hospital and other health services is becoming increasingly widespread, and many efforts to reform America's health care system would rely more heavily upon it. The information gathered in our investigations, where we frequently obtain the perspective of managed care payers, generally indicates that managed care slows hospital price increases where health plans have at least several hospitals to choose from in the markets they serve. This occurs because the plans can engage hospitals in a competitive process to obtain low prices, and can avoid doing business with those hospitals unwilling or unable to offer high-quality, cost-effective care.[10] The Commission places particular importance in its hospital merger enforcement activities on the preservation of the hospital alternatives needed to make managed care work.

The benefits of competition to the American health care system reaches beyond managed care price competition, and extends even to markets where managed care has not yet taken hold. For example, even the less intensive price competition that prevails in non-managed care markets places additional pressure on unusually high-cost hospitals to confront their inefficiencies and take the steps necessary to contain their costs.

This will be of particular importance as the Medicare system, and other payers with aggressive cost-containment programs, place more stringent reimbursement limitations on inefficient hospitals. Medicare in particular, through its prospective reimbursement system, is already forcing hospitals to absorb excessive operating costs rather than pass them on to the Federal Government. Medicare has also started moving in the same

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[10] As noted in testimony before this Subcommittee last week, some economic studies also indicate that managed care can substantially constrain hospital prices or costs, at least when managed care health plans can choose among a wide range of hospitals available to their beneficiaries. See Testimony of Michael A. Morrisey, Ph.D., discussing, e.g., G. Melnick, J. Zwanziger, A. Bamezai, and R. Pattison, "The Effects of Market Structure and Bargaining Position on Hospital Prices," Journal of Health Economics (forthcoming); J. Robinson, "HMO Market Penetration and Hospital Cost Inflation in California," Journal of the American Medical Association (Nov. 20, 1991); J. Zwanziger and G. Melnick, "The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California," 7 Journal of Health Economics 301 (1988).

direction with respect to excessive capital costs, which should by the 21st century also be denied Medicare reimbursement. This strategy provides powerful incentives for hospitals to reexamine their operations and take the sometimes painful steps needed to eliminate inefficiencies. But those incentives would be undermined if high-cost hospitals could freely "cost-shift" onto private payers the excessive costs Medicare refuses to pay for, without competition from hospitals with lower costs and more reasonable prices. It has been our experience that the presence of lower-priced competitors to whom consumers can turn significantly helps motivate inefficient hospitals to confront and overcome their inefficiencies and contain their costs.

As this Committee's invitation for Commission testimony here today points out, some in the hospital industry and elsewhere believe that the Commission's antitrust enforcement efforts impede rather than promote the provision of economical, high-quality hospital care, because it blocks or discourages pro-consumer mergers and joint ventures among hospitals. Indeed, it is said that the Commission's focus on preserving competitive hospital markets is at odds with other policies being implemented by HHS that encourage hospitals to become more efficient.

However, the Commission's health care antitrust enforcement program demonstrates that there is no conflict between antitrust policy and the health care cost containment efforts of the Administration and others. HHS seeks to promote low-cost, high-quality hospital care. So does the Commission.

In April of this year the Commission and the Justice Department jointly issued merger guidelines which set forth the analytical framework the agencies use in determining whether a merger is likely to lessen competition.[11] Those Guidelines emphasize the need to look beyond market concentration to determine whether a particular merger is inconsistent with the Federal antitrust laws' objective of preserving competition and thereby promoting low-priced, high-quality goods and services for the consumer. In any industry, it is necessary to look at a broad range of market characteristics to determine whether the increase in concentration and the elimination of a competitor through a merger would likely threaten consumer interests (i.e., whether increases in concentration and difficulty of entry increase the likelihood of collusion or anticompetitive unilateral effects). These other factors include efficiencies and other consumer benefits that the merger might make possible.[12] The Commission accordingly is careful to make sure that its enforcement actions in hospital markets in fact serve consumer interests.

The Federal agencies' enforcement record reflects their recognition that most mergers and joint ventures, in the hospital industry as in any other, are likely to help (or at least not harm) consumers. Out of approximately 50-100 hospital mergers and similar

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[11] Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines (April 2, 1992).

[12] Of course, claims of efficiencies will only be considered if they are realistic and supported by the evidence. Notably, in three of the four hospital merger cases decided after litigation in which potential efficiencies were a significant issue, the hospitals' arguments on that issue were rejected as factually unpersuasive. See FTC v. University Health, Inc., 938 F.2d 1206, 1223-24 (11th Cir. 1991); United States v. Rockford Memorial Corp., 717 F. Supp. 1251, 1287-91 (N.D. Ill. 1989), aff'd, 898 F.2d 1278 (7th Cir.), cert. denied, 111 S.Ct. 295 (1990); American Medical International, Inc. 104 F.T.C. 1, 148-155, 218-20 (1984). However, the Commission has weighed potential efficiencies in reaching its decision not to challenge certain hospital transactions.

transactions each year (including leases, management contracts, and other non-purchase, non-merger transactions consolidating the operations of previously independent hospitals), on average only a handful are investigated by either the Commission or the Justice Department. And less than once a year has either agency actually challenged a merger as anticompetitive. Moreover, neither the Commission nor the Justice Department has ever challenged any of the numerous joint ventures among hospitals. Indeed, when they have challenged proposed mergers, the agencies have identified joint ventures for example, an existing magnetic resonance imaging ("MRI") service shared between two hospitals in Augusta, Georgia, where the Commission challenged a proposed hospital merger in the University Health case[13] as desirable alternatives for hospitals to achieve efficiencies to improve specific services without sacrificing the larger benefits of price and quality competition by merging their entire operations.[14] Consequently, the vast majority of the more than five thousand hospitals in the United States are able to go about their business and pursue whatever cost-containment measures they find necessary without any intervention from antitrust regulation.

The Commission not only has limited its enforcement actions to hospital mergers which could have been genuinely harmful, but also has made considerable efforts to publicize and clarify its enforcement policies in that area so as not to discourage legal, beneficial transactions. The court and Commission decisions in litigated hospital merger cases explain in great detail how to apply antitrust principles to such transactions. These decisions are amply supplemented by not only formal statements, such as the 1992 FTC-Justice Department Merger Guidelines, but also by well over a dozen speeches by senior agency officials discussing hospital mergers and joint ventures, not to mention the hospital industry's own efforts to educate itself on how the antitrust laws apply to mergers and joint ventures.[15] And the Commission's staff is readily available for informal consultation to provide additional clarification and assistance to hospital officials thinking about a merger or joint venture. All of these resources are available to help hospital executives ensure that their proposed mergers and joint ventures comply with the antitrust laws, and dispel any unwarranted fears to the contrary.

In conclusion, the Commission emphasizes that antitrust enforcement has played an important role in facilitating reforms in the health care sector and the hospital industry in particular, by removing obstacles to the use of innovations such as managed care to take advantage of competition to contain costs and overcome some of the inefficiencies

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[13] FTC v. University Health, Inc., 1991-1 Trade Cas. (CCH) ¶¶ 69,400, 69,444 (S.D. Ga.), rev'd, 938 F.2d 1206 (11th Cir. 1991).

[14] See also The Reading Hospital, 55 Fed. Reg. 3264, 3266, 15290 (1990) (consent order) (Commission determined that voluntary separation of merged hospitals was sufficient to restore them as independent competitors, even though both hospitals continued to participate in hospital-sponsored health plan joint venture, and to share laundry, laboratory and biomedical equipment repair services). In addition, a pending consent order to settle the administrative proceedings in the University Health case (provisionally accepted by the Commission on June 18, 1992, subject to public comment) would expressly exempt a wide range of support service joint ventures between hospitals from the order's provisions for Commission oversight of respondents' future hospital mergers and joint ventures.

[15] E.g., American Hospital Ass'n, Hospital Mergers: An Executive's Guide through the Antitrust Thicket (Sept. 1989).

of health care markets. It continues to have a useful role in improving the performance of the hospital industry as it is now structured, and also in leaving the door open to further reforms of the health care system that would rely even more heavily on competition as a cost-containment strategy.

REPRESENTATIVE STARK. What I would tell you is that doctors learned the AMA is irrelevant. So, whether or not you blame them or not, they were going to go ahead and do the right thing, in spite of the AMA. That is an alternative.

MR. EGAN. I would only note that commentators——

REPRESENTATIVE STARK. I think you give AMA more credit than they deserve.

MR. EGAN. It is not only me. Other commentators, including a study by the American Bar Association, would suggest that the growth of managed care is at least, in part, due to the fact that the FTC eliminated those restrictions from the AMA's ethical code.

REPRESENTATIVE STARK. The bar association effectively can keep you out. But hardly half the doctors in the country belong to the AMA. I would presume that most practicing attorneys have to belong to a bar association. There is a difference. That is the point I was trying to make.

While I thank you for not letting the AMA discriminate against people who say, go to work for Kaiser on salary, because that used to be prima facie evidence that they were unethical. The fact is that it didn't make any difference. Kaiser grew in spite of them, and I think you did the right thing, but I don't want you to give too much credence to the AMA's ability to get much done in this country.

MR. EGAN. Well, without agreeing or disagreeing, I will move to my next point. That is the role of our merger enforcement program. Our merger enforcement program is to insure that there is consumer choice.

And this gets to a point that I am sure you were making earlier as to whether or not consumers really have a choice in this market, and we can discuss that if you wish. But competition as a process only works if consumers do have a choice.

An example is, again, managed care providers. Again, I am a lawyer. I have not performed studies as some of the economists who appeared here, but I have had the chance to see the internal documents from hospitals in the context of merger investigations.

I have had the opportunity to talk to managed care providers and get their perspective. From that very real world perspective managed care providers tell us, and the hospitals, I think, recognize that they are able to bargain to keep prices and costs down for hospitals only if they have a choice among hospitals. To me, that is a very common sense proposition and it is the proposition that drives all of our merger enforcement policy, not just hospital merger enforcement policy.

REPRESENTATIVE STARK. But is there any indication that these guys pass any savings on to you and me, the person who pays for the health care?

In other words, for all our good work, whether I try and save it for federal programs, or you try and save it, it probably ends up going in the pockets of insurance companies.

MR. EGAN. By managed care providers, that term is rather broad. It can mean, for example, in the case that we brought against the merger of

two hospitals in Augusta, Georgia, managed-care providers meant small businesses that were self-insured, and they were negotiating with the hospitals on behalf of their employees.

So, yes, it was passed onto the employees in the sense that the small businesses paid less money because of their ability to negotiate between two hospitals, and they were able to, in a sense, pass that savings along not only to their employees but to the community as a whole, I suppose.

REPRESENTATIVE STARK. And you saw no evidence that once they negotiated those contracts for those hospitals, they turn to the other folks in that community, raise their costs to make up for that and thereby harm the people who work in this small business consortium.

MR. EGAN. I think that is a concern. I think that in areas where managed care has a ... I am not a proponent of managed care, in particular. I am just pointing to managed care as a way that the market has adapted to perceived inefficiencies.

There are other ways of doing it, and other more traditional insurance companies are raising the copayment rates and raising the deductible. So, I think there are other ways, and there are various methods of getting consumers more information.

You talked about the lack of information. Managed care is a way of providing consumers with more information, and there are other ways of achieving that. I am sure you are aware that there are movements afoot to do that.

I would move to my third point, which is that there is no inconsistency with our merger enforcement and joint venture enforcement programs and the health care concerns at issue. I won't repeat the numbers that Mr. James has already indicated.

I think the bottom line is the same. The numbers are in my prepared testimony. The number of mergers that we investigate in the first instance is very few compared to the overall number of hospital mergers overall, and the number of challenges is exceedingly small compared to the number of mergers overall.

It is not credible to me that we can have a negative effect on the efficiency-enhancing likelihood of mergers and joint ventures, given the limited nature of our merger enforcement program. We recognize not only in the hospital industry but in all industries that most mergers and joint ventures are either pro-competitive or neutral. There are relatively few that cause competitive concerns. I don't think there is a single case that has been litigated that anyone can point to and say that there is an instance in which the Federal Trade Commission stopped an efficiency-enhancing merger or joint venture, not a single one.

REPRESENTATIVE STARK. Is there a case where you stopped a bad merger? Georgia?

MR. EGAN. Certainly.

REPRESENTATIVE STARK. Which one?

Mr. Egan. For example, the Augusta case, one which I am most familiar with. The discussion earlier was about the fact that doctors have a lot to say about where people go for their hospitalization and that is, I think, correct. I don't think it is the only consideration, but it is important.

In the case of Augusta, there were two primary hospitals that were going to merge where independent doctors had admitting ability. There were no other hospitals in the area that that was true of. Patients effectively could choose between those two hospitals because both doctors had admitting credentials in both hospitals. It wasn't true in any other hospital. The other hospitals were either located a further distance away——

Representative Stark. How far?

Mr. Egan. The hospital, which we included in the market, was located actually in South Carolina, across the river from Augusta in South Carolina—I forget the name of the county now, but that was one.

Representative Stark. A half-hour's drive?

Mr. Egan. Yes. We included it in the market, but the fact that was most of the doctors in the downtown Augusta area did not have the ability to admit patients in that hospital. So, if you acknowledge in the first instance that the doctor has a lot to say about where the patients go, the real two choices were the two hospitals that were going to merge. That was the primary concern in that case.

Representative Stark. In general, isn't it true that—I am just guessing—hospitals bend over backwards to let doctors admit that they are hustling doctors all the time to send them patients. Unless the doctor is a real quack, it seems to me that most hospitals are going to encourage the doctor to sign up.

Mr. Egan. That is true except, for example, in Augusta.

Representative Stark. Except in Virginia Beach where they discriminate. You have some problems there where it is race or religion. We have instances there where the hospitals are not as open as we like.

Mr. Egan. In Augusta, the facts are that one hospital was located a distance away. It was too far from doctors offices. A second hospital had its own employee staff. The physicians were employed by the hospital. It was not open for other doctors to come in and admit patients.

The third hospital was a hospital that was essentially utilized by the community for those who couldn't afford to go to any of the other hospital. So, doctors would not send their paying patients to that hospital.

To answer your question, we have had cases where it has been clear——

Representative Stark. What were they doing after the merger that led you to drop the hammer on them?

Mr. Egan. They never got to merge because we obtained an injunction.

Representative Stark. What did you think they were going to do?

What were you protecting me from?

Mr. Egan. Well, they would have the ability, we believed, after the merger, to raise their prices and probably also offer lesser quality. The documents in the case indicated that one of the primary reasons for the merger was to "lessen competition." We attempted to get an injunction in the District Court in Augusta. The court denied that. We went to the 11th Circuit Court of Appeals, and there is an extensive opinion——

Representative Stark. Let's say that they raised their prices. How would the citizens of Augusta even know that?

Mr. Egan. Again, in the example, managed care was not a big factor. As opposed to California, managed care has not taken hold in many sections of the country to the same degree. Managed care did exist. We had testimony from managed care providers about the ability to negotiate contracts in the future if they no longer had the two hospitals to leverage against one another.

Representative Stark. Managed care patients could go the half-hour drive away. Obviously, if you are in managed care, you are hooked. If the managed care guys say, you drive, you drive.

Mr. Egan. I don't think it is quite that simple. You are much more an expert than I am on this.

My limited understanding is that, for example, self-insured employers have to take into consideration where their employees live, and if they don't, they will have some mighty dissatisfied employees, and the same thing is true of managed care.

Representative Stark. I mean, in the real world, you are talking about that mythical employer in the United States who does give a hoot about his or her employees. That concern is generally, in my opinion, engendered by unions that look after the employee—it ain't the management.

The idea that managed care is anything but reducing benefits to the employees by restricting choice or restricting the amount of care they can give them, they are perfectly willing to make them drive a little ways. So, unless you are talking about some place that is so isolated that they literally can't——

Mr. Egan. Augusta is pretty isolated.

Representative Stark. Is it?

Mr. Egan. Yes. Certainly, that is something we look at, if Augusta was right up against another large city that had other alternatives available. Frankly, the hospitals did not argue that people could travel to Savannah, for example.

Representative Stark. Let's get Mr. Eaton into this. Mr. Eaton, please proceed.

STATEMENT OF ROBERT EATON, ASSOCIATE ADMINISTRATOR FOR PROGRAM DEVELOPMENT, HEALTH CARE FINANCING ADMINISTRATION

Mr. Eaton. My name is Robert Eaton. I am Associate Administrator for Program Development at Health Care Financing Administration. I am very pleased to be here today to discuss the Department's views on hospital mergers and the future structure of the hospital industry.

Mr. Chairman, as you know, the Department has no statutory role in the interpretation or enforcement of antitrust laws. The Department has historically been neutral and, therefore, has not taken a position on the enforcement actions of either the Department of Justice or the Federal Trade Commission.

Approximately two years ago, Secretary Sullivan convened a departmental task force to examine hospital mergers and enforcement of antitrust laws because of his concern about the effects of mergers on the availability and cost of hospital services. I co-chair that task force.

We are in the process of finalizing our report and, therefore, today I am unable to discuss our findings. But what I would like to do is discuss with you some of the issues with which we are concerned.

For many years, Department officials have spoken about overcapacity and inefficiency in the hospital industry. By our policies, we have endeavored to promote competition and efficiency without dictating whether hospitals should downsize, merge or close.

We believe that those specific business decisions are best made by hospital administrators and their boards. Of course, the Secretary and the Department are concerned that access to care be maintained.

The economic literature that we have reviewed does not support blanket statements about the economic consequences of mergers in the hospital industry. Studies have shown that the market in which a merger occurs is unique, so review on a case-by-case basis is necessary in order to assess the probable impact of a particular merger.

A merger could result in a strengthened institution that can continue offering services that otherwise may cease to be available, or offer new services for which the community would otherwise have to travel to. On the other hand, a merger could result in the institution, which is capable of wielding its consolidated market power, having to raise prices to local purchasers of care. Such a merger could adversely affect access by forcing consumers to absorb additional costs in order to receive care.

Furthermore, a merger could result in the loss of a hospital to the community as a result of consolidation of operation between merging hospitals. Recent studies indicate that individuals already travel for inpatient care, often bypassing the nearest hospital. Consequently, even mergers that result in a single facility in a county may not substantially affect access to care.

Hospitals argue that they operate in a severely regulated environment and, therefore, should be exempt from antitrust scrutiny. However, over the past decade, regulatory requirements have been eliminated; for example, the requirement that tied certificate-of-need approval to medical payment for capital expenditures. Most importantly, however, hospitals remain largely unregulated, and the very activities antitrust laws were intended to constrain, which is their ability to set prices and determine the supply of services to nonpublic purchasers of health care, are not constrained.

It does not seem either appropriate or necessary to automatically exempt certain classes of hospitals from antitrust scrutiny. There is no evidence to suggest that not-for-profit hospitals, or inner-city hospitals or, for that matter, rural hospitals are more likely to act in a noncompetitive manner than for-profit hospitals.

Clearly, the antitrust interest of the hospital industry is larger than just mergers. Hospitals are keenly interested in the antitrust implications of collaborative activities. This issue appears to be only partially one of antitrust; concerns also exist about nonprofit status as well as referrals. We will continue to look at these very important issues in the Department.

I would like to mention an activity that would help accomplish this end. I think my counterpart has already mentioned it, but just to reemphasize it, we have had informal talks in the past with a staff level work group to continue to address issues of common interests, such as joint ventures, managed care and peer review.

By continuing to work together, we will enhance the sharing of research and perspectives and permit early identification and discussion of emerging health-care policy issues.

As we look forward to the end of the decade, Mr. Chairman, and the advent of a new century, we see a health-care industry that is rapidly evolving. New technology, the performance of increasingly complex procedures on an outpatient basis and new ways of organizing delivery of health care, these and other changes have resulted in a hospital industry that is experiencing profound pressures.

To paraphrase your question, Mr. Chairman, is there a role for government as the hospital industry changes?

The answer is obviously yes. Government is interested in seeing that our quality of medical care is maintained, and in ensuring access to care for our citizens, and in promoting efficiency in health-care delivery.

It is impossible to state definitively how an efficient provider should be configured. Optimal efficiency varies by the type of provider. Rather than imposing standards, a better role for government is to establish incentives that leave medical and business decisions in the hands of medical administrators and professionals.

Over the past decade, we have turned to the market to give health-care providers the appropriate incentives to expand access and improve quality in a more efficient manner. The restructuring of Medicare payment

policies for a number of providers has furnished more appropriate incentives than existed previously under cost reimbursement. Most notably, the prospective payment system for operating and capital is intended to give hospital managers the incentives and flexibility to make appropriate decisions for their institutions and their communities.

Our hospitals are on the frontlines of providing care, and our physicians are practicing medicine in an environment of rapidly changing technology. Hospital managers should be the ones weighing these competing goals of controlling costs, providing access to proven new technologies, and meeting the needs of the communities they serve.

Establishing government quotas on the number of hospital beds or the mix of services that a hospital provides will not ready health-care providers for future challenges. Rather, we must continue establishing incentives that provide flexibility for health-care providers to develop creative solutions, tailored to their individual circumstances, for the problems that they will face now and in the future.

Thank you I will be happy to answer any questions.

[The prepared statement of Mr. Eaton follows:]

PREPARED STATEMENT OF ROBERT G. EATON

Mr. Chairman and Members of the Subcommittee:

My name is Robert Eaton and I am Associate Administrator for Program Development at the Health Care Financing Administration (HCFA). I am pleased to be here today to discuss the Department's views on hospital mergers and the future structure of the hospital industry.

As you know, the Department has no statutory role in the interpretation or enforcement of the antitrust laws. The Department has historically been neutral and non-interventionist regarding the application of the antitrust laws to the health care industry and, specifically, to hospital mergers. That is, in the absence of compelling evidence that hospital mergers have consistently helped or hurt consumers, or that the antitrust laws themselves were producing undesirable consequences, the Department has not taken a position on the enforcement actions of the Department of Justice and the Federal Trade Commission (FTC).

HOSPITAL MERGERS

Secretary Sullivan has been concerned about access to care and whether the financial pressures placed on hospitals have affected access to care. Over the past several years, for example, he has asked the Inspector General to study hospital closures and the impact of the prospective payment system (PPS) on the hospital industry. The Secretary has also been particularly concerned about the effects of mergers on the availability and cost of hospital services. Approximately two years ago, Secretary Sullivan convened a Departmental task force to examine hospital mergers and the enforcement of antitrust laws. I co-chair the task force for HCFA, along with Grover Hankins, Deputy General Counsel. Today, I would like to discuss with you some of the issues with which we are concerned.

For many years, Department officials have spoken about overcapacity and inefficiency in the hospital industry. By our policies, we have endeavored to promote competition and efficiency without dictating whether hospitals should downsize, merge, or close. We believe that those specific business decisions are best made by hospital administrators and their boards. Despite this, the Secretary and the Department are concerned that access to care -- in its broadest sense, not just to an inpatient bed -- be maintained and enhanced. In certain instances, we have identified specific classes of providers, particularly in rural areas, such as sole community hospitals, for targeted assistance.

The economic literature does not support blanket statements about the economic consequences of mergers in the hospital industry. Studies have shown that the market in which a merger occurs is unique, so that review on a case-by-case basis is necessary in order to assess the probable impact of a merger.

A merger could result in an institution that is capable of wielding its consolidated market power to raise prices to local purchasers of care. Therefore, a merger could affect access negatively by forcing consumers to absorb additional costs in order to receive care. On the other hand, a merger could result in a strengthened institution that is able to continue offering services that otherwise might cease to be available, or offers new services for which the community would otherwise have to travel.

Further, a merger could result in the loss of a hospital to a community as a result of consolidation of operations between merging hospitals. Recent studies sponsored by the Department and others indicate that individuals already travel for inpatient care, often bypassing the nearest hospital. Consequently, even mergers that result in a single facility in a county may not substantially affect access to care.

The Department's Inspector General examined the availability of services after hospitals merged. Examining 16 hospitals, resulting in eight mergers in 1987, the study found that before the merger, one or both of the merging hospitals suffered from declining occupancy, lagging revenues, and/or rising costs. The mergers addressed these problems; all of the remaining hospitals were reported to be stronger as a result of the mergers. None of the mergers studied drew community opposition, and significantly, none were formally investigated by antitrust enforcement agencies. No negative effects on the availability of hospital services resulted from any of the mergers. In all eight merger cases examined, the availability of services was maintained or improved.

Another study prepared by the Inspector General found that merged hospitals reduced costs, but did not increase revenues or patient volume in comparison to similar hospitals that had not participated in a merger. However, the study could not predict what effects a merger would have on a specific hospital's operating characteristics.

Unfortunately, there are no good studies of the effect of mergers on the quality of care provided by the resulting institutions, in part because of their comparatively low frequency. One could hypothesize that quality would either improve or be unaffected, since a financially stronger institution would be in a better position to maintain quality standards than one which is struggling to survive.

The hospital industry is concerned that antitrust enforcement actions have a "chilling effect" on hospital mergers. We understand that to mean that otherwise acceptable and appropriate mergers are not being proposed because the potential costs and complications of an antitrust investigation outweigh the potential benefits of consolidation. Such an effect, if it is indeed occurring, would be hard to demonstrate except anecdotally and impossible to validate. Even a significant decline in the number of mergers in a given year could be due to other factors -- such as the general state of the economy -- that are unrelated to possible scrutiny by Justice or FTC. Furthermore, the sources of any such restraint by hospitals could be either concrete, such as accelerated enforcement actions, or perceptual, such as unclear understanding of the merger guidelines.

The Merger Guidelines, which both Justice and FTC use as a framework for review, are generic. Consequently, interpretation of the guidelines is conducted with attention to the specifics of the proposed merger and its industry. Attorneys and economists with expertise in health care review hospital mergers that are proposed. The review is based on a range of economic factors as they relate to health care and the hospital industry, in particular.

Some observers have expressed concern that reliance on market concentration indexes to evaluate proposed hospital mergers permits a high level of intervention. However, the actual low rate of investigation and challenge is evidence that attention is given to more than just market concentration.

Over the past five years, Justice and FTC have investigated, on average, about 12 percent of all merger transactions that occur a year. The actual proportion of mergers investigated has varied annually: 10.4 percent in FY 1987, 10.2 percent in 1988, 6.2

percent in 1989, and 15.6 percent in both 1990 and 1991. Of the 27 out of a total 229 hospital mergers investigated from 1987 to 1991, only five were challenged in the courts, 19 were approved, and three were abandoned by the parties.

Antitrust scrutiny of mergers is just one aspect of the hospitals' environment that may contribute to uncertainty. Mergers are a subset of the larger set of collaborative activities that hospitals are considering for their financial well being. These activities include joint ventures among hospitals and between hospitals and physicians, or pooling arrangements, such as health maintenance organizations or preferred provider organizations; they can involve both inpatient and outpatient activities. Such activities are not just within the purview of Justice and FTC. There can be little doubt that these issues also contribute to the concerns of the hospital industry.

It does not seem either appropriate or necessary to automatically exempt certain classes of hospitals from antitrust scrutiny -- there is no evidence to suggest that non-profit hospitals, or inner-city hospitals, or rural hospitals are more or less likely to act in a non-competitive manner than for-profit hospitals. For that matter, there does not appear to be compelling reason to exempt the entire hospital industry from the antitrust laws.

Like the banking industry, hospitals argue that they operate in a severely regulated environment and, therefore, should be exempt from antitrust scrutiny. However, over the past decade, certain regulatory requirements have been eliminated, for example, the requirement that tied certificate-of-need approval to Medicare payments for capital expenditures. Most important, however, hospitals remain largely unregulated in the very activities that the antitrust laws were intended to constrain: in their ability to set prices and determine the supply of services to non-public purchasers of health care.

Clearly, the antitrust interest of the hospital industry is larger than just mergers. Hospitals are keenly interested in the antitrust implications of collaborative activities. This issue appears to be only partially one of antitrust; concerns also exist about non-profit status and referrals. We will continue to look at these important issues..

I would like to mention an activity that will help accomplish this end. Our Department will continue working with Justice and FTC to address issues of common interest in such areas as joint ventures, managed care, and peer review. Continuing to work together will enhance the sharing of research and perspectives and permit early identification and discussion of emerging health policy issues.

THE PRESIDENT'S COMPREHENSIVE HEALTH REFORM PROGRAM

The Administration recognizes that with the emergence of new methods of health care delivery, and increasingly sophisticated and costly technology, confusion about the application of the antitrust laws in the health care field has grown. As a result, clarification of certain parts of the antitrust laws is needed. The President's Comprehensive Health Reform Program includes provisions to reform elements of the antitrust laws -- most notably the provisions that apply to joint ventures. Two kinds of changes are outlined in the proposal. The first, which was incorporated in a bill that was passed by the Senate last February, would extend protection from <u>private</u> antitrust actions to jointly produced services, if certain public notification procedures are followed. Originally drafted to protect non-health care related joint ventures, this legislative change would limit the financial liability of physicians or hospitals that jointly engage in a service and

are subsequently sued by a private party for antitrust violations. While this change does not significantly change the role of Justice and the FTC in evaluating these relationships, it is important to note that private antitrust actions, with the penalty of treble damages, are substantially more frequent than government actions in this area.

The second set of antitrust reforms in the President's package concern improving the education and information provided by the federal government to the affected industry. The Administration has pledged to clarify antitrust policies as they relate to state peer review processes and to managed care arrangements. The Administration has already begun to expand these efforts; indeed, Justice and FTC issuing joint merger guidelines this spring was an important step toward standardizing and clarifying government action in the merger area.

THE HOSPITAL INDUSTRY AND THE FUTURE

As we look toward the end of this decade and the advent of a new century we see a health care industry that is rapidly evolving. New technological and medical advances have contributed to shorter inpatient hospital stays, the performance of increasingly complex procedures on an outpatient basis, and new ways of organizing the delivery of health care.

These and other changes have resulted in a hospital industry that is experiencing profound pressures. On the one hand, society is demanding that hospitals play an ever increasing role in providing health care to communities. Witness the increase in emergency rooms that are used as the primary care providers of last resort for the poor, the increase in AIDS patients, and other trends that are testing the ability of hospitals to provide care. In addition, alternate forms of care are growing and have increased the competitive environment for hospitals.

To paraphrase your question, Mr. Chairman, is there a role for government as the hospital industry changes? Obviously yes. Government is interested in seeing that our quality of medical care is maintained. We are interested in ensuring access to care for our citizens and in promoting efficiency in health care delivery.

As we see the proportion of gross national product that is devoted to health care continue to grow, the interest of government is appropriate because 40 percent of the personal health expenditures is paid by government. As a result, we have a very real desire for all providers of health care to operate in the most efficient manner. However, it is impossible to state definitively how an efficient provider should be configured. Optimal efficiency varies by type of provider and is affected by individual market characteristics. These variations among providers and their individual circumstances imply that government dicta to improve efficiency are probably not the best way to achieve those efficiencies.

A better role for government is to establish incentives that leave medical and business decisions in the hands of medical professionals and administrators. Over the past decade, we have turned to the market for examples of better ways to structure incentives -- to give health care providers the appropriate incentives to expand access and improve quality in a more efficient manner. The restructuring of Medicare payment policies for a number of providers furnished more appropriate incentives than existed previously under cost reimbursement. Most notably, the prospective payment system (PPS) for both operating and capital is intended to give hospital managers the incentives and the

flexibility to make appropriate decisions for their institutions and their communities. Our hospitals are on the front lines of providing care and their physicians are practicing medicine in an environment of rapidly changing technology. Hospital managers should be the ones weighing the competing goals of controlling costs, providing access to proven new technologies, and meeting the needs of the communities they serve.

CONCLUSION

Establishing government quotas on the number of hospital beds or the mix of services that a hospital provides will not ready our health care providers for future challenges. Rather we must continue establishing incentives that provide flexibility for health care providers to develop creative solutions, tailored to their individual circumstances, for the problems that face us in the future.

Thank you. I will be happy to answer any questions you may have.

REPRESENTATIVE STARK. Thank you. Did all three of you get your testimony cleared by OMB?

MR. JAMES. I did not, sir.

MR. EGAN. I did not, sir. We are not required to.

MR. EATON. I did, sir.

REPRESENTATIVE STARK. Boy. Great minds all seem to run in the same direction here. I guess I have three principal areas.

Would you all be willing to answer some questions in writing if I submit them to you?

MR. JAMES. Certainly.

MR. EGAN. Certainly.

MR. EATON. Certainly.

REPRESENTATIVE STARK. One of the things that I can't find is an actual case of anticompetitive behavior. I mean, everything you guys are talking about is where you anticipated somebody might act in an anticompetitive manner. If I could arrest drug dealers the same way you guys prevent mergers, I could clean up the situation in no time.

Gee, you look like a drug dealer. That would take care of that. That is what you guys are doing.

This hospital looks like it is going to cause some problems if it merges with that hospital. How many times in the past ten years, or however many you can remember, have you filed against the actual merger —somebody that did something that harmed the community? Got one?

MR. JAMES. Let me make a comment here. The enforcement responsibility that we have under Section 7 is necessarily forward looking. As Mr. Eagan indicated, however, we don't form these investigations merely by consulting a textbook. We look at actual facts, the records of the company, the company documents.

In the course of investigating our Rockford, Illinois case, we did discover—and the district judge did comment on the fact that there was evidence in that case that the hospitals had colluded in the past. In fact, they had worked together to prevent an insurance company from lowering the reimbursement.

So, these kinds of problems do exist. They can be evidence in our cases, but under this statutory authority, we are obliged to look forward.

REPRESENTATIVE STARK. What you found in Rockford were two hospitals. Are there more than that?

MR. JAMES. There were six hospitals.

REPRESENTATIVE STARK. Two of these guys.

MR. JAMES. Some of them.

REPRESENTATIVE STARK. Maybe, more than two.

MR. JAMES. Right.

REPRESENTATIVE STARK. They got together at Joe's Bar and Grill and said, let's get X bucks for reading an EKG or something like that, and let's all join ranks against Blue Cross, Aetna and anybody else.

MR. JAMES. That is the kind of problem.

REPRESENTATIVE STARK. And you caught them doing that.

MR. JAMES. We found evidence of that kind of conduct in the context.

REPRESENTATIVE STARK. Did you go after them?

MR. JAMES. No, we enjoined their merger.

REPRESENTATIVE STARK. All right. What I am saying is, you found evidence of that when they tried to merge ... you didn't know that was going on before they attempted to merge?

MR. JAMES. That is correct.

REPRESENTATIVE STARK. But when you went through all the forms they had to submit for a merger, somebody said, aha!—how did you find that?

MR. JAMES. In the course of the document discovery.

REPRESENTATIVE STARK. They were writing letters?

MR. JAMES. In the course of the document discovery. I was not at the Department when this case——

REPRESENTATIVE STARK. This wasn't like a market study where you said it looks like all these prices are coming together on a graph. This was like some guy writing a memo on a letter?

Mr. James. There was evidence in the record.

REPRESENTATIVE STARK. You weren't interpreting a market. You had the guys wired, more or less—figuratively speaking. I watch Perry Mason a lot. That is where I get all my legal stuff.

Mr. James. Congress has not allowed the antitrust people to wire people.

REPRESENTATIVE STARK. Wait until Ross Perot finds out about that. That will give him something to do. Okay.

MR. EGAN. Can I say something?

REPRESENTATIVE STARK. Sure.

MR. EGAN. The question that you raise about—

REPRESENTATIVE STARK. Let me start out here. I don't think we should let these guys go off into the wilderness without somebody controlling them. Don't misunderstand me for a minute. I am not going to say, let the hospitals loose to collude, to do what you found evidence of doing. I am just trying to indicate that they are different from General Motors, A&P and Kelloggs, because I think there is a market, but I think it ain't the kind of market most of us think about. I am trying to see whether there ought not to be some kind of a special system.

MR. EGAN. There is a special system, in the sense that we look at every market and try to analyze the likely competitive consequences of a merger in the context of that market and the special circumstances of that market.

REPRESENTATIVE STARK. Do you use this HHI index?

MR. EGAN. Yes.

REPRESENTATIVE STARK. Do you use anything else?

MR. EGAN. Yes. First, we define what the market is.

The ultimate question here is, who does the consumer have to turn to and if that person has market power, a monopoly in that market, would they be able to raise prices to the consumer. Our whole analysis goes to that. That analysis may differ from market-to-market, depending upon the real world of the market.

REPRESENTATIVE STARK. If somebody is raising prices to the consumer and the consumer can't stop that, is that like a crime?

MR. EGAN. Not necessarily. That is the concern of our merger enforcement policy. The market is being put in a position where the firms within the market can legally charge monopoly profits for the services.

REPRESENTATIVE STARK. By definition, are you guys just excluded from doing anything in Maryland? Basically, under the Maryland system, there is nothing for you to do there, is there?

MR. EGAN. I have to say, I am not familiar with the Maryland system, even though I live in Maryland.

REPRESENTATIVE STARK. It is a price fixed in conjunction with state regulators, so you are out of business in Maryland.

MR. EGAN. From what you described, it may fall within the state action doctrine that exempts activities of the state.

REPRESENTATIVE STARK. We exempted them from federal regulations because they have a system where they agree to a global spending and set the prices for every hospital. So, I think, by definition, they ain't competing.

MR. EGAN. It may be. I would hesitate to give a definitive answer because I am not familiar with the facts.

REPRESENTATIVE STARK. Do you know?

MR. JAMES. I am not familiar with the Maryland system.

REPRESENTATIVE STARK. Do you know?

MR. EATON. I am certainly familiar with the Maryland system, somewhat. I can't speak to why the enforcement agencies may or may not have been involved.

REPRESENTATIVE STARK. Think about it for a minute. Under the system, a third party, not an insurance company, the state sets the price. So, if they merge, they merge. I mean, is there any reason why you would have to have FTC or antitrust stuff in a system like that?

MR. EATON. I think my colleagues can speak better to whether there should or should not be any antitrust scrutiny. I think there are plenty of other problems with a system like Maryland or with a similar system like New Jersey.

REPRESENTATIVE STARK. You guys aren't investigating the veterans hospitals, are you? No reason to. I am just saying, if the prices are set and the market is gone, there is nothing to enforce.

MR. EGAN. Mr. Chairman, there certainly can be circumstances where their prices are regulated, but antitrust would still play a role. I don't know what the situation is in Maryland.

Competition has an effect on many elements: quality, service, as well as price. It may well be that you could have a market where prices were regulated, but you still wanted to maintain a competitive base in order to assure that quality and service was at optimal levels.

REPRESENTATIVE STARK. You guys don't get into quality.

MR. EGAN. Yes, we do.

REPRESENTATIVE STARK. How?

MR. EGAN. We are concerned with quality and service as a competitive element. We are concerned with competition.

REPRESENTATIVE STARK. Wait a minute. This is interesting. You mean to tell me that the Justice Department and the Federal Trade Commission has some way to measure hospital quality?

MR. EGAN. I am not suggesting that is what we do. I am suggesting——

REPRESENTATIVE STARK. If you can't measure it, how does it impact?

MR. EGAN. We can't measure exactly how much prices are going to go up, either.

REPRESENTATIVE STARK. I know that. The quality issue is what AMA always drives at me. Ain't paying them enough, they say quality will go down. I always say quality is not a function of price. It is a function of regulation and investigation to cleanliness, outcome. It has nothing to do with price.

MR. EGAN. We don't attempt to make a judgment on whether quality is good or bad. What we attempt to do is to see whether or not the market is likely to be competitive after the transaction. If the market is unlikely to be competitive after the transaction, our concern is that not only will price suffer, but also quality and service will suffer as well.

We don't attempt to measure to that degree and give any value judgment as to whether quality is good or bad.

REPRESENTATIVE STARK. There aren't any actual cases of this having happened, right?

MR. EGAN. That is true in our entire merger program. The question you raise goes to our merger program generally, not just hospitals. There are a few cases, but very rarely can we predict with any precision exactly how much prices are going to go up.

REPRESENTATIVE STARK. If some enterprising guy figures out that Kellogg or somebody else is screwing over the public, there are big damages.

MR. JAMES. After the fact.

REPRESENTATIVE STARK. Do you know how many cases of that kind have been brought by private civil suits to recover damages from collusion? Has there ever been one that you know of?

MR. JAMES. In the hospital industry?

REPRESENTATIVE STARK. Yes.

MR. JAMES. There are——

REPRESENTATIVE STARK. There may be one.

MR. JAMES. There are quite a number of private law suits dealing with hospital practices—conduct kinds of things.

REPRESENTATIVE STARK. I am not talking about malpractice.

MR. JAMES. Tying arrangements, exclusive dealing.

REPRESENTATIVE STARK. Was somebody given big trebles damages as a result of an antitrust suit?

MR. JAMES. There are treble damage cases now.

REPRESENTATIVE STARK. There are?

MR. JAMES. I believe so. Not that we brought. We don't monitor them.

REPRESENTATIVE STARK. My guess is that there probably haven't been any against hospitals. Have there been any?

MR. EATON. Not on the private side. I don't know this with certainty, but it is certainly something we can look into. In recent months, I have come across articles about the Carilion merger, the Roanoke merger—the only one the Justice Department has lost to my knowledge. It seems to me that there was a question of whether that particular merged facility had raised its prices and taken advantage of its market position. At least, there have been some articles that talked about that out there.

REPRESENTATIVE STARK. They aren't going to raise the price to Medicare, are they, because you guys do such a good job?

MR. EATON. There are other consumers besides Medicare.

REPRESENTATIVE STARK. I just want to compliment you.

MR. EGAN. I have a case that was just whispered in my ear. The Rochester anesthesiologist was a price fixing case where we brought a case, and private plaintiffs apparently followed on and they successfully obtained——

REPRESENTATIVE STARK. They collected for that?

MR. EGAN. Yes.

REPRESENTATIVE STARK. From whom? Hospitals or the doctors? Or were they employees? Do you know?

MR. EGAN. I don't know.

MR. HOROSCHAK. I am Mark Horoschak. I am also at the FTC. I believe they were anesthesiologists in individual private practice.

REPRESENTATIVE STARK. This is perspective, and I am not suggesting you shouldn't be ever-vigilant. It is difficult for me to just take a system that I can understand and applaud it, in the sense of what I think is a traditional market, where you are dealing with a linear relationship between the seller and buyer—and you guys have all gone through that even though you went to law school and studied economics—but this is one of those markets where nobody is quite sure who is paying and nobody really knows how much. Therefore, with the exception of a few sophisticated buyers, there isn't much chance for this market to work.

MR. EGAN. I think there is some misconception in your question about our major concern in merger enforcement. Our major concern is that after a merger the market will not operate competitively. That market

power will be placed in the hands of the market participants. It is not that they will do something that is necessarily a violation of the antitrust laws. It may be perfectly legal. It is just that the market will not be operating competitively. Therefore, the fact that no hospital has been sued for damages for price fixing really doesn't say anything about the effectiveness of our merger enforcements program. That is not our primary concern.

Those instances of hospitals getting together and fixing prices are subject to criminal penalties, as a matter of fact. What we are concerned about is that the market will be left in a state after the merger where they can legally achieve prices above a competitive level.

REPRESENTATIVE STARK. Mr. James, you have been pretty strong in your written statement that there is no conflict between the federal antitrust policy and federal health policy, right?

MR. JAMES. That is correct.

REPRESENTATIVE STARK. Now, Dr. Wilensky recently stated that we have to find sensible ways to reduce the level of duplication. Sharing facilities and equipment is certainly one reasonable strategy.

She also acknowledged meeting with the Department of Justice and reported: "They seem sensitive in trying to understand the concerns that we have. They have indicated they are willing to work with us."

Now, don't those comments suggest some ambiguity or differences in emphasis with respect to hospital mergers and joint activities, on the one hand, between Health and Human Services and Justice on the other?

MR. JAMES. I don't think so at all. I think there may be a misimpression that we are antagonistic about joint ventures. We are not. We see great potential benefits. Indeed, when you are talking about the kind of duplication of facility problems that are caused by these arms race things, this is an area where we have yet to challenge a proposed joint venture.

REPRESENTATIVE STARK. You also mentioned that you haven't challenged a single merger in communities under 200,000, right?

MR. JAMES. Certainly not in the last five years.

REPRESENTATIVE STARK. Why are you beating up on Ukiah Medical Center?

MR. JAMES. The Justice Department is not beating up on Ukiah Medical Center. It is the FTC.

REPRESENTATIVE STARK. Why are they beating up on them?

MR. JAMES. I can't speak to that.

REPRESENTATIVE STARK. MR. EGAN?

MR. EGAN. I am limited in what I can say about Ukiah because it is in litigation. Let me say there—

REPRESENTATIVE STARK. Why don't you indicate to me why you might pursue a case that Justice won't take, right?

MR. JAMES. Well, no. I shouldn't——

REPRESENTATIVE STARK. You passed it along. Given the size, what—

MR. JAMES. Let me just explain to you how we work together. We have——

REPRESENTATIVE STARK. Pretty well.

MR. JAMES. We have known each other for years, but we have a liaison agreement.

REPRESENTATIVE STARK. Good cop, bad cop.

MR. JAMES. We have a liaison agreement. Under that agreement, whenever a matter comes up for investigation, we make an initial decision between the two agencies about which agency pursues the investigation. If one federal investigation is a problem, certainly you don't want two. It is in that sense that Mr. Egan is involved in the Ukiah matter, and we are not.

MR. EGAN. Well, let me, once again, throw in a disclaimer that whatever I say about Ukiah would be my own views because it is in litigation. The Commission certainly can't take a position on it.

The size of the hospital raises the question of efficiencies—as the gentleman from Ukiah Hospital indicated—and that is one of the defenses that will be heard by the administrative law judge this summer. But the fact that you have two small hospitals is part of the equation that we look at. The other part of the equation is, by merging, is that going to cure anything? It may or may not.

REPRESENTATIVE STARK. It may or may not. It saves you a couple hundred thousand dollars in hospital administrators' salary. They will disclaim that, but they get paid pretty well. It will save you dues to the California Hospital Association.

But let's be hypothetical because I honestly didn't realize at the beginning of this hearing that there was litigation, or I would have gotten more into it with Mr. Ammon.

As I read this chart, you have two hospitals with a total of roughly 100 beds. On the map, it doesn't look so far, but you are a long drive between Santa Rosa and Oregon without much in between except for a lot of good grapes, which Virginia wouldn't know about.

There was a third hospital that went subsequently out of business. That was a community hospital that had 20 beds. So, you have two of them, with a total of about 100 beds, and the fact is that a whole hell of a lot didn't change when they merged.

So you and I can speculate that basically what they were saying to each other is, "do we need two?" And the answer is, "I don't know as they do."

Maybe it works, maybe it doesn't. For whatever reason, you and I wouldn't know unless we got into a lot more details. But it does seem that there ought to be a simpler way than having a couple million dollars worth of legal fees spent to hassle out whether this is a good system or not.

I guess that is my trouble in a town where there is no hospital close by. Two hospitals, both half empty. Still, the remaining hospital is now

half empty, so we didn't do much there. We just got one instead of two. So, you would have to make the case that two is bad on its face, and I would have to make the case and say, well, one ain't bad. It seems to me that we are wasting a lot of time arguing that point, given that so much of what they are being paid for is made by very sophisticated purchasers.

In their current situation, 50 percent is Medicare—arguably, the smartest purchasers of medical care in the country, right, Mr. Eaton.

MR. EATON. Arguably.

REPRESENTATIVE STARK. Certainly staffed by some of the brightest people in the country; right, Mr. Eaton?

MR. EATON. Yes, sir.

REPRESENTATIVE STARK. Medical is 20 percent. That is arguable as to how bright those people are under Governor Wilson.

So, there you have 70 percent of the business is federal and/or state. The prices are set. So, it doesn't make any difference whether you have one or 18, we are going to pay the same rate to all of them there.

You also have 15 percent that is HMO, PPO, and those guys can fend for themselves. Commercial insurance is about 11 percent. That leaves about 3 percent self-pay. I don't know where those come from, but basically where is the competition? Who is getting jammed?

How do you go about saying that that is good or bad? It doesn't seem to me that you deal with somebody like that under the same rules that you deal with General Motors and Ford merging, and you are. You are dealing with the same rules that you apply to those guys as you do to this rather rural community.

MR. EGAN. We are dealing with the same statute. We certainly take into consideration any differences in the market that are relevant to the question of competition.

I am hesitant for two reasons to respond to specific questions about Ukiah. One reason is that it is in litigation. The second reason is that it is being litigated by our San Francisco regional office. Therefore, I am not in the chain of supervision of it, and I frankly don't know as much as I should if I was going to talk about it.

But let me say this generally. When you say, look, some of this is for PPOs and other forms of managed care, and those guys can take care of themselves. They can't if they only have one hospital. They do not have any leverage. That is what they tell us, at least, and that is what the documents that we receive show.

Let me make a second point. The money that has been spent in that case—again, this is somewhat my judgment rather than precise knowledge—but my understanding is that most of the monies that have been spent on that case have not been in an effort to show how efficient this transaction is likely to be to the FTC. In fact, the money that has been spent so far has been to avoid getting to that question.

The Ukiah Hospital has sued in two separate district courts and taken us to two separate courts of appeals to keep us from trying that case. That is where the time has gone. That is where the money has gone.

I think eventually we will get to the question of whether or not the merger is likely to be efficiency-enhancing and whether, on balance, the anticompetitive effects, if there are any, offset the efficiency enhancements.

We will get to that and, presumably, if we are not interrupted by another federal court, the question will be answered this summer. Beyond that, it is hard for me to comment.

REPRESENTATIVE STARK. What if they agreed to charge no more than a fixed rate tied to what Medicare pays? Wouldn't that solve your problem? Hypothetically speaking?

MR. EGAN. I have a good story for you, Mr. Chairman. It won't take too long.

Very rarely do we know in advance what kind of savings we have achieved by preventing a merger. We had a case within the last few years of two companies that provided night vision devices to the U.S. Government. The U.S. Government was essentially the only buyer of these devices, and these two companies wanted to merge. We said that for this generation of night vision device, which both companies made, there is an important government bid coming up. It will encompass all buys for the next few years for this type of equipment. After that, that generation is no longer significant. They said, fine, we guarantee you that we will bid at least X amount on that important bid, but let us merge. We said no, we have to let the market decide that.

We got a federal court to stop them from merging. They both individually bid on the contract, and they bid below the price they offered to guarantee. We saved the government somewhere between $17 million and $23 million by preventing that one merger.

Once the contract was let, that generation device was over. We let the companies merge, and they went their merry way and got whatever efficiencies they could from the merger. It was the best possible result for the consumer, for the United States. It shows the problems where we decide what is a good price, as opposed to letting the market decide a good price.

REPRESENTATIVE STARK. So, I guess you guys sing this tune of market and competition. It is interesting to me that that becomes such a ... you were a banker, weren't you?

MR. EGAN. I was a banker?

REPRESENTATIVE STARK. You work for a bank?

MR. EGAN. I have a bank account.

REPRESENTATIVE STARK. You never worked for a bank?

MR. EGAN. No, sir.

REPRESENTATIVE STARK. Someone here.

MR. EATON. I was.

REPRESENTATIVE STARK. You were a banker. Do you think they ought to apply the same rules to banks merging as they do hospitals?

MR. EATON. Let me address two questions.

REPRESENTATIVE STARK. If there are only two banks in town, do you think they could raise their interest rates without any competition just because there is no other bank?

MR. EATON. I think there are distinctions between the banking market and the health-care market.

REPRESENTATIVE STARK. What are they?

MR. EATON. Global competition for one.

REPRESENTATIVE STARK. Global competition. Meaning?

MR. EATON. Meaning that, perhaps, the rates could be subject to—not international bank's interest rates—national banks or other regional banks. It is a different industry, a different market.

REPRESENTATIVE STARK. But the same laws apply to banks.

MR. EATON. I spent a lot of time discussing——

REPRESENTATIVE STARK. Isn't that right?

MR. EATON. No. I spent a lot of time discussing—

REPRESENTATIVE STARK. Same laws apply to banks apply to hospitals?

MR. JAMES. Same laws, different factual analysis. I should tell you that the banking industry wants an exemption, too.

REPRESENTATIVE STARK. Of course, they do.

MR. EATON. Same laws, different factual analysis. We spent a lot of time meeting with the Justice Department and FTC and talking about how they approach their factual analysis. I think they factor in quite a number of things that are unique to the health-care market.

I think they also have health-care lawyers and economists on their staff who understand the workings of the health-care market. I think their factual analysis is quite separate and distinct from other industries. At least, that is what we found.

I wanted to address the previous point that you made regarding possible conflict between some statements Dr. Wilensky made and the Justice Department. When Gail was at the agency, I certainly was present at a number of meetings with her and with Justice, both at Justice and the Agency, where we discussed the need for clarification.

We discussed the guidelines and the factual analysis that the Justice Department does. I think we both readily agree that continued education and communication was the best way to address whatever uncertainty there is out there in the marketplace on the part of the industry.

REPRESENTATIVE STARK. MR. EGAN, following along, you say that you guys don't endorse any particular health plan, right?

MR. EGAN. That is correct.

REPRESENTATIVE STARK. But your purpose is to encourage a competitive environment; is that correct?

MR. EGAN. In general terms, yes.

REPRESENTATIVE STARK. Isn't the competitive model a specific approach to health care?

MR. EGAN. I am sorry. I guess I don't understand the question.

REPRESENTATIVE STARK. I will say it once again, there is, in parlance of the people who would be trying to solve our health-care crisis today, a variety of models. One is the competitive model. Another might be the single-payer or the Canadian approach, correct?

MR. EGAN. Yes.

REPRESENTATIVE STARK. Both of which exist in this country in different communities. So, basically, you are picking one model over another—are you not—and saying that in your opinion that the competitive model is better than, for example, the single-payer model.

MR. EGAN. I don't think that is actually a fair characterization of what we do.

REPRESENTATIVE STARK. Wait a minute. Let's go back over this routine for just a minute. The competitive model is a model or a type for controlling health care costs and delivery of the benefits, correct?

MR. EGAN. I suppose it is.

REPRESENTATIVE STARK. Okay. There are other types. The State of Maryland, for example, has a control system. It is an all-payer system. And there are some single-payer systems, and there has been some difference of opinion even under various Republican secretaries of Health and Human Services. When you say that you want to use the FTC to direct people toward the competitive model, you are choosing one over the other.

MR. EGAN. If that is what the testimony is fairly read as saying, I would like to correct it. What I would say is that we have a mandate from Congress to enforce the antitrust laws, and the antitrust laws, in part, mean that we assure that the competitive process is maintained.

Now, when we come at various markets, they may be on the one end of a continuum of competitiveness or on the other. Certainly, there are markets which have aspects of regulation, but that doesn't mean all competition is removed.

Our mission in those markets where there are aspects of competition is to assure that where competition can work that it is not unfairly denied to the consumers. If Congress makes the decision to totally remove competition from a particular market—as that has been in some cases—then, obviously, in effect, we have been told that we don't have a place in that market. Quite often, though, Congress or some state will regulate a certain aspect of a market, but leave open other aspects, and we do have a role there. Our place is essentially designated by Congress or by how states regulate.

REPRESENTATIVE STARK. That is what we are here to do, to suggest that it may need changing. I am trying to say, you guys have picked one model that you are pushing and, therefore, you are not being even-handed in the administration of justice because you are tilting toward the

"competitive model." And I am not sure that Congress ever suggested that you ought to favor that.

I mean, our view, if you want to follow that along, the best competitive model that one would presume is profit-making corporations. Doesn't that make sense to you? If you extend this idea, the risk of rewards and benefits of a market generally are best exemplified or typified by for-profit corporations in this country. Fair statement?

MR. EGAN. Well, it is a fair statement, I suppose. I wouldn't want to have me saying that that is a fair statement, leading to the conclusion that I would suggest that not-for-profit hospitals act significantly different in their——

REPRESENTATIVE STARK. I don't think they do, either.

MR. EGAN. To the degree that we rely on competition—and I think today we rely on competition—it is important to keep both the managed care segment competitive, as well as the——

REPRESENTATIVE STARK. That is interesting. You take the for-profit hospitals, who arguably have the worst quality, the highest prices, and behave in a manner that we would consider the worst possible citizens in the country, and you want to encourage that. That doesn't make much sense, does it?

The only way they make a profit is by charging more than other hospitals for the same services and denying certain care—cherry picking in the community—and you want to tell me that that is something we should encourage.

Is there any difference between the guidelines you apply to hospitals—I know that recently you have been defending us from socialism by going after colleges and universities—I mean, I gather that somebody is going to get promoted if they can get treble damages against Harvard or Yale. Yale is probably exempt because the President will pardon them.

MR. EGAN. As a graduate from Saint John's, I will be glad to pass that on to my colleague on the right.

MR. JAMES. The college case is a case that deals with a simple matter, as we see it, of price-fixing-type conduct. It is entirely a different kind of analysis.

REPRESENTATIVE STARK. You mentioned services could be denied, and you could compete on other grounds. How do you suppose the University of Alabama competes to get football players? On price?

MR. JAMES. I wouldn't want to answer that particular question.

REPRESENTATIVE STARK. Are you willing to take that case?

MR. JAMES. If you bring and show it to us. We talked about the quality and service issue earlier. I think there is an important point to make here.

We don't seek to measure and optimize the quality of care by dictating to hospitals what their quality levels can be. We can, however, identify circumstances in the health-care industry and elsewhere where there are restrictions as to quality or services.

We see agreements in other industries, and it is not beyond the pale that they could occur in this type of industry where firms say, "we will limit our research and development budgets to X;" or "we are going to restrict the amount of some quantity of services that we give in order to lower the cost to us of providing that service, but we are going to charge the same price. If we are competing, we might have to offer some differential prices." You asked Jim the question about whether we are deciding on a particular model. You have us in a strange situation because our principal jobs are to enforce the laws that are given to us, and now you are asking us what the laws should be.

REPRESENTATIVE STARK. Or how you go about it. I suspect that you should approach Harvard, Yale, and Smith and Wellesley somewhat differently than you approach Roger Smith and Lee Iacocca.

MR. JAMES. We certainly analyze how Harvard, Yale, Princeton and others compete with each other. I have the sense that they compete with each other differently—the gentlemen——

REPRESENTATIVE STARK. Ford and Chrysler.

MR. JAMES. They compete with each other on a different dimension. That is not to say that protecting the way in which they do compete isn't an important value. That has been one perspective for a long time. We believe in the competitive process. We have seen time and time again how competition stimulates efficiency and makes people innovate.

REPRESENTATIVE STARK. You are preaching to the choir. That allows me to stay in this lousy paying job of mine because of dabbling in the competitive sector. I love it. I am all for it.

And imagine that I merged two stinky little banks under the shadow of all the giants—Bank of America and Wells Fargo. The merger of the banks I put together 30 years ago, you could have buried them in one of those banks you worked for, Mr. Eaton.

It boggled the imagination that I was about to challenge and overthrow the Bank of America and Wells Fargo. It was kind of fun. I said, me? It made me feel like Cash McCall, and it did didn't cost as much in those days.

Let me go back to this hypothetical small town where you are worried about no competition—and I don't want to prejudice the case—but let's take Augusta. Two hospitals, you say?

MR. EGAN. Five hospitals in the market.

REPRESENTATIVE STARK. Five, but you were worried about a couple getting together. Let me ask you if you know what would happen. Let's assume that 60 percent of the revenues for those hospitals was from federal payments, so they couldn't monkey with those prices. Let's assume 40 percent was from preferred providers or private insurance companies. Let's assume, further, they tried to set prices. What do you think the purchasers would do? They ain't dumb. They know what we are paying under Medicare and Medicaid. Most of them buy services in adjoining communities.

So, if the average rate just for room and board is $300 a day and one of these guys tries to jack the price up to $400, $450, what do you suppose the reaction offer of the principal purchasers—the HMO or the PPO, or Aetna or Blue Cross—is going to be? What would they do?

MR. EGAN. It would depend upon what their options are.

REPRESENTATIVE STARK. What are their options?

MR. EGAN. That is what I attempted to explain earlier. The options for managed care provider ... I forget what it was. Managed care was not a large percent of the market in Augusta.

But, for managed care providers in Augusta, their options essentially were the two hospitals at issue in the merger. There were other hospitals that they could theoretically turn to, but there were practical reasons why those weren't fully effective in meeting their needs.

And, in fact, the record contains documents taken from the files of University Hospital and Saint Joseph hospital—the two hospitals that proposed to merge—showing that when they sold themselves to managed care providers, when they went to a managed care provider and said here is why we think you should contract with our hospital, they emphasized their prices vis-a-vis University Hospital and University Hopsital would emphasize its price vis-a-vis Saint Joseph. Sometimes, other hospital prices were listed. Other times, it would be just the two hospitals.

REPRESENTATIVE STARK. What I think you are saying to me, these two hospitals were in the medical fraternity or community that were considered the two principal hospitals in town and the others were marginal; if that is a fair word?

MR. EGAN. The other hospitals ... I wouldn't say marginal. We had a very compelling story why these hospitals were certainly the closest competitors, but I wouldn't say marginal. I don't want to overstate the case.

REPRESENTATIVE STARK. What the insurance companies would do to the providers, fortunately or unfortunately, they would say that this is all we are going to pay, period, and then the hospital would turn to the patient, and they ain't going to get blood out of a turnip.

It is a little bit different market than you and I are used to. You don't buy the car until the price comes down, because if somebody is bleeding to death, they have to take them in by law.

Basically, what the insurers would do is to say that this is all we are going to pay. It backs up to the employer, and they tell the employer that we are going to limit our daily hospital benefit to X bucks.

If your hospital in the local community won't take them, tough. You pay the difference or your employee pays the difference, and eventually the union raises hell. The pressures are different from the way you and I might react when we are deciding whether to buy a Lexus or BMW or a Buick.

MR. EGAN. I have two reactions. First, as a former businessman, you realize before you can say, tough, this is all I am going to pay, you have

to have some leverage. And if you don't have any other choice among hospitals, you don't have any leverage. So, they can't say that.

REPRESENTATIVE STARK. I can say that because I am an insurance company and I can say to the hospital, okay, that is all our policy is going to pay. Then, you have to deal with some poor patient in town. You will end up with a lot of uncompensated care. If that person drops the insurance, they will come in the other door through the emergency room.

MR. EGAN. For a managed-care provider, they have to have contracts with hospitals, or they are not going to exist; or, a small business can either pay higher prices for the care for its employees or not. The other point I would make is——

REPRESENTATIVE STARK. You ignore this hospital in South Carolina; the distance people can travel is phenomenal.

MR. EGAN. My second point is that there is a cost even if they can travel to the hospital. For example, in South Carolina, there is a cost associated with that. The employers perceived that their employees wanted hospitals in Augusta—for those people who lived in the Augusta area. Sure, they could travel, I suppose, to Atlanta, but that would impart a cost onto the consumers for something they didn't wish.

REPRESENTATIVE STARK. Well, as I say, I keep running into this competitive model. Let's assume that justice and common sense prevail, and we go to a single or all-payer system, or a price cap, as it has been called. Then, you guys have all the resources. You are out of business relative to hospitals, correct, if we federally set maximum prices?

MR. JAMES. We are certainly out of business, depending on how it is done and the extent of the regulation.

REPRESENTATIVE STARK. If the hospitals wanted to get you off their back, they ought to support my bill for a single-payer system.

MR. JAMES. I think if hospitals want to get us off their back, they have to propose pro-competitive mergers.

REPRESENTATIVE STARK. They have two choices then.

MR. JAMES. They have more choices than that. They can have pro-competitive joint ventures.

REPRESENTATIVE STARK. Have you guys looked into any of the doctors, the referral deals?

MR. EGAN. We have some active investigations.

REPRESENTATIVE STARK. I have a whole series of suggestions for you if you don't have enough work in that area.

MR. EGAN. We are fairly active in that area and would welcome any information.

REPRESENTATIVE STARK. Let me ask you this. Both of you work together; you are buddies. How would you suggest to us that we change the system to make it better relative to hospitals, on the assumption that we are not going to make any change over the next six or eight years in the way hospitals are reimbursed and in the way they do business?

Would you leave it alone and let you guys work in the existing case law, or would you suggest some hospital-specific changes in the law?

MR. JAMES. I don't see that there is really a necessity for hospital-specific changes. We think general production joint venture legislation would be useful; that is why we proposed it. As to the hospital industry itself, I don't think we, the antitrust agencies, are their problem.

REPRESENTATIVE STARK. Mr. Egan.

MR. EGAN. I would have to agree. We had a meeting with Congressman Slattery to discuss this issue, and the essence of this question was presented at that time, too, and I am perplexed as to why there is currently a perception that antitrust is in the way. I think we presented some fairly compelling evidence that it isn't.

I would note that the American Hospital Association has published a guide entitled "Hospital Mergers: An Executive's Guides through the Antitrust Thicket," published in September 1989. A couple of things are probably relevant to this.

One, the general statement on page 20:

> The general analytical framework for analyzing the antitrust ramifications for hospital merges is well established.

I don't think it is any secret how we look at hospital merges.

In terms of joint ventures on page ten, there is a statement about alternatives to joint ventures. It states:

> Joint ventures, which are increasingly commonplace among health care providers, can range from joint purchasing of hospitals of expensive high technology to shared laundry facilities. Because joint ventures often involve less thorough investigations, they can typically be accomplished with fewer antitrust impediments than a merger.

That is what we have been saying. I don't think it is a secret to the industry. The industry's own guide apparently says the same thing.

REPRESENTATIVE STARK. Well, there seems to be some problem. You feel that if the system ain't broke don't fix it.

The Chair's theory, and certainly the other Subcommittee on which I serve, we aren't running around looking for things to do. We generally hear from our constituents or people that are involved.

We hear from HCFA if they don't like the way things are going. We hear from hospitals. I must say, there is a clarion call out that is saying, help us with this merger problem.

They are all screaming, if you want us to bid or provide competitive services, get the FTC rules off our back. I tend to think that they make you the scapegoat. They say that they can't even talk about how they price procedures because they will go to jail.

I rather suspect that they are overstating it for other purposes. But it does seem to me that there is enough grumping and dissatisfaction between the doctors and the hospitals, in general, and you guys are leaving the pharmaceutical industry alone.

I mean, talk about greedy, grubing people who are ripping off the economy, we are the sole buyers, us, the government, and you won't even let us force them to bid. I mean, come on, guys.

They are stealing taxpayers money. I can go buy the stuff in Europe; staple stuff for half of what I am paying here, and I don't hear a peep out of you guys on that. Let's get real. The competition there is hosing the consumer. When is the last time anybody took on a drug company?

MR. EGAN. One of our recent successes was a settlement that we achieved with Sandos Corporation, involving an antischizophrenia drug which they had tied——

REPRESENTATIVE STARK. Did they plead out?

MR. EGAN. Yes, sir, they did.

REPRESENTATIVE STARK. What was the fine?

MR. EGAN. We don't have that ability.

REPRESENTATIVE STARK. They said we will stop?

MR. EGAN. We will stop and there are a number of——

REPRESENTATIVE STARK. They don't pay any attention. That is like parking tickets for Congressmen in the District of Columbia, or overdrafts in our bank. How about jail?

MR. JAMES. Mr. Chairman, it is interesting that you should mention that because—I can't discuss this matter in any detail—but the Department does have an ongoing grand jury investigation of price fixing in the generic drug industry.

REPRESENTATIVE STARK. Go get them. I would love to go on with this all day. I would like to send you some more sensible sounding questions that have been phrased by the staff rather than my curiosity of how you guys run things.

I do hope you recognize that there is some disagreement, other than just litigants. I don't know how to solve the problem you have. I honestly don't know. He said in Ukiah that you have basically two hospitals. I don't know why that has to go through the courts. I would set the prices in Ukiah, since 70 percent of the prices are already set.

It seems to me to be a logical extension and go on. They might not like that, the hospital. They might take it. But it seems to me we are spending a lot of resources—yours and theirs—a couple million bucks, relative to the size, for basically 100 beds, and whether we should split them into two institutions or one institution. I have to think that it doesn't make a whole lot of difference. There ought to be an easier, quicker way.

MR. EGAN. The companies could have come in before they merged, even on an informal basis and then on a more formal basis, and consulted with the FTC staff and gotten a read on this. Now, we are being forced to wait essentially until trial to even hear their—in detail at least—efficiency story.

REPRESENTATIVE STARK. You think you will get to a trial.

MR. EGAN. They should have come in and have talked to us, and they didn't.

REPRESENTATIVE STARK. The Presbyterians in San Francisco told me it costs them a million-and-a-half bucks to come in and talk to you. You don't make that an inexpensive procedure.

I am not trying to pass the sins of private practice attorneys onto you guys. My friends in San Francisco said, here is a merger where arguably there is competition all over the place, and one hospital was in danger of going broke. I think it was a million-and-a-half dollars just to come in and get whatever you say, a waiver.

MR. EGAN. That was a different circumstance, in a sense—I am familiar with that case. The issues are a lot more complicated. The Commission did not challenge the merger, but it presented a very complex set of circumstances.

REPRESENTATIVE STARK. It was, as I say, a million-and-a-half dollars.

MR. EGAN. I don't know how much they spent.

REPRESENTATIVE STARK. I have reason to believe that it was $1.5 million. Do you know how far that would take me and my indigent care in Oakland across the Bay with my stinky little community hospital, which is the only one I really love? That would pay for a whole hell of a lot of trauma care.

I am not saying they would give it to me. Couldn't we get there for a half-million dollars?

MR. JAMES. Mr. Chairman, there is a real sense here, I can say, having been on both sides—he was a banker; I was an antitrust lawyer in private practice and represented hospitals, in which the parties can make this as expensive or as inexpensive as they want to make it.

We are more than happy to meet with people to deal with dispositive issues first. You talk about systems where there is a possibility of eminent failure. We say, let's look at this issue and see if that resolves the problem.

We try to reduce these peoples' costs. A lot of it depends on whether you are going to come in and litigate with us from the day we first call you, or whether you come in and we work on these issues in a cooperative way.

REPRESENTATIVE STARK. Sort of like when Judge Wilkie wrote me a letter and said, gee, if there is anything you want to tell me, would you send me a letter? I am not a lawyer, and there are some of us who have reason to be a little leary when a lawyer or prosecutor invites us into chat.

MR. JAMES. I think that is true. If you give into that concern and litigate from the very first second, your costs are going to go up.

MR. EATON. Before you get to that point, Mr. Chairman, the educational efforts, I think, have increased. Mr. Egan mentioned the guidelines that the AHA put out. I know they are in the process of putting out a newsletter on current antitrust issues in health care. I think the first letter that went out, both the Justice Department and the FTC reviewed that correspondence.

In the Department, we are talking to the industry. So, I think, as I said before, cooperation, more education, there is a lot of literature out there.

REPRESENTATIVE STARK. Do me a favor, guys. Look at your testimony tonight as I have to adjourn. Imagine two different scenarios: One, Perot was President and the other, Clinton,was President. How would you rewrite the testimony.

I will leave the hearing record open so that we can submit written questions to the witnesses.

Thank you. We will see you all.

[Whereupon, at 12:05 p.m., the Subcommittee adjourned, subject to the call of the Chair.]

[The prepared statement of the University Hospital follows. However, two lengthy White Papers and other matieral filed with the FTC (see footnote 4 of the University Hospital statement) are not included in this hearing record:]

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July 14, 1992

Honorable Fortney H. Stark
Joint Economic Committee
Room G-01
Dirksen Senate Office Building
Washington, D.C.

Re: Hospital Industry in the 21st Century: Hospital Mergers and Joint Ventures Hearing of the Subcommittee on Investment, Jobs, and Prices Held June 24, 1992

Dear Mr. Stark:

This statement is submitted for the record by University Health Services, Inc. a non-profit health care organization located in Augusta, Georgia. University Health Services is the operator of University Hospital, a 640-staffed bed teaching hospital also located in Augusta.

In 1990, University Health entered into an agreement with Health Care Corporation of the Sisters of St. Joseph of Carondelet, a Catholic health system headquartered in St. Louis, to acquire the then 169-staffed bed St. Joseph Hospital of Augusta, Georgia, Inc. The agreement arose out of the Sisters of St. Joseph of Carondelet unsolicited offer to sell its acute care facility to University Health Services, Inc. The Sisters made the offer after they determined that St. Joseph Hospital's future financial viability was extremely questionable and that the mission of the Sisters would be better served by redirecting the assets invested in their acute care hospital to other health care services in the community.

The proposed acquisition has been enjoined -- and the transaction subsequently abandoned by the parties -- as a result of a complaint initiated by the Federal Trade Commission under Section 7 of the Clayton Act. The acquisition was enjoined by a federal appeals court in the face of overwhelming support from the Augusta community, including employers and other purchasers of hospital services, and after a U.S. District Court, following a hearing on the matter, refused to enter a preliminary injunction as requested by the FTC.[1/]

1/ University filed pre-merger notification forms on November 30, 1990. On May 6, 1991, the Court of Appeals directed that a preliminary injunction issue. At that point, faced with the prospect of two years' additional proceedings before a final decision would be reached (i.e., a full hearing before the Commission's hearing examiner and likely appeals to the Commission and the U.S. Court of Appeals), the parties mutually agreed to abandon the proposed transaction. In particular, it was clear that St. Joseph Hospital, which had entered into the agreement based on concern for its competitive future, could not afford to maintain the status quo for the duration of the proceedings. This, in itself, illustrates a significant problem in antitrust enforcement. Once the enforcement agencies obtain preliminary relief, that relief is often tantamount to a permanent injunction. Indeed, the more urgent the merger, the more likely it is that the one or both parties will be unwilling or unable to withstand the time and expense of protracted litigation.

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We understand that testimony presented to the Committee on June 24 by representatives of the Federal Trade Commission made extensive reference to the FTC's action against University Hospital and may have presented a distorted view of the evidence in the case. We believe, therefore, it would be appropriate to bring to the Committee's attention certain facts concerning the proposed merger and the impact of the FTC's intervention.

The proposed acquisition resulted from both parties' commitment to reduce hospital costs in the Augusta area. Like many communities, Augusta has a surplus of hospital resources[2/] and a declining demand for inpatient hospital services.[3/] The declining demand for inpatient hospital services is especially troubling for an institution like St. Joseph Hospital, whose limited scope and intensity of services cripple its ability to acquire managed care contracts. The Sisters of St. Joseph, in the face of continued deterioration of St. Joseph Hospital's ability to cost-effectively provide inpatient hospital care and a consequent decline in the Hospital's market position, determined that their ministry would be better served by refocusing their efforts in the areas of rehabilitation services, hospice care, home health care, and other non-acute services. It was with this goal that the Sisters approached University Health in 1990. St. Joseph and University share similar values in the delivery of health services and had experience in cooperative health care ventures, including the operation of a rehabilitation hospital. The proposed transaction was structured to give the Sisters sole ownership of the rehabilitation hospital and other non-acute services operated individually and jointly by the two organizations, while transferring control of the St. Joseph Hospital assets to University.

In the course of its proceedings against the acquisition, and before this Committee, the FTC staff has continually made representations that it "uncovered" a document showing that the purpose of the transaction was to reduce competition. In fact, the document to which the FTC alludes was a "White Paper" prepared specifically for and furnished voluntarily to the Commission during the statutory pre-merger waiting period. The particular passage which so concerned the FTC was contained in the following paragraph:

> In addition to the fact that the proposed transaction will have no significant adverse effect on price competition -- to the extent it exists -- in the Augusta area, the transaction also will produce substantial welfare-enhancing benefits to consumers. Those benefits will exist in three areas. First, there will be a reduction in cost increasing non-price

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2/ The area covered by the FTC consent order recently published in the Federal Register contains 2,281 licensed acute care beds, of which 1,829 are staffed and operating, plus an additional 399 psychiatric beds. The market area also contains 1,024 veterans administration hospital beds and an Army Regional Medical Center with 384 beds.

3/ This conclusion was reached during St. Joseph's strategic analysis which preceded its offer to sell to University Health Services. Analysis of utilization rates and demographics lead to the conclusion that, even without considering the effects of the VA hospitals, the Army hospitals, or the several small hospitals in the surrounding counties, the three-county area covered by the FTC consent order has approximately 450 excess staffed acute care beds. The Georgia State Health Planning Agency has identified Richmond County as having a significant excess of acute care beds.

competition. As confirmed by empirical analysis, such a result is associated with lower long-run prices for hospitals in Georgia. Second, University Hospital and St. Joseph Hospital will be able to avoid, through consolidation, significant capital and operating costs which they otherwise would be required to incur. Third, the integration and consolidation of inpatient operations will produce efficiencies in both clinical and administrative areas, which will reduce community health care costs.

There can be no question that the context of the "admission" that non-price competition would be reduced was the parties' belief that the consolidation of the two hospitals would reduce wasteful (that is, economically inefficient) expenditure in the community. Indeed, the statement was followed by a full discussion of the "medical arms race" and the absence of consumer benefit from hospital competition based primarily on duplication of services, technology, and amenities. University and St. Joseph knew that the Augusta community could benefit from a reduction in the wasteful duplication of expensive hospital resources.[4/]

The motivations of this proposed transaction were not merely the perceptions of hospitals. The Augusta business community -- that is, those who pay the medical bills for the employed population and their dependents -- lined up solidly behind the proposal. Testimony of those employers submitted to the Commission and before the District Court clearly indicated their conclusion that the reduction of needless duplication of equipment and services was an important step in the process of controlling health care cost increases. The loss of this "competition" did not trouble them, nor did it trouble Georgia Blue Cross and Blue Shield, which likewise stood in support of the merger. Indeed, before the District Court, the FTC could produce no complaining buyers of hospital care. The witnesses for the Commission consisted of two physicians (whose testimony reflected a significant degree of economic self-interest), the president of a small health plan with a long-term contractual obligation to a competing hospital (who, on cross-examination, disavowed any past or future interest in obtaining competitive bids from Augusta hospitals), and an economic expert who conceded that she interviewed no employers or other purchasers in the Augusta market.

The FTC has claimed before this committee and in other forums that the hospitals had no proof of any economic efficiencies resulting from the proposed acquisition. This statement is simply untrue. The hospitals obtained expert analyses of both capital investment and operating efficiencies which could be achieved through consolidation. Those studies documented annual operating savings of $7-13 million, and capital cost savings over five to eight years of $19-22 million. Thus, the employers' perceptions that the merger would result in economic benefit to them and the community was well-founded. The FTC simply refused to consider this evidence, relying on its premise that the reduction of "competition", wasteful or otherwise, was not in the community's best interests.

4/ For the benefit of the Committee, we have attached the two White Papers submitted by the parties to the FTC, as well as our Non-binding Statement filed in the FTC proceedings.

The irony of the FTC's position is that ample hospital competition would have existed after the proposed consolidation. Three other strong hospitals operate in the Augusta market, and the evidence was clear that those hospitals have provided intense competition for University and St. Joseph in the past, and would provide even *greater* competition in the future. Major federal facilities in Augusta provide further acute care alternatives to veterans, military members, military retirees, and the dependents of active and retired military.

Illustrative of the competitive strength of other hospitals in the market is the situation of the Medical College of Georgia Hospital. MCG is a 500-bed teaching hospital renowned for its specialty referral services. At present, MCG is embarked upon a $37 million campaign to renovate and expand its inpatient and outpatient capabilities. Through its faculty and residents, MCG is the only Augusta hospital fully capable of offering managed care contracts covering both hospital and physician services. There is no question that MCG is equivalent to University in terms of the scope and intensity of services offered. It is physically located less than half a mile from University Hospital and within two miles of the St. Joseph Hospital. The FTC, however, discounted MCG as a competitor due to the FTC's misperception that MCG was merely an indigent referral hospital for the State of Georgia. The President of MCG has repeatedly stated that MCG is not the state's charity hospital. Nevertheless, the FTC apparently reasoned that MCG was undesirous of obtaining private-pay patients from Augusta, and that private patients would not use MCG. In fact, testimony before the District Court showed that MCG viewed the acquisition of a greater share of the private-pay markets as an economic imperative, and that University perceived MCG as a significant competitor. The District Court thus concluded that "the threat of competition from the Medical College of Georgia [is] an increasing, and indeed a welcome one." Moreover, it has come to light since the time of the trial that the State's funding of MCG's expansion project was expressly contingent on the hospital's commitment to seek out a greater share of the private-pay market.[5/]

Another hospital in the Augusta market is Humana Hospital-Augusta, a 324-bed general acute care facility located in an affluent suburban area less than ten miles from University Hospital. The Humana facility has one of the premier burn care services in the Southeast United States and has consistently been one of Humana's most profitable hospitals. While the FTC proceeding against University Hospital was pending, Humana announced its plans to invest $40 million in improvements to the hospital.

The third major competitive force is Hospital Corporation of America's Aiken Regional Medical Center in Aiken, S.C. The HCA hospital is located near growing Augusta suburbs in Aiken County, and is a clear alternative for hospital care for many Augusta area residents. HCA began a $19 million expansion of its hospital and several other multi-million dollar projects during the pendency of

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5/ This fact may have been known to the FTC staff at the time of the FTC's complaint and the District Court proceedings, as the administrator of MCG was deposed by the Commission's staff but refused to talk with counsel for University and the Sisters. In any event, the FTC did not call MCG's administrator as a witness in the proceedings.

the FTC proceedings. While the FTC maintained that Aiken was out of reach geographically for Augusta residents, the District Court understood that Aiken and Augusta, 20 miles apart, are economically linked. Indeed, the Central Savannah River Area, which includes both Augusta and Aiken, is a regional economic planning area and the largest employer of Augusta residents (the Savannah River site) is actually closer to Aiken than Augusta. The inclusion of Aiken County within the FTC approved consent order dramatically demonstrates that the FTC became convinced that HCA Aiken and University Hospital are competitors in the same market.

The FTC's intervention has not been well received in Augusta. The community supported the consolidation of St. Joseph's and University and believed in the ability of the consolidation to reduce wasteful health care spending and help control future increases in health services and health insurance costs. Those benefits now are lost and the opportunity will not soon return. The FTC's enforcement policy is out of touch with the economic realities of the health care marketplace. More particularly, the FTC appears to favor black-letter "rules" (that is, their rules) regarding market concentration over the clear evidence regarding purchaser attitudes and the functioning of the particular market in which the acquisition will occur.[6/]

What should most trouble the Committee about the result in Augusta, however, is the chilling effect it has had, and will continue to have, on collaboration among hospitals in the Augusta area and elsewhere. The terms of the consent order now pending in this matter prohibit University from acquiring the assets of any existing hospital in the area (including acquisitions in the form of joint ventures) for a period of ten years from the date on which the Consent Order is finally approved. (We note that the better part of a year passed before the Commission even published the proposed Consent Order for public comment; the Order thus will effectively operate for eleven years.) Also, for a period of ten years, University is prohibited from entering into many types of joint ventures with other area hospitals for the purpose of developing new hospital or medical services without prior notification to the FTC. This result is all the more difficult to accept given that the Sisters' and University's only "offense" was their audacity to propose this collaboration in the first instance. For merely proposing it, and playing by the Commission's rules, University has been branded as a likely future violator of the antitrust laws, and placed under ten years' supervision by the Commission staff. In the absence of any evidence of an intent to harm consumers, this surely is a harsh result. Since few geographic areas the size of the Augusta market contain a significantly greater number and quality of acute care hospitals and most contain markedly less, the FTC's position with its specter of monstrous litigation expenses and intractable delays must cast a dark shadow that reaches out from Augusta across the entire nation. The University Hospital case sends the message that engaging in consolidation is playing Russian roulette.

6/ It should be noted that the Commissioners were not unanimous in their decision to issue a complaint against University. Also, we believe that there were views within the Bureau of Economics staff that were opposed to the Bureau of Competition's hard line approach.

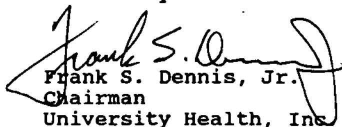
We urge the Committee to continue exploring ways in which local, state, and federal interests in reducing excessive health care expenditures through collaboration among hospitals can be accommodated under the federal antitrust enforcement policy. If we can provide additional information regarding our experiences to the Committee, please do not hesitate to contact the undersigned.

Sincerely,

Donald C. Bray
President/CEO

Levi W. Hill, III
Past Chairman
University Health Services, Inc.

T. Richard Daniel
Chairman
University Health Services, Inc.



Frank S. Dennis, Jr.
Chairman
University Health, Inc.

[The following material was submitted for the record in response to written questions posed by Representative Stark:]

Questions for Dr. David Kaplan

What effect do all payer systems such as that operating in the State of Maryland have on the need for Federal antitrust enforcement? To what extent would Federal involvement differ if an all payer system were instituted nationally?

To what extent do you see the need for planning activities to complement other means of influencing hospital bed supply?

Some have suggested that more specific guidelines than those provided in the joint FTC-Justice issued Merger Guidelines would assist in clarifying matters for both FTC and Justice, and the hospital industry. Would you support the creation of more specific guidelines that did not preempt the application of existing antitrust laws but would assist in their application to the hospital industry?

WRITTEN RESPONSE OF DAVID P. KAPLAN TO ADDITIONAL QUESTIONS PROVIDED BY LETTER DATED JUNE 26, 1992

1. What effect do all payer systems such as that operating in the State of Maryland have on the need for Federal antitrust enforcement? To what extent would Federal involvement differ if an all payer system were instituted nationally?

Response

The Federal antitrust laws as a whole are primarily designed to facilitate or maintain competition, including price and non-price competitive activity. The so-called "all-payer system" operating in the State of Maryland, based upon my current understanding, is focused on price or rate control. In this sense, the need for federal antitrust enforcement designed to facilitate or maintain competitive pricing would be diminished. This conclusion would apply equally if the system currently operating in the State of Maryland were instituted nationally. The need for Federal antitrust enforcement would not, however, be eliminated. Federal antitrust enforcement would still have a useful role as a means of facilitating and encouraging non-price competition, such as the provision of services. In this regard, it should be noted that our legal history includes many court cases focused on alleged anticompetitive conduct on behalf of firms regulated in some fashion by Federal or State authorities.

2. To what extent do you see the need for planning activities to complement other means of influencing hospital bed supply?

Response

Joint planning activities between hospitals can facilitate the provision of lower-cost medical care. Better planned and managed healthcare also allows for a more efficient and effective mechanism to match the actual and projected demand for hospital beds with the supply of hospital beds. Joint planning activity between hospitals, therefore, should be encouraged. However, proper safeguards should be considered to prevent the use of joint planning activities as a means to eliminate all competitive activity between hospitals which are in direct and substantial competition.

3. Some have suggested that more specific guidelines than those provided in the joint FTC-Justice issued Merger Guidelines would assist in clarifying matters for both FTC and Justice, and the hospital industry. Would you support the creation of more specific guidelines that did not preempt the application of existing antitrust laws but would assist in their application to the hospital industry?

Response

The recently introduced joint FTC/Justice Merger Guidelines are generally designed to provide an analytical framework for a review of those issues which may be relevant when considering the likely competitive impact of the merger of two competing entities. In this sense, it could be argued that no additional guidance is necessary from Federal antitrust authorities concerning hospital mergers. This conclusion is untenable for a number of reasons.

As suggested in the attached article, the two enforcement agencies currently disagree on how to interpret the Merger Guidelines ("from the moment the Guidelines were released, FTC and DOJ staffers have been putting differing interpretations or 'spins' on the Guidelines"). If the two enforcement agencies disagree on how to interpret the Merger Guidelines, it is not hard to appreciate some degree of confusion in the business community, including the hospital industry, and a clarifying statement would be quite helpful in this regard.

Moreover, application of the Merger Guidelines (as best they can be interpreted) raise a number of troubling substantive issues related to the combination of hospitals. First, despite representations by enforcement authorities to the contrary, concentration measures continue to play too large a role in merger enforcement by unreasonably increasing the evidentiary burden on parties advocating a transaction. Government representatives have stated that concentration data are only the "first step" in merger review. In reality, however, the impact of concentration data infiltrates each step in the merger review process. FTC Commissioner Yao and Kevin Arquit, Director of the FTC Bureau of Competition, recently stated that the "amount of clarity of evidence necessary to overcome the presumption of competitive concern increases" as concentration increases and that higher concentration "clearly requires the more persuasive showing that other factors rebut the presumption of anticompetitive effect."[1]

1 Yao and Arquit, "Applying the 1992 Horizontal Merger Guidelines," Antitrust (Summer, 1992), at 17.

Many hospital mergers violate the structural thresholds established in the Merger Guidelines because of the rather limited number of hospitals in many areas of the country. The FTC/DOJ reliance on these data when attempting to reach conclusions concerning the likely competitive effect of a particular merger, therefore, makes it much more difficult (e.g., time consuming and expensive) for hospitals to obtain necessary government approval. This increased difficulty enhances the risks of obtaining government approval for a hospital merger thereby reducing incentives for hospitals, striving for effective mechanisms to reduce costs, to engage in the time consuming and expensive exercise of a merger review. In this regard, it would be helpful for the agencies to clarify their position on how concentration data will be used when reviewing the merger of two hospitals.

In addition, the Merger Guidelines recognize the importance of efficiencies in merger review. Efficiencies and cost reductions are, of course, a key motivating factor associated with many hospital mergers. As discussed in my previous written and oral testimony, however, representatives of the FTC have argued that most efficiency arguments associated with hospital mergers are pure speculation and the FTC recently argued in Federal Court "that the law recognizes no . . . efficiency defense in any form."[2] The conflict between the Merger Guidelines and actual enforcement policy (at least at the FTC) requires clarification.

Given the importance of controlling healthcare costs, the apparent disagreements between the FTC and DOJ on how to interpret allegedly "joint" guidelines, and the apparent confusion on how to interpret concentration data and efficiencies when analyzing a merger of two hospitals, it is my opinion that it is incumbent on Federal antitrust authorities to develop a clear statement on how hospital mergers will be reviewed by antitrust officials. This clarifying statement should include identification of the type and quality of evidence necessary to gain government approval for a merger of two hospitals.

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[2] Federal Trade Commission v. University Health, Inc., 938 F.2d 1206, 1222 (11th Cir. 1991) rev'g 1991-1 Trade Cas. § 69,400 (S.D. Ga. 1991).

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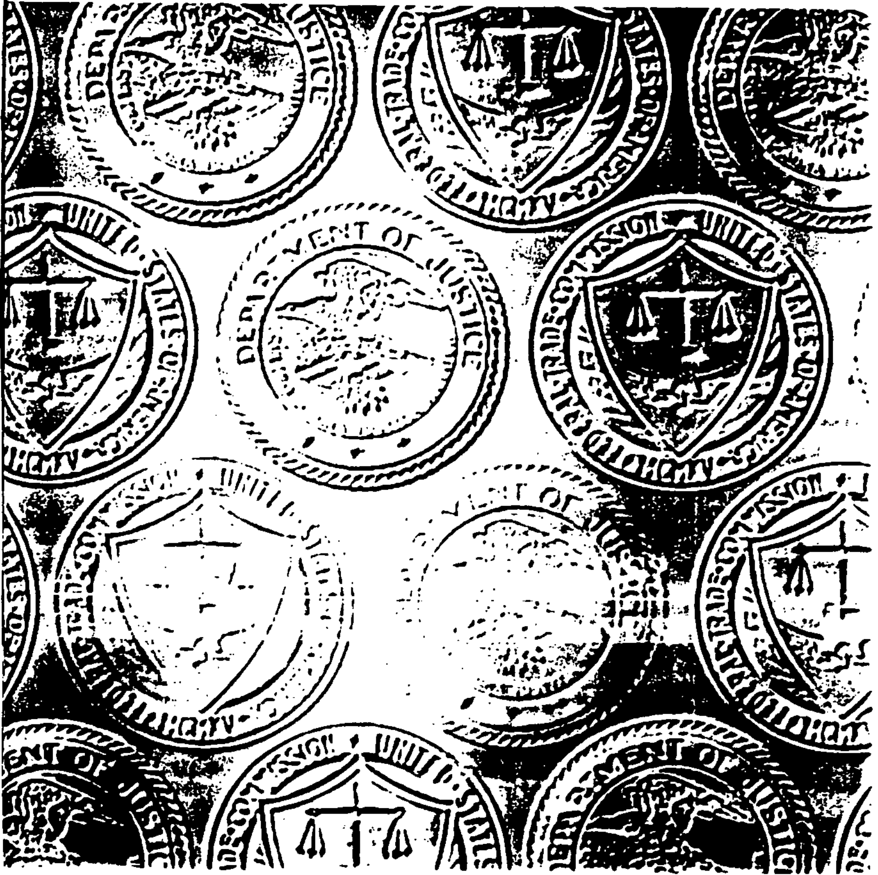


EDITOR'S NOTE:

The Guidelines That Almost Weren't

by Daniel M. Wall

This issue of ANTITRUST was almost entitled "Mergers Without Guidelines." Until literally a day or two before they were issued at the Antitrust Section's 40th Annual Spring Meeting in Washington, D.C., it was unclear whether there would even be new merger guidelines, let alone what they might say. Last minute cold feet at the highest levels of the Justice Department and ongoing debate within the Federal Trade Commission threatened to foil a full year's worth of effort by the Antitrust Division to provide the first formal statement of U.S. antimerger policy since the 1984 Guidelines.

But the 1992 U.S. Department and Justice and Federal Trade Commission Merger Guidelines were issued, and they are cited as evidence of unprecedented harmony between the two enforcement agencies. In fact, however, so much political infighting preceded their release that they can only be understood as the product of a difficult political compromise. As has been reported elsewhere, the first draft of the Guidelines presented by the Antitrust Division to the FTC was not warmly received. Among other things, FTC staffers felt that the controversial "competitive effects" section could undermine the government's preferred prima facie case based on market shares and increases in concentration. Months of negotiations ensued on this and many other issues. At times it appeared that no compromise would be reached and the Justice Department would be forced to issue the Guidelines alone, if at all.

Daniel M. Wall, Editorial Chair of ANTITRUST, *is a member of McCutchen, Doyle, Brown & Enersen in San Francisco, California, where he specializes in antitrust and other complex litigation.*

Eventually, four FTC Commisioners (Commissioner Mary Azcuenaga dissenting) agreed to go along with a heavily modified version of the Guidelines. That at least created the appearance of uniformity. But it remains to be seen whether there will be uniformity of *application* by two agencies which had so much trouble agreeing on the Guidelines in the first place, and still disagree over significant issues of substance and policy.

The early signs are not promising. From the moment the Guidelines were released, FTC and DOJ staffers have been putting differing interpretations or "spins" on the Guidelines. Privately, FTC personnel complain that the Antitrust Division's public statements attempt to "take back ground" given up in negotiations. DOJ personnel reply they are simply explaining the natural meaning of the Guidelines as revealed by their underlying economics.

Without question, much of the unease government enforcers have with the Guidelines stems from the way some courts treated the '82 and '84 Guidelines as admissions against interest. In case after case, government merger prosecutions presumably based in Guidelines analysis were defeated by defendants able to convince the court to cite the Guidelines back in the government's face. *See, e.g., United States v. Baker Hughes Inc.*, 908 F.2d 981, 985 (D.C. Cir. 1990); *United States v. Archer-Daniels-Midland Co.*, 781 F. Supp. 1400 (S.D. Iowa 1991). Imprecise language in the old Guidelines' discussion of entry was especially troubling and contributed to government losses in both merger and non-merger cases. *See United States v. Waste Management, Inc.*, 743 F.2d 976, 982 (2d Cir. 1984) (Clayton Act Section 7 prosecution); *United States v. Syufy Enterprises, Inc.*, 903 F.2d 659 (9th Cir. 1990) (Sherman Act Section 2 civil action). Often, the courts' interpretations of the Guidelines were terribly unsophisticated or one-sided, but that just highlighted the fundamental problem: *any* guidelines which purported to set forth a full merger analysis, no matter how carefully written, would contain *something* that could be intentionally or unintentionally misconstrued against the prosecutor's interest.

Of course, this concern would have all but disappeared if the new Guidelines signaled a turnaround from the substantive merger policies embodied in the '82 and '84 Guidelines. Many FTC and DOJ litigators would like nothing more than to have guidelines simplifying the prosecutor's case and constricting to the point of strangulation defenses such as easy entry, power buyers, and efficiencies. But that's not what they got. For the most part, the new Guidelines carry forward the strict and generally pro-merger analysis demanded by William F. Baxter and his Reagan Administration successors. And the effects test, especially as articulated in the original drafts of the Guidelines, was, and to an extent still is, seen by some government litigators as the coup de grace to whatever is left of the structural case-in-chief permitted by *United States v. Philadelphia National Bank*, 374 U.S. 321 (1963).

It is difficult to characterize the final document as more or less permissive of mergers than its predecessors. The effects test is a good example. Though cited by many as the best evidence of still more permissive enforcement, it is arguably no more than an awakening to reality. The fact is that courts are not buying the structural case anymore; they want specific "stories" as to how and why a particular merger is likely to harm consumers. Prosecutors who do not take heed of this trend, and who steadfastly

defend *Philadelphia National Bank*, are living in denial—and losing. To be sure, the DOJ's own '82 and '84 Guidelines may be the chief suspects in the demise of *Philadelphia National Bank*, but it is too late to worry about that now. In 1992, merger prosecutions without effects stories are doomed to failure.

Similarly, the much-criticized change in the predictive language associated with Herfindahl calculations—mergers which previously were "likely" to be challenged now "potentially raise significant competitive concerns"—at least removes an embarrassing misrepresentation about real-world merger practice. Contrary to what the old Guidelines said, mergers increasing the Herfindahls by 100 points in moderately concentrated markets were *not* "likely to be challenged," and mergers increasing the Herfindahls by 100 points in highly concentrated markets were *not* challenged except in "extraordinary cases." Unless the government genuinely intended to challenge both kinds of mergers routinely—and no one suggests the Bush Administration or the current FTC was going to do that—the language had to be changed.

For the most part, the new Guidelines carry forward the strict and generally pro-merger analysis demanded by William F. Baxter and his Reagan Administration successors.

Some parts of the '92 Guidelines are significantly more "pro-prosecutor" than the old versions. The entry section is the clearest example, and is especially noteworthy given Clarence Thomas' decision in *Baker Hughes* rejecting a government entry argument very similar to the new Guidelines' standard. Clearly, the government has decided to fight for its position that entry easy in the abstract doesn't count unless it is genuinely likely to resolve competitive concerns. The '92 Guidelines also significantly increase the merger proponent's burden under the failing company and failing division defenses and may, depending on how the distinction between "committed" and "uncommitted" entrants works in practice, lead to narrower relevant markets and correspondingly higher Herfindahls.

About a year ago, ANTITRUST decided to devote an issue to the then-imminent 1991 revision of the Merger Guidelines. We had no idea that the story of that issue (two issues later) would itself be a testament to the tension that exists between the FTC and DOJ about the meaning of the Guidelines.

The original concept for this issue was simple and tracked the understanding that the Guidelines would be jointly issued—and ascribed to—by the two agencies. An overview article summarizing what was new about the Guidelines would be followed by an interview exploring their economic rationale. DOJ personnel were selected as both author and interviewee, but not because of their institutional affiliation or perspective.

As time passed, however, and the difficulty of obtaining FTC DOJ agreement on the Guidelines became clear, so did the need for an individual, independent FTC perspective. So a second interview, this one with an FTC staffer, was added. An additional article by a former DOJ economist on entry analysis, which figures prominently in the Guidelines, was a later addition.

After the Guidelines were announced and the issue was set, FTC Commissioner Dennis Yao's office called asking if it was too late to add another FTC voice, and suggesting that a 3:1 DOJ-FTC participation was inappropriate. While it never occurred to anyone at ANTITRUST that the issue reflected a balance of the agencies—or that it needed to—we couldn't resist the suggestion that the new FTC article would take issue with DOJ interpretations of the Guidelines. Our two articles had now become five.

The articles and interviews that follow present important perspectives on the Guidelines, and particularly the differing meanings they have at the two agencies. In the first article, Paul T. Denis, then Special Counsel to the Assistant Attorney General, gives an overview of the Guidelines from the DOJ's point of view. Next, Janusz A. Ordover, Deputy Assistant Attorney General for Economic Analysis, is interviewed regarding the economic foundation of the Guidelines. These two pieces are followed by the article which FTC Commissioner Dennis Yao and Bureau of Competition Director Kevin Arquit prepared in response to them. In reading this article, one should consider not only what Yao and Arquit say, but also that they felt obliged to say it after reading the Denis and Ordover pieces.

In a second interview, Steve Newborn, Director for Litigation of the FTC's Bureau of Competition, provides another FTC perspective on the Guidelines. Robert D. Willig, who served as Deputy Assistant Attorney General for Economic Analysis when the Guidelines revision project began (and who is currently a Professor of Economics and Public Affairs at Princeton University), then addresses sunk costs and the Guidelines' approach to entry analysis. Robert M. Langer, Chairman of the National Association of Attorneys General Multi-State Antitrust Task Force, is interviewed regarding the states' perspective.

The interviews with Ordover and Newborn were conducted by ANTITRUST Editorial Chair Daniel M. Wall and Contributing Editor Stephen F. Ross. All of the government authors and interviewees prefaced their remarks with the usual disclaimer that they speak only for themselves and not for their agencies or organizations. Given how the articles came about, those disclaimers are even more ironic than usual. •

Questions for Ms. Rita Ricardo-Campbell

What effect do all payer systems such as that operating in the State of Maryland have on the need for Federal antitrust enforcement? To what extent would Federal involvement differ if an all payer system were instituted nationally?

To what extent do you see the need for planning activities to complement other means of influencing hospital bed supply?

Some have suggested that more specific guidelines than those provided in the joint FTC-Justice issued Merger Guidelines would assist in clarifying matters for both FTC and Justice, and the hospital industry. Would you support the creation of more specific guidelines that did not preempt the application of existing antitrust laws but would assist in their application to the hospital industry?

HOOVER INSTITUTION
ON WAR, REVOLUTION AND PEACE

Stanford, California 94305-6010

July 6, 1992

The Honorable Pete Stark, Chairman
Subcommittee on Investment, Jobs, and Prices
Joint Economic Committee
Congress of the United States
Washington, D.C. 20510-6602

Dear Congressman Stark:

Thank you for your letter of June 26.

In response to the questions you raise, I answer briefly as follows:

1) All-payer system. That over 30 states during the early 1980s had an all-payer system which required a hospital to bill the same charges regardless of payer, and today only one state, Maryland, has such a system is significant. The all-payer system appeals because it seems fairer that hospitals should charge every payer the same per given service. But such a system may not contain cost increases as well as more competitive hospital markets, such as in recent years in California.

I assume that in an all-payer system Medicare as one of the multiple payers, would be dominant, yet the Medicare payments are on average higher than payments by Blue Cross and other private insurers according to *Business and Health*, June 1992, p. 20. For heart-bypass surgery, Medicare's nationwide average is reported as $35,220 while Blue Cross and other private insurers' is $29,875. Are Medicare's higher payments entirely due to sicker and older patients?

Medicare is experimenting to save costs by one-fee billing and with this, all-payer systems fit well. Unquestionably, an all-payer system reduces by definition cost-shifting. In my non-legal judgment, it reduces the need for federal antitrust enforcement, but does not eliminate that need. Different hospitals can still collude with other hospitals and conceivably share by arrangement the pool of patients.

If there were a national all-payer system, the latter would still be true and the need for antitrust enforcement still exists.

A national all-payer system of hospital rates could have a high cost of administration. For a long number of years I have advocated uniform accounting by hospitals that could be monitored by the private Financial Accounting Standards Board much in the same way that Board supervises accounting by corporations in other industries. This would

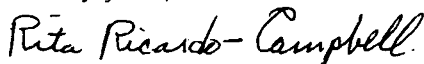
reduce the cost of this government regulation, make it easier for outside audits and help consumers to understand their hospital bills. The key to competitive markets is more information to the consumer.

All-payer hospital rate-setting does not set charges or prices to maximize consumer satisfaction from the resources used for health care as would more competitive markets. The hospital prospective payment system and the newer, resource based, relative value system (RBRVS) of physician fees are flawed. Price regulation has to use some criteria and whatever are used are artificial, subject to interest groups' valuations and pressures. My experience on the Health Services Industry Committee, 1971-74, tells me that price control, however well-intended, does not work in the long run.

2) I do not see a "need for planning activities to complement other means of influencing hospital bed supply." I believe that the private competitive market regulates, although somewhat imperfectly, hospital bed supply and note that nearly 60 percent of community hospital beds are in systems or chains of hospitals. Growth in specialization and participation in hospital chains will continue to increase.

3) In the application of existing antitrust laws I support specific guidelines which would recognize that small hospitals (less than 50 beds) and with low occupancy rates (less than 60 percent) as *de minimus* should be allowed to merge. This would recognize that in today's high-tech medicine, a hospital must do a given number of procedures if it is to retain quality. It also recognizes that the geographic area of competition among hospitals is much wider than 50 years ago before the new information age had evolved.

Sincerely yours,



Rita Ricardo-Campbell, Ph.D.
Senior Fellow

Questions for Mr. D. Kirk Oglesby, Jr.

What effect do all payer systems such as that operating in the State of Maryland have on the need for Federal antitrust enforcement? To what extent would Federal involvement differ if an all payer system were instituted nationally?

A new review mechanism has been instituted in the State of Maine to deal with joint venture activities. What is the position of the American Hospital Association on this initiative?

The Federal agencies responsible for enforcement of antitrust laws have provided an explanation of how they interpret and enforce antitrust laws. Is this sufficient to address the concerns of the hospital industry? In what ways may the short-comings be rectified?

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Washington, D.C. 20001
Telephone 202.638-1100
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August 10, 1992

David Podoff, Senior Economist
Joint Economic Committee
Dirksen Senate Office Building
Room G-01
Washington, D.C. 20510

Dear Mr. Podoff:

On June 24, 1992, D. Kirk Oglesby, Jr., Chairman of the American Hospital Association Board of Trustees, testified on hospital antitrust issues before Congressman Pete Stark's Subcommittee on Investment, Jobs, and Prices. On behalf of Mr. Oglesby, I am pleased to submit the following responses to Congressman Stark's follow-up questions (copy attached), to be included in the hearing record.

Question #1

(a) The all payer system operating in the State of Maryland involves significant supervision and regulation by the State. This State involvement is probably (although not certainly) sufficient to meet the requirments of the "state action immunity" doctrine established by the U.S. Supreme Court. This doctrine immunizes the collaborative activities of private parties acting pursuant to State law from Federal antitrust laws, thereby eliminating the need for Federal antitrust enforcement with regard to protected activity. Note, however, that a recent U.S. Supreme Court decision emphasizes the strict standard for State regulation which must be met in order to obtain immunity. See F.T.C. v. Ticor Title Insurance Company, 60 Law Week 4515 (June 12, 1992).

(b) The level of Federal antitrust involvement necessary in Maryland (which has a State all payer system) is minimal due to the probable application of the "state action immunity" doctrine discussed above. A Federal all payer system would not automatically provide similar protection because, by definition, the existing exemption applies only to states. Legislation therefore would be necessary to expressly create an antitrust exemption under a federal all payer statute, in order to modify Federal involvement on antitrust at a national level.

Question #2

The American Hospital Association supports the efforts of the State of Maine in instituting a system to encourage collaborative activities. Under the "state action immunity" doctrine described above, hospitals in Maine which meet the State's requirements can engage in beneficial collaboration without fear of antitrust liablity. AHA views this initiative as an important step in addressing the health care antitrust problem.

The Maine approach contains many positive aspects. First, it allows information exchange and collaboration among hospitals while providing immunity from antitrust liability. Second, the Maine program adds the health perspective to antitrust enforcement, with a focus on access to quality care. Third, the statute sets forth considerations (or criteria) for the reviewing and enforcing agencies to apply in assessing collaborative activity. Finally, the inclusion of time limits ensures that decisions on proposals for collaborative activity will be timely.

AHA notes that two approaches to the health care antitrust problem can be taken. States (such as Maine and others) can establish systems with state involvement sufficient to immunize the activities of hospitals within the State from Federal antitrust liability. A second approach, which can be pursued simultaneously, is Federal in nature and involves clarifying and, where necessary, modifying application of the Federal antitrust laws to health care. AHA would view favorably a Federal proposal containing the positive aspects of the Maine legislation noted above.

Question #3

AHA is not aware of any explanation by the federal enforcement agencies of how they interpret and apply the antitrust laws to health care settings. Specifically, we have seen nothing which adequately reflects the difference between hospital markets and other markets to which antitrust laws apply.

The lack of guidance for the health care community may be rectified with several measures. First, criteria and/or guidelines specific to health care would be immensely helpful to providers trying to meet the health care needs of their communities and operate efficiently without risking antitrust liability. Providers who know by what standards their actions will be judged, and who may tailor their collaborative efforts to meet criteria acceptable to the enforcement agencies, will be encouraged to move forward with health care initiatives. The current health care crisis facing the United States calls for unique efforts by all players--and would seem to justify "special attention" by the antitrust enforcement agencies.

Second, an expedited and affordable review process, through which hospitals could receive approval from the enforcement agencies for collaborative activities in a timely and efficient manner, would go far to spur beneficial collaboration. Existing mechanisms for review take too long, cost too much, can result in inconclusive responses, and are not binding on private parties.

Finally, AHA recognizes Congressman Stark's suggestion put forth at the June 24 hearing concerning retrospective review. Current enforcement agency policy is to apply antitrust laws based on the speculative anti-competitive effects of hospital activity. The enforcement agencies could instead adopt a policy of challenging collaboration retrospectively--when there is actual evidence of harm to consumers through higher prices, lower quality or reduced output as a result of the collaboration. In the absence of a change in administrative policy, legislation to establish an administrative review process involving both the health and enforcement agencies may accomplish the goal of enforcement based upon the actual, rather than predicted, negative impact of collaboration.

* * *

Thank you for the opportunity to submit the above responses. I hope that this information proves useful to you. If you have any questions, please feel free to contact Gaelynn DeMartino (202/626-2301) of my staff.

Sincerely yours,

Richard J. Pollack
Executive Vice-President, Federal Relations

attachment

Questions for Mr. Don Ammon

Some have suggested that more specific guidelines than those provided in the joint FTC-Justice issued Merger Guidelines would assist in clarifying matters for both FTC and Justice, and the hospital industry. Would you support the creation of more specific guidelines that did not preempt the application of existing antitrust laws but would assist in their application to the hospital industry?

What do you anticipate the effect of an all payer system would be on your facility?

To what extent do you see some State or Federal planning mechanism as beneficial to your facility's attempts at eliminating over capacity and redundancies of services while maintaining necessary services for your community?

July 23, 1992

The Honorable Pete Stark, Chairman
Subcommittee on Investment, Jobs and Prices
Congress of the United States
329 Cannon Office Building
Washington, D.C. 20510

Dear Congressman Stark:

Thank you for your letter of June 26. I just received it in San Francisco on July 14, while involved in the FTC trial on the Ukiah Valley Medical Center consolidation.

This is a very unreasonable burden for a small rural hospital running a census of 45 patients in a town of 14,000.

To respond to your questions, specific guidelines concerning the application of existing antitrust laws to hospitals would be very beneficial for all hospitals. I would also urge you to consider the approach of Representative Slattery's Bill, No. 2406. This is consistent with the testimony of Charles James of the Department of Justice to you on June 24 indicating that they have not pursued any hospital smaller than 200 beds, or in a community with a population of less than 200,000. This approach is simple and straight forward and allows hospitals to respond to the changing healthcare market.

The distinction you make between urban and rural hospitals, while essential for certain issues, may not be appropriate for the rate regulation question. An all payor system does not eliminate the problems in our current system for hospitals in general. Controlling spending by payors does not necessarily control costs to providers. We need to change the incentives for providing and utilizing healthcare services, not ratchet down from the top with all payor rate regulation.

On your last question regarding a State or Federal planning mechanism, I do not believe that an additional bureaucracy would be helpful in resolving these issues. I have been through years of CON regulations. After being in California for several years without CON regulations, I believe there are better ways of dealing with these issues.

The current direction of moving to HMO and selective PPO contracting I believe is moving the healthcare delivery system in a way that soon the economic incentives will or could be aligned in a way that precludes the necessity for a new CON or regulatory system. It has been my experience at Ukiah that the consolidation of healthcare provides better HMO and PPO negotiated rates and services for the payors as stated by the payor in this case.

Thank you for the opportunity to respond to your questions.

Sincerely yours,

Donald R. Ammon

Donald R. Ammon, FACHE
Executive Vice President

Questions for Mr. Charles James

The case brought by the Federal Trade Commission against the Rockford Memorial Corporation was cited by FTC as a successful application of antitrust laws to the hospital industry. What has been the experience with costs and prices in the Rockland, Illinois area since the April, 1990 conclusion of the case?

Compared to the Rockford Memorial Corporation case, what has been the experience with costs and prices in Roanoke, Virginia since February, 1989 when the Carilion Health System case brought by the Department of Justice was ruled in the favor of the hospitals?

What effect do all payer systems such as that operating in the State of Maryland have on the need for Federal antitrust enforcement? To what extent would Federal involvement differ if an all payer system were instituted nationally?

Because the Herfindahl-Hirschman Index could trigger a Federal agency market concentration presumption for most communities (over 80%) with more than one hospital, the usefulness of the HHI Index to the hospital industry is extremely limited. Please outline the criteria applied other than the HHI Index to determine the Justice Department position on a proposed merger.

Please provide information regarding Hart-Scott-Rodino filings. Please identify the number of applications under Hart-Scott-Rodino concerning hospital mergers over the past eight years. What is the length of time from the point of application submittal to the point of a "second request" for information and to the final determination of the application? Please list the number of applications that have taken one month, three months, etc.

Please provide information regarding the "Business Review Letter" procedure. Please identify the number of applications under this process over the past eight years concerning hospital mergers. What is the length of time from the point of application submittal to the final determination of the application? Please list the number of applications that have taken one month, three months, etc.

Office of the Assistant Attorney General

Washington, D.C. 20530

August 5, 1992

The Honorable Pete Stark
Chairman
Subcommittee on Investment, Jobs and Prices
Joint Economic Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing in response to your recent letter, in follow up to Acting Assistant Attorney General Charles James's testimony before the Joint Economic Committee on June 24, in which you pose several questions concerning the Antitrust Division's merger policy as it relates to the hospital industry. Your questions are set forth below along with the Department's responses.

1. The case brought by the Federal Trade Commission against the Rockford Memorial Corporation was cited by FTC as a successful application of antitrust laws to the hospital industry. What has been the experience with costs and prices in the Rockland, Illinois area since the April, 1990 conclusion of the case?

Answer: The Antitrust Division has collected no data concerning changes in hospital costs and prices in the Rockford, Illinois area hospital market since it successfully obtained a permanent injunction on February 23, 1989 against the proposed consolidation of SwedishAmerican Corporation and Rockford Memorial Corporation.

There is, however, a growing body of economic research that has verified the application to the hospital industry of the standard economic theory that competition helps to control prices and costs. Specifically, several studies conducted in

recent years support the proposition that competition controls hospital prices and costs. 1/

2. Compared to the Rockford Memorial Corporation case, what has been the experience with costs and prices in Roanoke, Virginia since February, 1989 when the Carilion Health System case brought by the Department of Justice was ruled in the favor of the hospitals?

Answer: The Antitrust Division similarly has collected no data concerning changes in hospital costs and prices in the Roanoke, Virginia area hospital market since it lost its suit on February 13, 1989, to obtain a permanent injunction against the consolidation of Community Hospital of Roanoke Valley and Carilion Health System. However, articles published recently in Modern Healthcare suggest that the level of capital expenditures that the merged hospital has made is significantly more than the level that the two hospitals had anticipated making before they merged. The merged hospital has taken issue with the thrust of these articles and responded to them through a letter of its President. While the Department neither endorses nor rejects the conclusions reached in these articles, we have attached copies of the articles and associated correspondence to this letter for your information.

1/ Zwanziger, J. and G. Melnick, "The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California," Journal of Health Economics, 7 (1988) 301-20; Robinson, J. and C. Phibbs, "An Evaluation of Medicaid Selective Contracting in California," Journal of Health Economics, 8 (1989) 437-55; Robinson, J. and H. Luft, "Competition, Regulation, and Hospital Costs, 1982 to 1986," Journal of the American Medical Association, 260 (1988) 3676-81; and Dranove, D., Mark Shanley, and William White, "Price and Concentration in Hospital Markets: The switch from Patients-driven to Payor-driven Competition," March 1992; Melnick, G., Zwanziger, J., Bamezai, A. and R. Pattison, "The Effects of Market Structure and Bargaining Position on Hospital Prices," Journal of Health Economics (forthcoming). For example, Robinson and Phibbs estimate that the California Medicaid program saved $836 million due to selective contracting.

3. What effect do all payer systems such as that operating in the State of Maryland have on the need for Federal antitrust enforcement? To what extent would Federal involvement differ if an all payer system were instituted nationally?

Answer: Generically, all-payer ratesetting systems consist of some form of a mandatory establishment of the rates that hospitals charge to all patients and, thus, all third-party payers with which they do business. Maryland was the first state to adopt an all-payer system in the mid-1970's, and it is today the only state to continue operating such a system; in the interim, several other states adopted, and subsequently dropped, all-payer systems.

The features of particular all-payer systems can vary significantly, so it is difficult to draw firm conclusions about what effect the establishment of a national all-payer system would have upon federal antitrust enforcement. For example, in Connecticut, which has an all-payer system that applies to all nongovernmental third-party payers (but not to the Medicare or Medicaid programs), it is still possible for HMO payers to engage in selective contracting with hospitals and to obtain discounts from a hospital in return for channeling increased patient volume to the hospital. Under such an all-payer system, it is clear that the federal antitrust laws, which prevent antitcompetitive hospital mergers, as well as collusion among hospitals, would be fully applicable. Accordingly, if a national all-payer system were to consist of the regulatory setting of the maximum rates that hospitals could charge -- still allowing hospitals to compete by offering discounts to managed care payers -- then the basis for hospital competition and, hence, antitrust enforcement would remain essentially unchanged from what it is today.

On the other hand, a national all-payer system might more closely resemble the one that Maryland has, which eliminates price competition among hospitals, by prohibiting them from offering to payers volume discounts off the rates set by regulation. Even in such a situation, however, competition and antitrust enforcement still have an important role to play. If hospitals were unable to compete on price terms, they would have increased incentives to compete on the basis of adding needed services and quality of care. Indeed, with rates in an all-payer system being set by regulation, rather than by market forces, the maintenance of quality competition among hospitals could assume a role of increased importance in the marketplace: it would help ensure that hospitals did not become unresponsive to the preferences of patients for

high-quality medical care, the addition of upgraded medical capabilities, including advanced technology, and the provision of amenities desired by patients.

4. Because the Herfindahl-Hirschman Index could trigger a Federal agency market concentration presumption for most communities (over 80%) with more than one hospital, the usefulness of the HHI Index to the hospital industry is extremely limited. Please outline the criteria applied other than the HHI Index to determine the Justice Department position on a proposed merger.

Answer: The 1992 Horizontal Merger Guidelines ("1992 Guidelines"), which were jointly issued in April 1992 by the Department and the Federal Trade Commission, set forth the analytical principles of federal merger enforcement. It is important to note that the 1992 Guidelines contain a number of refinements and clarifications of the legal and economic approaches of previous guidelines. One of the significant refinements of the 1992 Guidelines is their movement away from wooden, concentration-based standards for evaluating competitive harm and toward a more dynamic analysis that takes proper account of real-life business conditions in the affected market.

Under the Guidelines, the Department begins by defining the relevant market -- the product or group of products and geographic area -- affected by the merger. Then the levels of pre-merger and post-merger market share and concentration in the market are calculated. We use the Herfindahl-Hirschman Index ("HHI") as a measure of market concentration. See 1992 Guidelines at § 1.5. Depending on how high the HHI is for a given hospital market, the 1992 Guidelines categorize the market as "unconcentrated" (HHI below 1,000), "moderately concentrated" (HHI between 1,000 and 1,800) or "highly concentrated" (HHI above 1,800). Id. at § 1.51. As the 1992 Guidelines explicitly recognize, however, market share and concentration data "provide only the starting point for analyzing the competitive impact of a merger." 1992 Guidelines at § 2.0. Therefore, after market concentration is calculated, our merger analysis proceeds to consider all other market factors, including the potential for adverse competitive effects, entry, efficiencies and failure of one of the merging hospitals.

It is clear that many communities would be viewed as having highly concentrated markets for hospital services under the 1992 Guidelines -- that is, the HHI calculation for the

community's hospitals would exceed 1800 points. This is so because many towns and smaller cities simply can not support the minimum number of independent hospitals that must be in a market in order to keep the HHI level below 1800. Notwithstanding this fact, the Department and the Federal Trade Commission have challenged very few hospital mergers. Based on available data, we believe that during the period 1987 to 1991 there were at least 229 hospital mergers, including 106 that were submitted to the Department and the Federal Trade Commission for review under the Hart-Scott-Rodino Act. (See Question 5 for a further analysis of this latter group of mergers.) Only five of these 229 hospital mergers were challenged.

This enforcement record reflects the critical importance of factors other than concentration that affect our competitive analysis. Thus, despite the existence of a highly concentrated hospital market as measured by the HHI, in hospital merger investigations, the Department routinely conducts a thorough analysis of both general conditions in the market and any factors specific to the merging hospitals that might suggest that adverse competitive effects are unlikely to result from the merger. This might be the case, for example, where a hospital's market share overstates its future strength as a competitor in the market. There may be other circumstances, as well, unique to particular hospital markets, that militate against the potential of anticompetitive effects resulting from a merger. The thrust of this analysis is to identify a specific set of circumstances -- a "story" if you will -- under which the merger would be likely to create or enhanse market power or to facilitate its exercise. In interpreting market concentration data, the Department will consider the implications of any such circumstances or any reasonably predictable effects of recent or ongoing changes in market conditions so as to arrive at the most realistic assessment of the competitive significance of the hospital merger under investigation. <u>See</u> <u>1992 Guidelines</u> at § 1.52.

In addition, during our merger investigations, the parties often assert that one or more of the several other factors that are recognized in the <u>1992 Guidelines</u> as militating against challenge are applicable to their merger. First, the parties often claim that their merger creates substantial efficiencies that outweigh the possible competitive harm. Second, they sometimes claim that one or more of the merging hospitals is financially failing and therefore would exit the market absent the merger, or that its market share does not accurately reflect its competitive significance. A third factor that can be raised in merger investigations generally -- the ease with

which new firms can enter the hospital market and successfully compete with the incumbents, see 1992 Guidelines at § 3 -- is not typically a significant factor in hospital merger investigations. This is so because state certificate of need regulation and the excess capacity that often exists in hospital markets make it unlikely that the entry of new hospitals into a hospital market could deter or counteract the effects of an anticompetitive merger.

The Department considers, as part of its competitive analysis and where raised by the parties, the possible efficiencies that would result from a hospital merger. See 1992 Guidelines at § 4. Ultimately the Department might forego challenge of an otherwise anticompetitive merger if the merger is reasonably necessary to achieve significant net efficiencies that cannot otherwise be achieved by less anticompetitive means and that, when balanced against the anticompetitive potential of the merger, result in a net increase in consumer welfare.

For example, the Department would consider efficiencies to result from a merger if the merged hospital's average costs declined because its fixed costs were spread over a larger volume of business after the merger. For instance, all hospitals must have staff and equipment available to service emergencies and provide a core group of acute inpatient services. But in smaller hospitals having fewer than the minimum efficient number of occupied beds, that staff and equipment will often be idle, and thus not efficiently employed, during slack periods. If, through merger, these hospitals could achieve a minimum efficient size, such as by physically consolidating the hospitals in one building, we would recognize that significant efficiencies might thereby be achieved. The Department, however, must be satisfied, based on the unique facts of each case, that the proposed merger would achieve the claimed efficiencies and that the efficiency gains are substantial and cannot be achieved other than by the merger.

In addition, the 1992 Guidelines provide that the so-called "failing firm" defense is available where the hospital is likely to fail in the near future, it is unlikely successfully to reorganize under the Bankruptcy Act, and there are no less anticompetitive alternative purchasers. See 1992 Guidelines at § 5.1.

5. Please provide information regarding Hart-Scott-Rodino filings. Please identify the (1) number of applications under Hart-Scott-Rodino concerning hospital mergers over the past eight years. What is the (2) length

of time from the point of application submittal to the point of a "second request" for information and to (3) the final determination of the application? Please list the number of applications that have taken one month, three months, etc.

Answer: By way of background, under the Hart-Scott-Rodino Act, 15 U.S.C. § 18a ("HSR"), the Federal Trade Commission and the Department of Justice have a maximum of 30 days (the period is shortened to 15 days for cash tender offers) after a party submits an application regarding a proposed merger in which to review the application and determine whether it contains sufficient information on which to base an enforcement decision, or whether additional information needs to be obtained from the parties through the issuance of a "second request." If a second request is not issued, the parties are free to consummate their transaction 30 days after the date they filed their application, or sooner if the parties have requested and been granted early termination of the 30-day waiting period. In those instances where second requests are issued, the requests are almost always issued at, or close to, the end of the 30-day waiting period.

The duration of an investigation conducted pursuant to the HSR after a second request has been issued is controlled in large part by the parties to the transaction. Under the HSR, the parties are free to consummate their transaction 20 days (or 10 days for a cash tender offer) after supplying all the documents and information called for by the second request. Thus, in situations where the parties to a transaction have submitted information promptly in response to second requests, the investigations have been completed in a few months. In other cases, parties, perhaps for reasons unrelated to the HSR investigation of the transaction, have chosen to defer the collection of data or documents responsive to second requests, and the investigations accordingly have remained open for a longer period. For example, the merging hospitals in one transaction reported in fiscal year 1989 encountered difficulty in reconciling differences between their institutional philosophies and chose to resolve these problems before responding to second requests. After almost a year, the hospitals informed the Division that they were abandoning their plans to merge, and the investigation was closed.

Regarding HSR investigations of acute-care hospital mergers, we do not have information available to calculate the statistics you have requested for an eight year period; however, we can provide data for the last five fiscal years. During these fiscal years, 106 filings relating to acute-care

hospitals were made. Most of these (88) did not necessitate the opening of a formal investigation by either the Antitrust Division or the Federal Trade Commission. The remaining eighteen were the subject of an investigation; five of these transactions ultimately were challenged.

The following breakdown shows for all HSR filings relating to acute care hospitals for fiscal years 1987 to 1991, the length of time between the parties' submission of the filing and the date on which the Antitrust Division or the Federal Trade Commission made a final determination on the transaction. A final determination was considered to have been made when early termination was granted, an investigation was closed, the waiting period expired or a decision was made to challenge the merger:

Time Period Elapsed	Number of Applications
One month or less	90
One to two months	1
Two to three months	1
Three to four months	3
Six to seven months	3
Seven to eight months	2
Ten to eleven months	1
Eleven to twelve months	3
Twelve to thirteen months	1
Thirteen to fourteen months	1
Total	106

6. Please provide information regarding the "Business Review Letter" procedure. Please identify the number of applications under this process over the past eight years concerning hospital mergers. What is the length of time from the point of application submittal to the final determination of the application? Please list the number of applications that have taken one month, three months, etc.

Answer: Although the Department is not authorized to give advisory opinions to private parties, for several decades the Antitrust Division has been willing in certain circumstances to review proposed business conduct and state its enforcement intentions pursuant to its Business Review Procedure. This procedure, which is governed by the regulations set forth in 28 C.F.R. 50.6, benefits both the Division and the business community by providing a mechanism for the Division to analyze and comment on the prospective competitive impact of proposed

business conduct. The procedure relates only to the government's enforcement intentions under the antitrust laws, not under any other federal or state statute or regulatory scheme. 28 C.F.R. § 50.6(7)(a).

Over the past eight years there have been no applications under the Business Review Procedure concerning the competitive effect of a proposed hospital merger. However, the business review procedure is available to parties to a hospital merger, and so is briefly described below.

The Business Review Procedure is initiated by a written request to the Assistant Attorney General in charge of the Division. At the outset, the Division, in its discretion, may refuse to consider the request. Such a refusal would occur where the request did not qualify for business review treatment, which most frequently happens when a request relates to on-going business conduct, since only proposed business conduct qualifies for the Business Review Procedure.

Under the Business Review Procedure regulations, the requesting parties are under an affirmative obligation to provide the Division with all information and documents in their possession that the Division may need to review the matter. 28 C.F.R. §50.6(5). The Division may also request additional information from the party or parties seeking review. Staff attorneys also conduct whatever independent investigation they deem necessary.

A party requesting a business review generally receives one of three responses from the Division: (a) that the Division does not presently intend to bring an enforcement action against the proposed conduct; (b) that the Division declines to state its enforcement intentions; or (c) that the Division will sue if the proposed conduct is put into effect. The second response means that the Division might or might not file suit should the proposed conduct be implemented. It should also be noted that a business review letter states only the enforcement intentions of the Division as of the date of the letter, based on the information that the Division has been provided by the party requesting the review. The Division remains free to bring whatever action or proceeding it subsequently comes to believe is required in the public interest.

When the Division notifies the requesting party of its action on the business review request, it also issues a press release describing the action and attaching a copy of the Division's letter of response. In addition, at this time, the letter requesting the business review and the Division's letter

in response are indexed and placed in a file available for public inspection. Within 30 days after notification, the information supplied in support of the business review request is placed in a publicly available file in the Division's Legal Procedure Unit.

* * *

I hope that you will find the above information to be useful. Thank you for your interest in this matter and in enforcement of the antitrust laws. Please let me know if we can be of further assistance.

Sincerely,

W. Lee Rawls
Assistant Attorney General

Enclosures

The costs of hospital mergers

Expense of consolidating operations is an eye-opener; new construction and technology spending also cut into those promises of big savings

By Jay Greene

Most hospital mergers are sold to the community as a way to reduce service and staffing duplication, consolidate clinical programs, achieve economies of scale and increase profits to invest in new services.

But two new studies on hospitals that merge in small markets also indicate most mergers were more costly than expected because of new construction and renovation projects.

To reach their publicly stated goal of becoming the area's most comprehensive provider, the merged hospitals also expanded into high-technology specialty services and hired additional personnel to provide them.

The expansion of services improved the hospitals' quality and reputation, but it also increased their operating costs.

The studies were conducted for MODERN HEALTHCARE by Cleveland-based Robert Carter & Associates and Baltimore-based Health Care Investment Analysts.

Robert Carter & Associates interviewed executives representing 17 hospitals that merged between 1985 and 1990 (See related story, p. 42). HCIA's study is based on consolidated Medicare cost reports of 14 hospitals that merged between 1985 and 1988 (See related story, p. 40).

Of the 14 hospital mergers HCIA studied, 12 were part of the Robert Carter survey. Financial data weren't available for five hospitals surveyed.

The merged hospitals were chosen because they are considered "market leaders." Twelve of the hospitals HCIA studied control more than 40% of their area's acute-care admissions; one controls 35%; and another controls 25%.

The purpose of the studies was to determine whether the mergers met the expectations of administrators and whether those conclusions could be proven empirically.

Although each merger had its own individual flavor, three general observations were made:

- The mergers were more difficult and expensive than originally expected. The hospitals that underwent more due diligence of financial and human side effects were more successful.
- Price increases and net revenues per patient continued to rise despite lower annual cost increases per patient after the merger. Those price increases, however, appeared to moderate four years after the merger. Efficiency gains were attributed to the effects of downsizing acute-care operations and stabilizing occupancy rates.

[illegible]

[illegible]	Number of beds[4]	1990 total profit margin
Firelands Community Hospitals, Sandusky, Ohio[1]	183	7.71%[5]
[illegible]	[illegible]	[illegible]
1985 mergers		
Community Hospitals of Williams County, Bryan, Ohio[1]	121	4.21
[illegible]	[illegible]	[illegible]
Southwest Washington Medical Center, Vancouver[2]	290	3.00[6]
[illegible]	[illegible]	[illegible]
Allentown (Pa.) Hospital-Lehigh Valley Hospital Center[1]	823	3.01
[illegible]	[illegible]	[illegible]
United Samaritans Medical Center, Danville, Ill.[1]	343	3.00[6]
[illegible]	[illegible]	[illegible]
Newton (Kan.) Medical Center[3]	72	14.72
[illegible]	[illegible]	[illegible]
Battle Creek (Mich.) Health System[1]	281	2.13
[illegible]	[illegible]	[illegible]
Ukiah Valley Medical Center, Ukiah, Calif.[1]	94	1.17
[illegible]	[illegible]	[illegible]
1989 mergers		
[illegible]	[illegible]	[illegible]
Golden Triangle Regional Medical Center, Columbus, Miss.[2]	326	1.50[6]
[illegible]	[illegible]	[illegible]
1990 mergers		
[illegible]	[illegible]	[illegible]

1 [illegible]
2 [illegible]
3 [illegible]
4 Acute-care beds only; does not include specialty beds or nursing home beds. [illegible]
5 Based on 1989 HCIA data. [illegible]
6 Based on Robert Carter survey [illegible]

Source: Robert Carter & Associates and Modern Healthcare survey based on interviews with 17 hospitals that merged from 1985 to 1990; Health Care Investment Analysts.

Graphic by Cynthia Watson

- While the mergers ended the local "medical arms race" between formerly competing hospitals, some of the mergers unintentionally triggered a regional medical arms race. As newly merged institutions added tertiary-care services to compete for a wider range of patients, hospitals in the surrounding area spent more money to beef up services or build primary-care clinics in response to their new and stronger competitor.

The combination of higher prices and lower annual expense increases also appeared to indicate a short-term strategy to improve profit margins to help finance new construction and technology, said experts reviewing the studies.

But many chief executives said the improvements were overdue and necessary to improve quality, consolidate services or buy technology to become the market's regional provider, said Ann Knoll, vice president and general manager of Robert Carter & Associates.

"Some CEOs were embarrassed because they said the merger would save all this money and it ended up costing the hospital" more than they promised, Ms. Knoll said. "CEOs were not really into cutting expenses."

Several of the CEOs also said they were embarrassed by the premerger quality of their institutions.

"They (merged) to improve quality and accessibility of services and to become a regional referral center where more than 95% of the services are performed in the community," Ms. Knoll said.

One such hospital is 121-bed Community Hospitals of Williams County in Bryan, Ohio. The two hospitals had been operating under common management since 1978 but didn't merge assets and boards until 1986, said Rusty O. Brunicardi, president.

Mr. Brunicardi said the hospitals needed to formally merge to become classified as a rural referral center, making them eligible for higher Medicare and Medicaid reimbursements.

"We met that criteria by merging," Mr. Brunicardi said. "Our revenue increased by more than $500,000 per year. With more revenue and reduced capacity through consolidation, we were able to slow up cost increases and put our effort into improving quality. That's increasing costs."

More hospital spending. Despite the additional capital expenditures for a magnetic resonance imaging device, a computed axial tomagraphy scanner and other tertiary-care services, Community Hospitals still is one of the lowest-cost facilities in western Ohio, he said.

But to become the area's strongest provider, merged hospitals such as Community had to spend money.

After their mergers, six hospitals added magnetic resonance imaging; three added cardiac catheterization labs; and three added a CAT scanner. Other services included psychiatric units (three hospitals), echocardiography (three hospitals), lithotripsy (two hospitals) and gamma nuclear medicine scanner (two hospitals), the survey found.

In addition, seven of the merged hospitals converted the other facility to either long-term care (four hospitals), psychiatric (two hospitals) or outpatient uses (one hospital). One merged hospital is closing both facilities and building a new one. Another merged hospital plans to convert one of its acute-care facilities to long-term care, the survey found.

CEOs said merger costs ranged from $10 million for Ukiah (Calif.) Valley Medical Center to $70 million for Augusta Hospital Corp. in Waynesboro, Va., to build a new 225-bed hospital.

In the Augusta merger, the two merged hospitals, 131-bed Community Hospital in Waynesboro and 105-bed King's Daughters Hospital in Staunton, are located 12 miles apart. Neither of the communities wanted its

	Number of respondents
Eliminated services	4
SERVICES THAT WERE ADDED	
Cardiac catheterization lab	3
Echocardiography	3
Lithotripsy	2
Rehabilitation unit	2
Other	3
[illegible]	
Sports fitness	2
Inpatient and outpatient surgery	[illegible]
Radiology	[illegible]
[illegible]	[illegible]
Cardiac catheterization lab	[illegible]
Computed tomography	[illegible]
All imaging	[illegible]

Note: Some hospitals responded with more than one answer.
Source: Robert Carter & Associates and Modern Healthcare survey based on interviews with 17 hospitals that merged from 1985 to 1990.
Graphic by Cynthia Watson

in two installments

The beginning of 1992 was marked by a wave of hospital mergers and affiliations. This issue of MODERN HEALTHCARE kicks off a two-part series designed to examine in detail what has happened following some earlier healthcare mergers.

The series continues research on mergers begun two years ago in a cover story titled *Why Hospitals Merge* (MH, March 19, 1990, p. 24), which found that merged hospitals were able to reduce expenses 1% to 2% annually. While many executives sold their mergers as a way to reduce price increases, the study found that the hospitals increased charges about 2% per year following mergers.

While the hospitals were able to improve their own efficiencies, the study raised questions about whether communities and patients truly benefited from the mergers in lower prices.

The story raised another question: How accurate were the hospitals in estimating capital savings that would accrue from their mergers? We found most hospitals' capital expenditures exceeded expectations, in some cases leading to far less savings than promised.

This week, we examine hospital mergers in mostly non-metropolitan or small markets. The majority of these hospitals now control more than 40% of their markets' acute-care admissions.

Part two of the series, to appear in the Feb. 10 issue, will take an in-depth look at the Carilion hospital merger in Roanoke, Va. The merger, completed in July 1990, was the first not-for-profit hospital merger ever challenged by the Justice Dept.

The merger brought under one parent company two of the market's three acute-care hospitals, 623-bed Roanoke Memorial Hospital and 314-bed Community Hospital of Roanoke Valley.

What's happened in the 18 months since the merger was consummated could best be described as a medical arms race between Carilion's two hospitals and the market's third hospital, 324-bed HCA Lewis-Gale Hospital in nearby Salem, Va. The results mirror the predictions and results of this issue's analytical look at hospital mergers in smaller markets.

All three hospitals have expanded their services, adding physicians and equipment. All three have completed or are undergoing construction projects. And to pay for it all and maintain a healthy bottom line, all three have substantially raised their prices.

Are employers and the community satisfied with the way things turned out? Read next week's MODERN HEALTHCARE to find out. ■

hospital to close.

As a compromise to complete the 1988 merger, the hospitals proposed building a new hospital in Fishersville, a town located between the two rival cities. The new $70 million hospital is expected to open in 1994.

A less costly option would have been to renovate King's Daughters at a cost of $8 million, but operational savings wouldn't have been as large, so the board approved the new hospital.

"There was an understanding in the community that the merger would lead to a single hospital," said Wayne Davis, a spokesman for Augusta. "People supported the merger for that reason. But the board didn't officially vote on the new hospital until 1989."

In Waterloo, Iowa, 302-bed Covenant Medical Center spent $27 million in 1989 to renovate St. Francis Hospital after the 1986 merger with Schoitz Hospital (MH, March 19, 1990, p. 26).

The original plan was to keep both hospitals open and save $40 million in expansion projects independently planned by the two facilities.

As a result of the renovations at St. Francis, Covenant's net capital cost savings were $13 million, far less than originally anticipated. But the hospital expects to save several million dollars per year by closing Schoitz.

Partly because of high building costs and the addition of technologically advanced services, some CEOs believe it may take seven to 10 years to gain all of a merger's benefits, Ms. Knoll said.

Building a common corporate culture between the two institutions' work forces, physicians and trustees may take less time, perhaps five to seven years, she said.

"Most merger talks don't involve the age of buildings, experience of employees, the range of services," she said. "They look at access, beds and physicians. There isn't enough due diligence (about the costs). The necessary capital to reconfigure the institution is about 180 degrees opposite what they think. It's overwhelmingly expensive. No one expects it to cost that much."

Mr. Abbott

Despite financial planning and studies of community benefits, the 1988 merger of 288-bed Battle Creek (Mich.) Health System was more expensive than expected, said Stephen Abbott, president and CEO.

"We needed to make major capital expenditures to restructure the operations so that we could become efficient to reduce operating expenses," he said. "We sold the higher costs (in the community after the merger) as an investment toward cost savings down the road."

Battle Creek spent an extra $9.6 million on new construction and technology, which included the addition of an MRI, cardiac catheterization lab and several tertiary-care services.

But even bigger expenses are on the way. Battle Creek recently approved a plan to spend $50 million to $60 million to consolidate acute-care operations in one facility, convert the second to long-term care, build a new ambulatory-care center and buy a new information system, Mr. Abbott said.

Like most mergers, the need to spend as much as $60 million for capital expansion wasn't addressed during merger discussions. "That data wasn't available at the time," Mr. Abbott said. "We expect to save $2 million a year through operational efficiencies."

HCIA study. While the consolidations were costly, Health Care Investment Analysts found that eliminating acute-care beds and stabilizing occupancy rates were the primary reasons that the hospitals became more efficient.

"The best news is that the mergers seem to be a vehicle for eliminating unneeded beds in the community," said Steven Renn, HCIA's managing director. "The key thread that runs through the mergers involved consolidation or downsizing. The hospitals are better able to match their delivery system with the demands in the community."

Mr. Renn said the success of the 14 mergers studied varied considerably. "We didn't have a very homogeneous group," he said. "Some had greater success than others" in containing costs.

Most of the hospitals were able to restrain expense increases to an annual postmerger increase of 5.36%

	Number of respondents
Physician objections	3
Community objections	3
Administrator objections	[illegible]
Low employee morale	14
Management clashes	11
Consolidating services	3
Parity in wages	[illegible]
Peer hospital objections	[illegible]
Antitrust investigation	[illegible]

Source: Robert Carter ... Healthcare survey based on ... hospitals that merged from 1985 to 1990 ...
Graphic by Cynthia Watson

	Number of respondents
To reduce duplication of programs and staffing	16
To consolidate clinical programs	14
To add facilities, services	9
To increase market share	6
To improve debt position	6
To increase system size	5
To eliminate competition	1

Source: Robert Carter ... Healthcare survey based on ... hospitals that merged from 1985 to 1990 ...
Graphic by Cynthia Watson

	Number of respondents
Employee layoffs	6
No layoffs or attrition	11
Administrators resigned	12
Administrators stayed	5

Source: ... Healthcare survey based on ... hospitals that merged from 1985 to 1990 ...
Graphic by Cynthia Watson

from a premerger annual average of 7.06% (See chart on this page).

Cutting expense growth was primarily accomplished by taking beds out of service, improving occupancy rates, closing or converting facilities and reducing administrative costs through layoffs and departmental consolidation, Mr. Renn said.

By year four of the merger, the hospitals were able as a group to dramatically cut annual expense increases to 2.12%, compared with a 6.5% increase the year after the merger, HCIA said.

The national average expense increase for all U.S. hospitals was 6.27% from 1985 to 1990, HCIA said.

"If hospitals spent money to implement new services and purchase high-technology equipment (as the CEO survey showed), you would expect expenses would be higher right after the merger than later on," Mr. Renn said. "But capital costs don't hit the income statement right away. Capital dollars are amortized over the life of the asset. Only (a fraction) of the expense is in the next year."

Prices rise. Despite slowing average expense increases, prices per patient continued to rise for the merged hospitals, HCIA said.

Price increases were higher after the mergers than before the hospitals consolidated. Before the merger, hospitals increased prices an average of 8.33% annually. After the merger, annual price increases averaged 9.42%.

But the merged hospitals' price increases appear to be in line with national averages. The average annual price increase for all hospitals was 9.38% from 1985 to 1990, HCIA said.

The largest price hikes were in the year after the merger. Prices increased an average of 11.27% and net revenues per patient jumped 7.33%, both of which were higher than any of the three years before the merger. But by the fourth year of the merger, price increases were held to an annual 7.94%, the smallest increase in the study period since two years before the merger and less than premerger averages, HCIA said.

One question antitrust regulators usually investigate in a merger is whether hospitals would use their market power to increase prices.

"It's hard to generalize that increased prices are a result of increased market share," Mr. Renn said. "There is a good chance that some of the financially troubled hospitals might have closed without the merger. The market share (and price) increases would have happened anyway."

Six CEOs said one important reason for the merger was to increase market

How the HCIA data were calculated

Health Care Investment Analysts examined 28 general acute-care hospitals that merged into 14 facilities between 1985 and 1988.

Financial measures for the individual hospitals that later merged were restated on a consolidated basis. As a result, premerger measures of occupancy, revenues, expenses and staffing for the individual hospitals were calculated on a combined, weighted-average basis.

Mr. Renn

For all years, revenues, expenses and staffing measures also were adjusted for outpatient volume and were standardized to control for differences in case-mix complexity among hospitals, using each hospital's Medicare case-mix index.

After these adjustments, annual percentage changes from the previous year were calculated for each measure, with the exception of the merged facilities' total profit margins, which were expressed as their actual values.

The annual percentage changes that were calculated were grouped according to the number of years before or after the merger, and an unweighted mean of the merged hospitals' rates of change was calculated.

Finally, annual rates of change between 1985 and 1990 were computed for the same measures for all U.S. hospitals, from which unweighted means were calculated.—*Steven Renn* ■

	Discharges[1]	Occupancy[2]	Charge per case[3]	Revenue per case[4]	Cost per case[5]	Employees per day[6]	Total profit margin
2 years before merger	-5.10	-3.31	7.52	5.11	5.31	5.56	2.97
Year of merger	-4.86	-3.94	9.79	6.39	8.56	6.68	1.30
1 year after merger	-6.40	-0.83	11.27	7.33	6.50	-1.88	2.55
3 years after merger	-2.62	0.03	10.13	6.94	5.85	0.68	3.68
Post-merger average change	-3.62	0.07	9.42	5.92	5.36	0.43	3.47

Source: Health Care Investment Analysts, Baltimore

Graphic by Cynthia Watson

share, Ms. Knoll said. But only one of those CEOs said the merger was undertaken to eliminate a competitor, she said.

Most CEOs said their hospitals' annual charge increases were no more than 6%. The hospitals tried either to match price hikes to the national consumer price index or to keep them less than those of other hospitals in the state, she said.

But Ms. Knoll said most of the hospitals surveyed had no price sensitivity because managed care wasn't present in the marketplace to divert patients to lower-cost facilities.

"It appears to be totally up to the discretion of the board and management," she said. "Some of the CEOs said their boards have a philosophy of not generating more than a 5% margin. More than that wouldn't be considered as keeping with the not-for-profit mission."

Mr. Brunicardi

However, post-merger total profit margins have improved steadily. Before their mergers, hospitals averaged a 2.27% annual total profit margin. After the mergers, total profit margin averaged 3.47%.

Total profit margins have increased from 2.11% in year two to 3.68% in year three to 5.52% in year four, HCIA said.

The national average for annual total profit margin was 3.51% during the study period from 1985 to 1990.

Before the mergers, staffing growth remained at about the same levels, despite a 5.06% annual average decrease in discharges, HCIA said.

The year after the mergers, however, employees per patient decreased 1.88%; it was the only year during the study period that a reduction in staffing occurred. That same year, the occupancy rate decrease stabilized at 0.83%, indicating the hospitals laid off employees to operate more efficiently, Mr. Renn said.

Would they do it again? Most of the administrators interviewed said the mergers met their expectations. But most CEOs indicated they would hesitate before doing it again because of the pain and confusion surrounding the merger.

"One CEO said he had been involved in four mergers and expected the merger process to be easier because of his experience and tougher skin. He said it wasn't any easier," Ms. Knoll said.

In Battle Creek, the two former competitors had discussed a merger on and off for 10 years but couldn't agree on the terms, Mr. Abbott said. Because of the growing acceptance of mergers nationally, the two hospitals finally compromised on a merger of equals, he said.

"It was believed that consummating the deal was so difficult that anything that followed would be easier," he said. "That wasn't the case. It was harder."

While financial results were important, CEOs were more interested in discussing the human side of the merger, especially in how the hospitals dealt with the difficulties of making adjustments following merger approval, Ms. Knoll said.

"The impact of a hospital on its community and employees is great," Ms. Knoll said. "One CEO repeatedly tried to convince his public (in an effort to close one of the merged hospitals) that one bed and one doctor did not equate to the Mayo Clinic. CEOs tried to convince their community that they didn't need the other hospital. Despite facing significant financial pressures and even closure, the community wouldn't give it up."

She said most CEOs said that if they had to go through another merger, they would work far harder and longer in educating the community about why the merger was needed and what could be realistically expected. "They would tell them immediate benefits would not be forthcoming but that (the merger) is necessary for the long run," she said.

Each hospital's merger discussions also were colored by socioeconomic factors. For example, many religious hospitals were founded to treat patients with similar religious beliefs.

"Over the years, these hospitals believed their brand of medicine was the best," she said. "Very different cultures developed at these hospitals. To erase that through a merger is very traumatic and involves a great deal of sensitivity."

Ms. Knoll attributed a general lack of premerger financial planning, which led to surprises from higher-than-expected merger costs, to the fears of boards and administrators that the merger would fall apart unless they acted quickly.

"More than half of the mergers were results of failed previous attempts," she said. "The emphasis on the discussions was how to construct the deal (with equality) so each board could save face. They were just anxious to get the deal done and scared to death that it would be thwarted again. They wanted to sign the papers and worry about the rest later."

Ms. Knoll said most hospitals failed in previous merger attempts because of community and medical staff opposition.

"The boards and administration worked very hard to make the merger happen," she said. "Because of the number of mergers nationally, the communities and medical staffs felt if others were doing it, it must be a prudent idea."

To win community and medical staff support, however, some of the CEOs

One benefit of an Ohio hospital merger was the purchase of this $189,000 echocardiography machine, which the facility said it otherwise could not have afforded.

Robert Carter & Associates surveyed 36 hospitals that merged into 17 institutions from 1985 to 1990.

Interviews were conducted with 16 administrators and one trustee in November and December 1991. The managers were identified as those who had been involved in the merger process or who were hired shortly after the merger. Only one hospital declined to participate. Two of the hospital mergers involved three partners.

Ms. Knoll

Eighty-four questions were asked: four on the merger process, 14 on operational changes made after the merger, 18 on financial changes or outcomes of the merger, 16 on reasons for the merger, 12 on individuals or groups with which the organization may have had difficulties because of the merger, 13 on issues that may have caused problems for the merger, four on expectations and strategies and whether the goals were achieved, two on the impact the merger had on managed care and one on total costs of the merger.

Respondents were permitted to editorialize and provide any additional details they chose. That information was provided to MODERN HEALTHCARE but not included in statistical summaries. —*Ann Knoll*

said the hospitals promised to add services and improve quality, which in turn increased costs.

From a practical standpoint, competition, the lack of regional healthcare planning and each hospital's tradition would make it extremely difficult for the facilities to overhaul their delivery system on their own, Ms. Knoll said.

Mr. Abbott of Battle Creek said hospitals could make short-term changes to reduce costs, but long-term improvements have to be achieved through removal of excess beds.

"There is too much capacity in the system," Mr. Abbott said. "Too many communities have two to three hospitals when only one is needed. Mergers are the only way available to reduce capacity. Without healthcare reform, survival instincts are too great for institutions to do anything else." ■

	Number of respondents
Reduced costs	10
Increased costs	8
Increased operating margins	13[1]
Decreased operating margins	[illegible]
Don't know	4
Too soon to tell	[illegible]
Increased market share	5
Lost market share	1
Don't know	9
Too soon to tell	1[3]

Note: Some hospitals responded with more than one answer.

Source: Robert Carter & Associates and Modern Healthcare survey based on interviews with 17 hospitals that merged from 1985 to 1990.

Graphic by Cynthia Watson

Carilion denies capital spending broke promises

In response to a MODERN HEALTHCARE special report on the Carilion hospital merger in Roanoke, Va., Carilion executives have denied any suggestion that the hospital system has spent more on capital improvements than it promised during its celebrated antitrust trial over the merger.

After a two-year fight with the Justice Dept. in federal court, 314-bed Community Hospital of Roanoke Valley was allowed to merge with 623-bed Roanoke Memorial Hospital, the flagship facility of Carilion Health System. The merger was completed in July 1990.

During the January 1989 antitrust trial in federal district court, one of Carilion's consultants, Andrew Mazurek, president of Metis Associates, a Chicago-based healthcare architectural consulting firm, testified that the two hospitals would spend $76 million on capital improvements during the next eight to 13 years if the merger weren't allowed to proceed. The figure didn't include the capital costs related to a new obstetrics department at Roanoke Memorial.

If the hospitals merged, they would spend $58 million on capital improvements, including a new obstetrics department at Community Hospital, Mr. Mazurek said. He also testified that, in addition to the $18 million savings, another $2 million to $7 million could be saved if the hospitals scrimped on materials and equipment. Hence, under the most optimistic scenario, the hospitals would trim $20 million to $25 million off the $76 million estimate.

Sometime after the legal proceedings, though, Carilion developed a $60 million budget for capital improvements, system executives said.

"Such intent was evidenced at the antitrust trial by undisputed testimony by an expert witness, and his testimony was the only testimony regarding capital additions at the trial," said Thomas Robertson, Carilion's president and chief executive officer.

However, in a June 1988 press release—issued about six months before the trial began—Carilion executives said, "If the affiliation is not approved, Carilion must proceed with an expansion and renovation plan to meet the needs of the community in the future. Preliminary plans call for spending about $30 million. These expenditures could be avoided to a significant degree if the hospitals are allowed to affiliate."

MODERN HEALTHCARE reported that the hospitals said they would spend $36.5 million on capital improvements if they didn't merge and $23 million if they did merge. These figures were extrapolated from affidavits filed in June 1988 by Mr. Robertson and William Reid, Community Hospital's president and CEO, with the federal district court (MH, Feb. 10, p. 38).

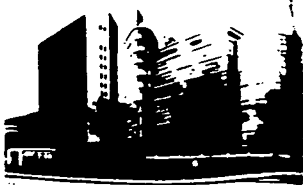
Since the merger was consummated, Roanoke Memorial has undergone a major renovation project, adding a $55 million, 350,000-square-foot patient pavilion. Construction of the pavilion began last April and will be completed in December 1993.

Community Hospital, meanwhile, is adding an extra 75,000 square feet at a cost of $3.5 million. The additional three floors will open in April.

These are the only capital costs attributable to the merger, Carilion executives said.

Adding the two projects together, Carilion will spend $58.5 million on capital improvements in 3½ years ending December 1993. That's more than $20 million above what Carilion estimated in June 1988. That's also $2.5 million to $7.5 million more than what Carilion said it would spend over eight to 13 years, according to Mr. Mazurek's most optimistic construction scenario. But it's $1.5 million less than what Carilion ended up budgeting for the projects.

Carilion executives said it was unfair to compare the capital expenditures made by the two hospitals with their original estimates in June 1988 because the affidavits' figures were outdated. Second, the projects described in the affidavits were different from the ones undertaken by the hospitals, they said. And third, the affidavits' figures weren't used during the actual trial, they added.



Artist's rendition of the patient pavilion under construction at Roanoke Memorial

"I am proud that we have been able to achieve the $20 million savings in capital costs testified to by the expert witness at the trial," Mr. Robertson said. "Because of the favorable environment for construction that now exists, we are significantly under budget and have been able to expand the scope of the project to include one floor (surgery) that was not originally planned in phase one of the Roanoke Memorial renovation."—*David Burda*

FTC plan would foster cooperation with states

The Federal Trade Commission has developed a plan under which the agency and state law enforcement officials would work together more closely in investigating mergers, including those of healthcare organizations, for possible antitrust violations.

The FTC proposed the plan in the March 6 issue of the *Federal Register*. It's subject to a 30-day public comment period before it can become final.

Under the plan, states would be allowed to conduct a simultaneous antitrust review of a merger using the same documents being used by the FTC in its investigation. The FTC also would give states limited assistance in analyzing the competitive effects of mergers. But states wouldn't be able to start concurrent investigations or seek the FTC's help unless the merging parties agreed to provide the states with the same documentation given to the FTC.

Currently, states are barred from investigating a merger and seeking documents from merging parties until the FTC completes its investigation.

While it appears that merging parties would be foolish to voluntarily supply states with the same documentation submitted to the FTC to undergo a simultaneous review, that may not be the case, said Steven Newborn, director for litigation in the FTC's Bureau of Competition.

"Lots of merging parties don't like the fact that after an FTC review they still have to face a state review," Mr. Newborn said. "They prefer to get the whole thing over with at one time rather than letting it drag out."—*David Burda*

SPECIAL REPORT

The aftermath of the Carilion merger

Prices, costs, construction are up in Roanoke since the July 1990 combination. A competitor is up, too—up in arms and upset. Consumers, businesses are mum.

By David Burda

What's up since the controversial Carilion merger in July 1990? You name it: prices, costs, construction and the dander of its competitor.

The only thing that hasn't risen is the temperature of the public and the business community, which are happy with the way things turned out or hesitant to criticize Roanoke's largest employer.

The merger attracted national attention because it was the first not-for-profit hospital merger ever challenged by the Justice Dept. The government said the merger, which gave Carilion control of 74% of the staffed inpatient beds in the Roanoke, Va., area would allow the system to act anti-competitively, such as arbitrarily raising prices or refusing to negotiate with managed-care plans.

The Justice Dept. sued Carilion in May 1988, and, after a two-year legal battle, the system and its attorneys convinced the federal courts that the Justice Dept. was wrong.

Court decisions aside, the merger appears to have given Carilion and its lone acute-care competitor in the Roanoke area the power to do just about anything they want.

The Carilion family. The Carilion Health System was the Roanoke Hospital Assn., the parent company of 623-bed Roanoke Memorial Hospital. The company changed its name to Carilion shortly after it revealed plans in July 1987 to add two hospitals: 314-bed Community Hospital of Roanoke Valley in Roanoke and 126-bed Radford (Va.) Community Hospital.

It was the addition of Community Hospital that attracted the Justice Dept.'s attention, while the Radford merger was viewed as posing no antitrust threat. Radford, located 50 miles west of Roanoke, merged with Carilion in October 1988 and also has profited from the merger.

Today, Carilion operates seven hospitals and 19 subsidiaries. Sixteen subsidiaries are for-profit entities, including three real estate companies and two debt-collection agencies. In its fiscal year ended Sept. 30, 1990, Carilion earned $15.1 million on total revenues of $348.2 million, compared with a $6.6 million profit on total revenues of $302.9 million in fiscal 1989.

What it said. During its battle with the Justice Dept., Carilion argued that the merger of Roanoke Memorial and Community Hospital could provide significant economic efficiencies.

Carilion said Roanoke Memorial was an aging, overcrowded facility built in four phases from 1926 to 1971 and badly in need of renovation. Community Hospital, built in 1967, was a newer, underutilized facility. Combining the two would solve everyone's problems without any major expenses.

In an affidavit filed in U.S. District Court in Roanoke, William Reid, Community Hospital's president and chief executive officer, said that without the merger, Community would have to spend $6.8 million on capital improvements to open tertiary-care services to compete with Roanoke Memorial and HCA Lewis-Gale Hospital, the market's third hospital.

In his affidavit, Thomas Robertson, Carilion's president and chief executive officer, said that without the

Roanoke merger mirrors findings of 2 studies

Last week, the first part of this two-part series on hospital mergers detailed how two studies conducted for MODERN HEALTHCARE found that most merged hospitals spent far more on construction and equipment than they had expected.

The two studies also showed that, on average, merged hospitals raised prices by a larger percentage than the average increases of the two combining hospitals before the merger. However, by the fourth year after the merger, prices moderated and were less than premerger averages, said Health Care Investment Analysts, a Baltimore-based financial information firm that conducted one of the studies. Analysts said this suggests that merged facilities used a short-term strategy of raising prices to pay for new tertiary-care services and related capital costs.

Administrators of merged hospitals said annual savings through operating efficiencies eventually would pay for the increased costs associated with mergers. But some said it might take as long as 10 years to reap the full financial benefits for their communities.

In this part, we'll study the controversial 1990 merger of two competing hospitals in Roanoke, Va. The two studies reported last week didn't include data from this merger because its complexity set it apart from the other mergers. However, the results of this story mirrored the findings of the studies—the Roanoke hospitals spent more money on construction and capital equipment than they had suggested would be necessary before the merger. In addition, the cost of healthcare continued to increase after the merger.

However, most of the people in the community aren't upset about these developments. For business leaders in Roanoke, construction and increased hospital spending appear to be more important for the community than higher hospital prices.

merger. Roanoke Memorial planned to add seven floors to its facility, adding 168,000 square feet for $30 million.

By merging, the two hospitals would generate $41.3 million in savings over the first five years of the consolidation, said a consulting firm hired by Carilion. About half of the savings would come from administrative areas, the other half from clinical areas.

About a third of the savings, $13.8 million, would come from avoiding certain capital expenditures. Rather than spending $36.8 million on capital improvements, the hospitals would spend $23 million.

And Carilion has embarked on a program to consolidate many services. The goal of the clinical consolidation is to make Community Hospital the site for primary care and Roanoke Memorial responsible for tertiary care.

In the clinical area, the major consolidation has been in the area of women's and children's health. The two hospitals have consolidated their pediatric services and moved them onto the Community Hospital campus. In April, the hospitals will consolidate their obstetrics and gynecology services, also at Community Hospital.

In other clinical areas, the hospitals have placed the direction of both hospitals' emergency departments under one medical director; consolidated sleep laboratories, moving them to Community Hospital; and combined occupational health programs, also moving them to Community Hospital.

The two hospitals already have consolidated such administrative areas as data processing and marketing, compensation and benefits plans, medical information systems, patient accounting departments, laundry services and physician referral services.

But consolidation doesn't necessarily mean contraction.

Under Carilion's plan, Community Hospital will become the main site for primary care.

The hospitals' pediatric program added two specialists: a pediatric cardiologist and a pediatric pulmonologist. The hospitals' cardiology program added an electrophysiologist. When they combined sleep labs, they added a mobile sleep laboratory. They expanded the emergency department at Roanoke Memorial.

Mr. Reid boasted that the number of physicians on staff at the hospitals has risen to 420 from 320. Also, there have been no employee layoffs since the consolidation. The two hospitals employ 3,363 full-time and 687 part-time workers.

And when they merged administrative services, they bought and remodeled a 40,000-square-foot lumber company located between the two campuses. The remodeled building, opened last September, houses patient accounting as well as the hardware of a new medical information system purchased by the hospitals.

Other construction. Community Hospital—the newer facility with excess capacity—is adding three floors to its existing building. The extra 75,000 square feet will open in April at a cost of $3.5 million.

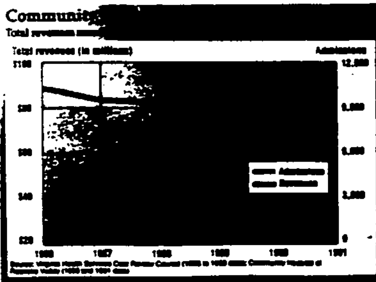
Community also expanded its parking lot to 850 from 520 spaces, and it's building a 67,000-square-foot medical office building. Groundbreaking on the new building occurred last month.

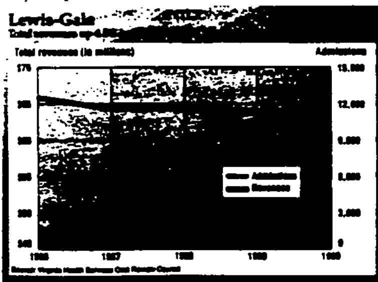
Roanoke Memorial, meanwhile, is building a $55 million patient pavilion with 350,000 square feet. Construction started last April and won't be completed until December 1993.

To help pay for the construction at both sites and some construction at another Carilion hospital, the system sold $145.5 million in revenue bonds last September, just two months after the merger was completed.

Of the $145.5 million, $61 million was devoted to construction, renovation and equipment at Roanoke Memorial; $6 million was to be used for equipment at Community Hospital. That's quite a bit more than the $23 million in new capital spending originally described in court.

"Because of the economy, it's a good time to build," Mr. Robertson said. "Contractors need the work. We're





SPECIAL REPORT

going to spend from 15% to 20% less than what we budgeted."

Mr. Reid agreed. He said the hospital had budgeted $7.5 million to add three floors to the facility: now, it's costing less than half that amount.

Both Mr. Robertson and Mr. Reid rejected the suggestion that the construction projects aren't in keeping with Carilion's promises during the antitrust trial. Both said the projects had been planned before the merger and should come as no surprise to anyone in the community.

In fact, Mr. Robertson said Carilion is "right on target" in meeting the projected $20 million in savings on needed capital expenditures.

During the trial, a second consultant for Carilion testified that Roanoke Memorial needed to spend $76 million over a 10-year period to replace its deteriorating facility. A merger could shave at least $20 million off the bill.

Karl Miller, president of HCA

Mr. Reid

Construction projects under way at the Carilion facilities had been planned before the merger and should come as no surprise to anyone in the community.

Lewis-Gale Hospital in nearby Salem, Va., and a critic of the merger, sees things differently.

"All we heard throughout the whole antitrust process is how the merger is going to reduce expenses," Mr. Miller said. "Frankly, they haven't curtailed expenses. In fact, expenses and prices are up at both hospitals."

Mr. Miller said the *coup de grace* was the revenue bonds for new construction. "There's been a major bait and switch, and the ruse has worked."

But Mr. Miller hasn't been sitting idly by, watching Carilion expand. During the 18 months following the Carilion merger, HCA Lewis-Gale began an open-heart surgery program, opened a surgical intensive-care unit, opened two operating-room suites and expanded its inpatient oncology services.

Mr. Miller wouldn't disclose the total cost of the new and expanded programs but said the major cost was the cardiac program last April, which came with a $3.1 million price tag.

Meanwhile, Lewis-Gale Clinic, the major source of patients for the hospital next door, also has been expanding. The 115-physician group practice admits most of its patients at HCA Lewis-Gale. The hospital and clinic are separate corporations.

Artist's rendition of the future facility that will house Roanoke Memorial.

Darrell Whitt, the clinic's administrator, said he has recruited eight new physicians who will start shortly and plans to recruit more. The clinic will find room for those physicians to practice in a 60,000-square-foot addition. Groundbreaking on the $6.5 million project occurred last October, and completion is set for September.

In an understatement, Mr. Miller said, "Competition between us and Roanoke Memorial remains heated."

Money talks. Even with the new spending on facilities and services, providers still are making lots of money in Roanoke.

Last year, Roanoke Memorial alone earned $10.5 million on total revenues of $252.3 million, according to figures provided by Carilion. Community Hospital earned $3.2 million on total revenues of $89.5 million last year.

Mr. Miller wouldn't release hospital figures, but the Virginia Health Services Cost Review Council said HCA Lewis-Gale earned $2.4 million on revenues of $66.6 million in 1990.

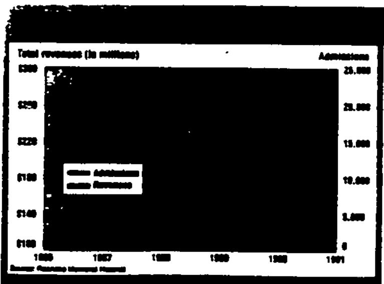
None of the three hospitals would give price information sought by MODERN HEALTHCARE, but total revenues at the facilities have risen dramatically despite a generally static number of admissions (See charts).

Other data from the Virginia Health Services Cost Review Council support the theory that prices have increased. Last year, the average charge per adjusted admission rose 12.9% at HCA Lewis-Gale, 9.0% at Roanoke Memorial and 6.8% at Community Hospital. The statewide median increase was 8.9% (See chart).

In fact, the council's data show that the average charge per adjusted admission at Roanoke Memorial was 42% higher than the statewide median last year. HCA Lewis-Gale is right behind with an average charge per adjusted admission that was 33% higher than the statewide median in 1991. The average charge per adjusted admission at Community Hospital is right at the statewide median.

"Price increases have been held down because of the merger," Mr. Robertson said. "We're looking to years three, four and five of the merger for the major savings."

Mr. Miller declined to discuss HCA Lewis-Gale's pricing strategy. However, data from the Virginia Health Services Cost Review Council suggest that HCA Lewis-Gale has been able to



increase its prices to keep pace with Roanoke Memorial without any backlash from the community.

Managed care. When the Carilion merger was proposed, managed-care plans generally hadn't penetrated the Roanoke market. In the 18 months since the merger, things haven't gotten much easier for payers.

Three years ago, Community Care Network, a preferred provider organization based in Arlington, Va., entered the Roanoke market and contracted with HCA Lewis-Gale. CCN then approached area employers.

"CCN tried to negotiate with Carilion, but they didn't get to first base," said Dick Robers, president of the Blue Ridge Regional Healthcare Coalition, a group of area employers. "We would have liked to see it work out."

The coalition still may get its wish. A source in the Roanoke business community said Carilion has approached CCN about joining the PPO. Thomas Handy, program manager for CCN, wouldn't comment on the report.

In addition, the coalition is talking to another organization, the Buyers Healthcare Cooperative, to attempt to negotiate prices with Carilion and HCA Lewis-Gale on behalf of employers, said Mr. Robers, who is executive vice president of Maid Bess Corp., a local apparel manufacturer. His company offers the PPO option.

During the trial and even today, Carilion officials said their system stands ready to negotiate with managed-care plans, but employers haven't been interested in such arrangements. They blame the lack of interest on Virginia law that requires PPO arrangements to be nonexclusive. Because all hospitals can participate in a PPO as long as they meet participation requirements, PPOs are less attractive to purchasers of healthcare services.

A case in point: HCA Lewis-Gale and two other hospitals sued Blue Cross and Blue Shield of Virginia in November 1989 after the plan contracted with Carilion to be the exclusive hospital provider in its new PPO, called KeyCare. Six months later, the plan settled the suit and the plaintiff hospitals were allowed into the PPO.

Mild words. Interestingly, Mr. Robers testified on behalf of the government against the merger during the antitrust trial. He said less competition in the market would result in higher prices for hospital services.

Now Mr. Robers isn't so sure.

"I think prices have gone up, but I don't know how much is related to the merger or to inflation," he said.

The closest Mr. Robers came to criticizing the merger was to say that Carilion testified that there was no need for additional capacity at the two hospitals. "That hasn't turned out to be the case," he said, referring to the building boom.

A business coalition member who requested anonymity said it would be hard to find a local business leader who would criticize Carilion publicly.

"Many of us feel that Carilion is exploiting its market share, but no one wants to be quoted," the source said. "Many business leaders are on the boards of the hospitals. Carilion is a member of the coalition, and we have to see them at meetings."

The city of Roanoke, meanwhile, didn't take a position on the merger but supports the major construction projects under way because of their positive impact on the local economy, said Brian Wishneff, Roanoke's director of economic development.

"Carilion's role as a large corporate citizen in the community has been excellent," Mr. Wishneff said. "They're active in a number of projects. They lend us their time and expertise. They're everything you'd hope a large corporate citizen would be." ■

Radford sees profits, admission charges rise

And what about Radford Community Hospital whose merger with Carilion wasn't challenged by the government?

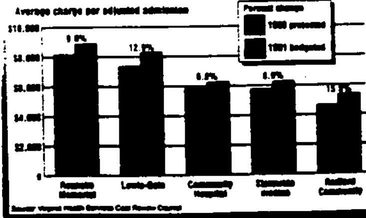
Radford's profits nearly doubled to $2.9 million on total revenues of $47.7 million in 1991 from $1.6 million on total revenues of $39.5 million in 1990.

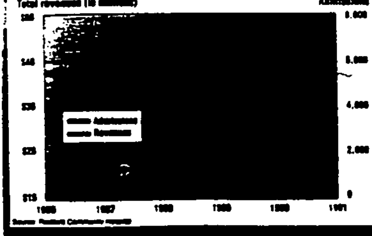
Between 1989, the first year after the merger, and 1991, the average charge per adjusted admission at the hospital rose 38.4% to $5.396 from $3.899, the hospital said. The average expense per adjusted admission rose 24.9% to $3.501 from $2.803.

Mr. Lamb

The hospital plans to build a replacement hospital with a yet-to-be-decided construction budget. Construction will begin in late 1994 and take about 30 months to complete.

"I'm pleased with the Carilion affiliation," said Lester Lamb, Radford's president and chief executive officer. "I recommended that we merge with Carilion, and I'm comfortable with the ways things turned out."—*David Burda* ■





March 16, 1992

Mr. Robert Bloch
Chief
Professions & Intellectual Property
Antitrust Department
U. S. Department of Justice
555 - 4th Street, N.W., Room 9903
Washington, D.C. 20001

Dear Mr. Bloch:

On February 10, 1992, Modern Healthcare published an article regarding "the results" of the affiliation between Roanoke Memorial Hospital ("Roanoke Memorial") and Community Hospital of Roanoke Valley ("Community Hospital"). Unfortunately, the article contains numerous factual inaccuracies and conveys a completely erroneous theme. Thus, the headline appearing on the issue's cover baldly states "high-profile merger brings unpleasant cost, price surprises." In addition, the descriptive subheading of the article itself incorrectly states that "prices, costs, construction are up in Roanoke since the July 1990 combination." The truth is far different. In fact, our actual experience has been entirely consistent with the projections which we testified to at trial.

The March 16, 1992 issue of Modern Healthcare contains a second article which addresses some of the inaccuracies included in the initial article. Also, the March 2, 1992 issue of Modern Healthcare reported two corrections to the original story. I am still not satisfied that the facts regarding the progress made since the merger have been accurately and comprehensively reported. For that reason, I am taking the liberty of writing to you in order to set the record straight.

The major error contained in the article is the reporter's assertion that we originally planned to spend only $23 million on capital improvements if the merger was approved. The undisputed testimony by expert witnesses and hospital officials at trial was that the two hospitals would spend $56-60 million if the merger was approved. Our projections established that capital expenditures at this level would produce capital avoidance savings of approximately 20 million dollars. We believe that the projected savings will be achieved.

Unfortunately, the article was written after a few, brief telephone conversations with hospital management, which the reporter apparently misinterpreted, or misunderstood. The reporter did not review the transcript of the trial which included the undisputed testimony of expert witnesses regarding the capital expenditures planned, or the news coverage

which accurately reported this testimony, although these original news articles were provided to Modern Healthcare.

An example of the careless manner in which the information was compiled is the report of Carilion's gross revenue and net income for the fiscal years ended September 30, 1989 and 1990. The information about revenue for 1989 is incorrect. Thus, no mention is made of the fact that the two years are not comparable because the operations of Community Hospital were reflected in the 1990 data but not in the 1989 data (because Community Hospital was not part of Carilion at that time). Also, operations in 1989 were negatively impacted by the approximately $2.5 million in expenses associated with the antitrust litigation. When this extraordinary item is considered, the net margin increased from 4.0% in 1989 to 4.3% in 1990--hardly an excessive profit margin level.

The article also reports negatively that a major financing was completed soon after the merger. However, this financing was needed because the hospitals had not accumulated building funds from operations and bond proceeds were consequently required to support the capital improvements planned before the merger and articulated at the trial. In view of the interest rates available at the time of the financing, it is difficult to understand just how consumers were harmed by this action.

One portion of the article that is reasonably accurate is a review of the consolidation of clinical and administrative services that have occurred in the 18 months since the merger. However, this review concludes by stating "consolidation doesn't necessarily mean contraction" and notes that two pediatric subspecialists have been added to the staff since the merger. In fact, one subspecialist was employed before the merger and one of the benefits of the merger was the creation of the critical mass of patients required to justify the recruitment of pediatric subspecialists such as those in pulmonology and cardiology. Clearly, consumers benefit from the higher quality services now available in our community.

Undisputed testimony at the trial projected that Community Hospital would have to spend between $1 million and $4.5 million to accommodate the consolidation of obstetrical and pediatric services. However, the article incorrectly implies that the construction and attendant costs were not anticipated in the testimony, or the forecast of savings. In fact, these costs were netted against the capital avoidance savings forecast at Roanoke Memorial. The testimony on this point is very clear. Moreover, the new space at Community Hospital will be completed at a cost of $3.5 million, less than the maximum cost of $4.5 million which was projected.

The article also mentions a 40,000 square foot building that was remodeled on a site between the two campuses where the patient accounting and data processing services of the two hospitals have been consolidated. However, the article doesn't mention that these services were previously scattered over seven sites in rented space, that operational, cost and functional

efficiencies have been achieved in the remodeled space, and that testimony at the trial indicated data processing would be one of the first areas consolidated.

The article also states that the emergency department at Roanoke Memorial has been expanded. In fact, the emergency room at Roanoke Memorial has not been expanded in at least 20 years. However, a new emergency room is a major component of the addition which will be completed in 1994, as initially planned. The number of physicians on the Community Hospital staff has increased from 320 to 420, as the article notes, but only because physicians who previously had privileges solely at Roanoke Memorial are now treating their patients at the new consolidated facilities at Community Hospital.

Finally, the article also criticizes the medical office building constructed by Community Hospital. Community Hospital completed construction of this new medical office building on its campus in November, 1990, four months after the merger was approved. Work on this building and the parking to accommodate the tenants of this building and their patients began in October, 1989, nine months before the merger. Obviously, the ground breaking did not occur last month as the article reports. As a matter of interest, 70% of the building is owned by its tenants.

The anguished cries from Carilion's closest competing hospital, Lewis-Gale, which the article does note, speaks volumes to the effects of the merger on the competition in the region. Carilion's rate increase in 1991, which was 60% of Lewis-Gale's increase, demonstrates the potential for cost control that the merger has created. As testimony indicated at the trial, 18 months is too short a period to evaluate the full financial impact and effect of the merger, but the report of increased competition between the two systems in Roanoke is one of the few accuracies in the story.

Nevertheless, the article goes on to improperly compare Roanoke Memorial's average charge per adjusted admission to the statewide median. Of course, comparison of Roanoke Memorial's charges to the statewide median charges without any adjustment or mention of acuity levels or scope of services is clearly inappropriate. There are approximately 115 hospitals in the Commonwealth of Virginia and 75 of them are under 200 beds. Only four hospitals in the state have comparable case mix, scope of service and complexity of Roanoke Memorial. Clearly, one cannot compare a regional referral center with a trauma one designation, a major cancer center and comprehensive cardiology services, such as Roanoke Memorial, to an unadjusted statewide average. Judged by any appropriate standard Carilion remains the low cost provider. Perhaps for this reason Blue Cross agreed to contract with us to be the exclusive provider under their Key Care PPO. However, Lewis-Gale challenged the arrangement under the state's "any willing provider" law, and Blue Cross capitulated, to the detriment of price competition in the Roanoke area. We continue to support such competition.

In short, Carilion is proceeding with implementation of the merger, and its capital plans, within the budgets detailed in testimony at the trial in January, 1989. We are ahead of the 1989 timetable for consolidation of clinical and administrative services and I am pleased with our progress toward meeting all goals set forth for the merger.

I can only speculate about the motives of Modern Healthcare. However, I do note that the same issue containing the initial story regarding the merger also contained a cover headline which read "Justice Department Stepping Up Heath Care Investigations." Undoubtedly, scaring people sells newspapers and "horror stories" certainly fuel the fire. There is no "horror story" in Roanoke. Suggestions to the contrary do not serve the public interest.

If you or any of your associates at the Department of Justice have any questions, I would be happy to meet with you to discuss our progress.

Sincerely,

Thomas L. Robertson
President

REB:AEH
60-8062-0010

Judiciary Center Building
555 Fourth Street, N.W.
Washington, D.C. 20001

March 27, 1992

Mr. Thomas L. Robertson
President
Carilion Health System
P.O. Box 13727
Roanoke, Virginia 24036-7347

Re: Modern Healthcare Series on Hospital Merger Costs

Dear Mr. Robertson:

Thank you for your letter of March 16, 1992, in which you describe the progress Carilion has made in consolidating Community and Roanoke Memorial hospitals and your views about the recent two-part series of articles by David Burda, which appeared in the February 10 and February 19, 1992 issues of Modern Healthcare magazine. I had previously read the Modern Healthcare series with interest, and I appreciate your effort to clarify the nature and magnitude of the capital expenditures Carilion has made since the conclusion of the antitrust suit.

Sincerely yours,

Robert E. Bloch
Chief
Professions & Intellectual
Property Section

Questions for Mr. James Egan, Jr.

What effect do all payer systems such as that operating in the State of Maryland have on the need for Federal antitrust enforcement? To what extent would Federal involvement differ if an all payer system were instituted nationally?

Because the Herfindahl-Hirschman Index could trigger a Federal agency market concentration presumption for most communities (over 80%) with more than one hospital, the usefulness of the HHI Index to the hospital industry is extremely limited. Please outline the criteria applied other than the HHI Index to determine your position on a proposed merger.

It has been the stated position of the FTC that the efficiencies gained by a merger are weighed against the harm to competition in determining whether to allow a merger or joint venture activity to take place. Please explain how this weighing of factors is accomplished.

Questions for Mr. James Egan, Jr. (continued)

To better understand how antitrust laws are applied to joint venture activities, please comment on the following examples:

What if two or more hospitals want to get together to share equipment in order to reduce health care costs. They want to join together and purchase one piece of expensive equipment in order to update their separate existing pieces of equipment. They all plan to use the new piece, and will charge the same price for using it. Is this sharing of equipment acceptable?

Another case involves "centers of excellence". Say that a community is served by 3 hospitals, all of which have an open heart surgery program. Each preforms roughly 150 procedures each year. The hospitals get together and agree to jointly establish one program in order to create high enough volume to be considered a "center of excellence" for open heart surgery. We can assume that the quality of the procedure will likely increase with the greater number of procedures, and costs per procedure will likely fall. As to price, we are less certain. Can the hospitals conduct this joint activity without being fearful of antitrust actions by the FTC, Justice or private individuals?

Assuming that the price for the procedure does not increase after this agreement, can the hospitals expect to be protected from antitrust claims?

Let's now consider the issue of an agreement to not duplicate services. In a two hospital community, the administrators of the hospitals act in a forward looking manner. Instead of each hospital providing every high technology service, they agree to specialize. One hospital agrees to purchase a lithotripter and the other to purchase an MRI. The community ends up with both services but with out the cost of having duplicated each. Would such an agreement on division of services put the hospital at risk? What factors may make this acceptable or unacceptable under antitrust laws?

BUREAU OF COMPETITION

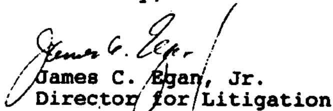
UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

The Honorable Fortney H. "Pete" Stark
Chairman
Subcommittee on Investment, Jobs, and Prices
Joint Economic Committee
U.S. Congress
Washington, D.C. 20510-0002

Dear Mr. Chairman:

Thank you for your letter of June 26, 1992 that included additional questions arising from the Subcommittee's June 24 hearing on hospital mergers and joint ventures. Enclosed are my answers to those questions (as modified in conversations with Joint Economic Committee staff). These represent my views and not necessarily those of the Commission or any Commissioner. Thank you for providing me with the opportunity to share my views on these issues.

Sincerely,



James C. Egan, Jr.
Director for Litigation

Enclosure

QUESTION 1: What effect do all payer systems such as that operating in the State of Maryland have on the need for Federal antitrust enforcement? To what extent would Federal involvement differ if an all payer system were instituted nationally?

ANSWER: I believe that Federal antitrust enforcement relating to hospital mergers and joint ventures can help improve the price and quality of hospitals operating under existing "all payer" reimbursement systems such as Maryland's (under which a hospital is generally reimbursed under a single government-regulated rate schedule for all its patients, including Medicare, Medicaid and privately-insured patients). Federal antitrust enforcement likely would also be necessary and beneficial under a Federal "all payer" system, to the extent that the system leaves room for, or relies upon, competition among hospitals.[1]

Competition among hospitals, and antitrust enforcement preserving such competition, can strengthen an "all payer" regulatory system by encouraging hospitals to charge even lower rates than the maximum regulators would allow them to charge. For example, competition may force relatively high-cost hospitals to hold down their standard charges, even more than state regulators would require, to avoid losing patients to more economical hospitals. Competition may also enable certain third-party payers, such as health maintenance organizations, to negotiate discounts with hospitals in return for increased patient volume, if discounts are permitted by the relevant "all payer" system.[2] Competition would also encourage hospitals to continue striving for medical excellence and superior customer service, or at least discourage them from cutting corners on quality to generate higher-than-competitive profits without violating a government rate ceiling. Competition and antitrust enforcement in the hospital industry would be of particular importance if the Federal government, or a state government, devised and implemented an "all payer" reimbursement system relying substantially on competition instead of regulation to help set the "all payer" rates for hospitals.

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[1] The level of competition among hospitals would depend on the characteristics of the specific "all payer" system in question. There are substantial differences among the "all payer" systems already in place, and among proposals for a new Federal "all payer" system, that may affect the role of competition and antitrust enforcement in the hospital industry.

[2] We understand that such discounts are not allowed under Maryland's system, but are allowed under somewhat similar systems such as Connecticut's (which covers all payers other than Medicare and Medicaid).

"All payer" systems (or other forms of hospital rate regulation) may reduce the need for, and therefore the level of, Federal antitrust enforcement by making hospital mergers and joint ventures less likely to be anticompetitive than they would be in less-regulated markets. Such regulatory systems may reduce the level of Federal antitrust enforcement in other ways, such as by blocking anticompetitive mergers and joint ventures on their own without any involvement by the FTC or the Justice Department. The level of Federal antitrust enforcement against hospitals will automatically decline to the extent that "all payer" systems leave less work for the antitrust enforcement agencies.

QUESTION 2: Because the Herfindahl-Hirschman Index could trigger a Federal agency market concentration presumption for most communities (over 80%) with more than one hospital, the usefulness of the HHI Index to the hospital industry is extremely limited. Please outline the criteria applied other than the HHI Index to determine your position on a proposed merger.

ANSWER: First, I should note my disagreement with your premise that the Herfindahl-Hirschman Index is not as useful in the hospital industry as in others. The HHI is merely a measure of market concentration that takes into account both the number of firms in the market and the different sizes of those firms. I suspect that few would disagree that in assessing the competitive implications of a merger, it is important to know the number and size of the hospitals available to consumers in the relevant geographic market. This is the general function of the HHI.

In determining whether to commence an enforcement action the Commission uses market concentration (normally as measured by the HHI) as a starting point; in certain circumstances the Federal courts use the fact of high concentration in a well-defined relevant market to arrive at a rebuttable presumption of illegality. Whether characterized as a "starting point" or a "rebuttable presumption," the level of market concentration is never viewed in isolation. The 1992 Merger Guidelines issued jointly by the FTC and the Justice Department set forth a variety of other factors the agencies consider in their enforcement decisions, and the Supreme Court has held that the presumption of illegality may be rebutted by evidence that "show[s] that the market share statistics [give] an inaccurate account of the acquisition['s] probable effect on competition."[3] The most recent hospital merger case — the Eleventh Circuit's decision in FTC v. University Health, Inc.[4] — illustrates the variety of

[3] United States v. Citizens & Southern Nat'l Bank, 422 U.S. 86, 120 (1975).

[4] 938 F.2d 1206 (11th Cir. 1991).

factors that are ultimately considered in a typical merger analysis.

The Merger Guidelines recently issued jointly by the FTC and the Justice Department discuss in some detail the variety of factors, in addition to market concentration, the agencies consider in their merger enforcement decisions. A copy of the Guidelines is enclosed.

I would note in particular that once it is determined that a hospital merger (or joint venture) would significantly increase concentration to levels raising competitive concerns — taking into account the hospitals' future competitive prospects, not just their past market shares — the next step is to determine whether it is likely that as a result of the merger (1) the merging hospitals can by themselves profitably and substantially raise prices above the competitive level (or reduce quality below competitive levels) for some or all of their services, or (2) the merging hospitals can achieve the same results through coordinating their pricing and other competitive strategies with other hospitals in the market. The first question arises when the merging hospitals have very high market shares, or are much more direct competitors of each other than they are of other hospitals; the answer depends on how readily customers of the merging hospitals (including patients, their physicians, and their third-party payers) could turn to other hospitals, and how easily the other hospitals could accommodate those dissatisfied customers. The answer to the second question depends on, among other things, how easily hospitals in the market could establish and maintain a "united front" to significantly raise prices and/or lower quality relative to competitive levels.[5] The ability of those hospitals to coordinate their activities in that way is in turn affected by, among many other things, how similar are the services and economic interests of those hospitals, how well publicized are hospitals' price changes and other competitive moves, and whether large third-party payers can disrupt the "united front" by offering irresistible temptations for individual companies to break ranks (such as long-term contracts that suddenly move large blocks of business to one hospital from its competitors).

Also an important factor in the competitive analysis is how easy or difficult it would be for a new competitor to enter a market to serve customers unhappy with how existing firms are meeting their needs. (In hospital markets, this factor is most

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[5] See, e.g., United States v. Rockford Memorial Corp., 717 F. Supp. 1251, 1286, 1304-06 (N.D. Ill. 1989), aff'd, 898 F.2d 1278 (7th Cir.), cert. denied, 111 S. Ct. 295 (1990) (discussing three hospitals' collective efforts to thwart Blue Cross cost-containment measures).

important for mergers, or joint ventures, involving specific services, because it often is easier to enter the market for a single service than to accomplish the generally difficult task of bringing a whole new hospital into the market.) Efficiencies flowing from a merger, likewise, are an important consideration (as discussed in more detail in response to the next question). And the "failing firm" defense will protect a merger that is essentially a "last resort" for a hospital that otherwise would have no choice but to leave the market.

The above list of factors other than market concentration affecting the legality of a merger (or joint venture) is not exhaustive; in particular cases, additional considerations not discussed in the Merger Guidelines may also be relevant (for example, the implications of state rate regulation).

QUESTION 3: It has been the stated position of the FTC that the efficiencies gained by a merger are weighed against the harm to competition in determining whether to allow a merger or joint venture activity to take place. Please explain how this weighing of factors is accomplished.

ANSWER: In general response to this question, I would again rely upon the joint FTC-Justice Department Merger Guidelines. Section 4 of the Guidelines explicitly recognize that in some instances "mergers that the Agency [the FTC or the Justice Department] otherwise might challenge may be reasonably necessary to achieve significant net efficiencies," which must be weighed in the competitive analysis. The Guidelines elaborate on this point as follows:

> Cognizable efficiencies include, but are not limited to, achieving economies of scale, better integration of production facilities, plant specialization . . . and similar efficiencies relating to specific . . . operations of the merging firms. The Agency may also consider claimed efficiencies resulting from reductions in general selling, administrative, and overhead expenses . . . although, as a practical matter, these types of efficiencies may be difficult to demonstrate. In addition, the Agency will reject claims of efficiencies if equivalent or comparable savings can reasonably be achieved by the parties through other means. The expected net efficiencies must be greater the more significant are the competitive risks identified in Sections 1-3 [of the Guidelines].

As noted in the Guidelines, the potential efficiencies from mergers and joint ventures take many forms. Whatever the type of efficiency at issue, the first consideration is how great is the efficiency that can realistically be achieved through the particular merger or joint venture. The experiences of other

hospitals (for example, as reflected in scholarly studies) can shed some light on that issue; however, factors specific to the hospitals involved in the merger or joint venture may affect whether their specific transaction will achieve the results obtained by others. It is also important to focus not only on the potential cost savings (or quality improvements) of consolidations of services or facilities, but also the adverse side effects and costs of such consolidations — for example, the sometimes substantial capital costs of consolidating two underutilized facilities into one larger facility.[6] How carefully the hospitals have considered the costs and other obstacles to their plans, as well as how realistically they have projected the potential benefits, significantly affects the credibility of their efficiencies arguments.

It is also important to consider whether the efficiencies can be achieved only through the proposed merger or joint venture, as opposed to some alternative that poses less or no risk to competition. For example, efficiencies through the consolidations of hospitals' laundry and data processing facilities would normally merit little weight, because those services usually could be shared by the hospitals without a complete merger, and there would thus be no justification for endangering competition with respect to the hospitals' other services.

A final consideration is how much of the efficiencies achieved through a merger or joint venture will flow to consumers, as opposed to the hospitals (or their shareholders).[7]

To better understand how antitrust laws are applied to joint venture activities, please comment on the following examples:

QUESTION 4: What if two or more hospitals want to get together to share equipment in order to reduce health care costs. They want to join together and purchase one piece of expensive equipment in order to update their separate existing pieces of equipment. They all plan to use the new piece, and will charge the same price for using it. Is this sharing of equipment acceptable?

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[6] The district court in the Rockford case criticized defendants' efficiency claims for overlooking the costs of achieving the claimed efficiencies. 717 F.Supp. at 1289.

[7] University Health, 938 F.2d at 1223; American Medical International, Inc., 104 F.T.C. 1, 220 (1984).

ANSWER:

As a preface to the answer to this question and the two that follow, I would like to emphasize three points:

(1) The Commission's experience with hospital joint ventures is much more limited than with hospital mergers, since the Commission has never had occasion to challenge, and rarely has investigated, such joint ventures. My responses to these questions are therefore more abstract and hypothetical than the answers to the preceding questions.

(2) I am unsure whether the scenarios presented in some of these questions reflect situations found in real-world hospital markets. Not only has the Commission never encountered them in connection with an investigation, they have never been presented by hospitals requesting the advice (formal or informal) of Commission staff.

(3) Although the Commission has not been faced with the specific factual scenarios presented in these questions, it is aware that hospitals throughout the country are engaged in a variety of cooperative activities that accomplish the objectives posited in the scenarios without creating antitrust risks. Many hospitals, for example, share expensive equipment such as magnetic resonance imagers ("MRIs") to reduce costs.

Whether the antitrust laws would be an obstacle to the above-described arrangement to share equipment depends on the circumstances of the particular case. One must first consider whether the reduction in the number of competitors for the service provided by the item of equipment has any potential to adversely affect competition in the market for that service. For example, there may be no significant antitrust issue raised at all if the hospitals wishing to share equipment are not competitors in the first place, or face strong competition from many other providers of the same or competitive services, such as other local hospitals or non-hospital providers (in the case of outpatient services, such as magnetic resonance imaging), or if new competitors could easily enter the market should consumers find the hospitals' sharing arrangement not to be in their interests. If a merger bringing the two hospitals' existing machines under common ownership would not raise competitive concerns, neither should the replacement of those machines with a jointly-owned new machine.

If that inquiry is not enough to resolve the question, it is then necessary to consider the efficiencies to be achieved through the sharing arrangement (along the lines of the answer to Question # 3 above), and weigh them against whatever threat to

competition may result from having fewer competitors for the shared service. If the sharing arrangement will in fact significantly lower health care costs, that would argue in favor of the arrangement, unless there was some other way to achieve those cost savings (for example, if competing hospitals could efficiently each share a mobile MRI machine with other hospitals outside the market, therefore serving the community with two competing part-time MRI machines, instead of sharing one full-time MRI machine with each other). Any improvement in quality made possible by the sharing arrangement would also be taken into account (for example, if the new item of equipment is technically superior to the existing machines, and none of the sharing hospitals could by itself support a new machine).

Assuming that the hospitals' arrangement jointly to purchase the new equipment is appropriate, the hospitals' joint decisions regarding pricing and other aspects of the operation of the new equipment would also be acceptable, if such joint decisions are reasonably necessary to the functioning of the sharing arrangement (which is not necessarily true for all hospital joint ventures), and if the hospitals avoid any coordination of pricing or other competitive decisions concerning services where they remain competitors.

QUESTION 5: Another case involves "centers of excellence." Say that a community is served by 3 hospitals, all of which have an open heart surgery program. Each performs roughly 150 procedures each year. The hospitals get together and agree to jointly establish one program in order to create high enough volume to be considered a "center of excellence" for open heart surgery. We can assume that the quality of the procedure will likely increase with the greater number of procedures, and costs per procedure will likely fall. As to price, we are less certain. Can the hospitals conduct this joint activity without being fearful of antitrust actions by the FTC, Justice or private individuals?

Assuming that the price for the procedure does not increase after this agreement, can the hospitals expect to be protected from antitrust claims?

ANSWER: This question, like the preceding one, could be easily resolved if the characteristics of the relevant market made it unlikely that reducing the number of competitors would endanger competition even if there were no benefits from the transaction. Particularly for an expensive "tertiary" service like open-heart surgery (for which patients tend to travel longer distances than for more routine services), it is important to consider whether competition from outside the community offers the community's residents good alternatives should the "center of excellence" turn out to make things worse instead of better.

In any event, whether the transaction is likely to draw an antitrust challenge from a government antitrust enforcer, or whether a private challenge would succeed, will depend in large part on whether consumers can expect to enjoy a net benefit from the "center of excellence" program, either through higher quality without higher prices (whether the "price" be the hospital's list price, the discounted price charged to many third-party payers, or the reimbursement paid by Medicare or Medicaid), lower prices without lower quality, or higher quality that is only partially offset by higher prices (so consumers pay a lower price, adjusted for quality).

Finally, it is necessary to consider whether the market is already working to concentrate open-heart surgeries at the best of the three programs, and to force the weaker programs out of the market. If that is true, competition among the three hospitals to determine which of their open-heart programs will survive may yield a "center of excellence" with lower prices and/or higher quality than one established by agreement among the hospitals.

QUESTION 6: Let's now consider the issue of an agreement to not duplicate services. In a two hospital community, the administrators of the hospitals act in a forward looking manner. Instead of each hospital providing every high technology service, they agree to specialize. One hospital agrees to purchase a lithotripter and the other to purchase an MRI. The community ends up with both services but without the cost of having duplicated each. Would such an agreement on division of services put the hospital at risk? What factors may make this acceptable or unacceptable under antitrust laws?

ANSWER: This agreement presents a substantial antitrust risk to the hospitals. The courts have historically — and rightly — treated with great suspicion agreements to divide markets.[8] This is based on the premise that market divisions pose significant dangers to competition, without the prospect of countervailing efficiencies that justifies the more liberal treatment accorded to mergers and joint ventures.

The hypothetical posited in this question does not seem to provide a compelling justification for departing from the normal treatment of market divisions under the antitrust laws. One must ask at the outset whether the community (along with other communities served by the two hospitals) can support competing lithotripters and MRIs, whether as fixed-base full-time machines or as mobile machines shared with hospitals in other communities (as noted in the response to Question # 4 above). Even if it is

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[8] See, e.g., Palmer v. BRG of Georgia, Inc., 111 S. Ct. 401, 402-03 (1990).

not feasible for two lithotripters and two MRIs to operate in the community, one must ask why a market division agreement between the hospitals is necessary. If the administrators are truly "forward looking," each hospital will on its own specialize in what it can do best and avoid what can be done best by the other (especially given a reimbursement environment increasingly unforgiving of inefficient duplication of services). Or one hospital might purchase both an MRI and a lithotripter, and the other will purchase neither (recognizing that it is likely to lose money if it wastefully duplicates the other machines). This kind of specialization goes on all the time in hospital markets — for example, not every hospital tries to set up an open-heart surgery program, and many hospitals even forgo basic services like obstetrics when they have no realistic hope of outperforming other hospitals already offering the service in their markets.

Questions for Mr. Robert Eaton

Some have suggested that more specific guidelines than those provided in the joint FTC-Justice issued Merger Guidelines would assist in clarifying matters for both FTC and Justice, and the hospital industry. Would you support the creation of more specific guidelines that did not preempt the application of existing antitrust laws but would assist in their application to the hospital industry?

In your written testimony you note that "over the past decade, certain regulatory requirements have been eliminated..." Furthermore, you observe that "hospitals remain largely unregulated in the very activities that the antitrust laws were intended to constrain; in their ability to set prices and determine the supply of services to non-public purchasers of health care."

Is it the opinion of HHS that the enforcement of Federal antitrust laws by FTC and Justice is sufficient to protect against monopolistic behavior <u>and</u> to eliminate hospital bed over supply and duplication of high technology services, or do you support additional measures as well?

What is the time-line for the Working Group that you discussed? What is the goal of the Working Group? When are findings due to be completed?

RESPONSES TO CHAIRMAN STARK'S QUESTIONS OF ROBERT EATON

Question 1:

Some have suggested that more specific guidelines than those provided in the joi FTC-Justice issued Merger Guidelines would assist in clarifying matters for both FTC and Justice, and the hospital industry. Would you support the creation of more specific guidelines that did not preempt the application of existing antitrust laws but would assist in their application to the hospital industry?

Answer:

The Merger Guidelines that the Department of Justice (Justice) and the Federal Trade Commission (FTC) issue are by definition, guidelines, and are not industry specific. The Guidelines detail the steps used by Justice and FTC to evaluate a proposed merger. As recently revised, the Guidelines state clearly that Justice ar FTC "will apply [the Guidelines] reasonably and flexibly to the particular facts ar circumstances of each proposed merger." In light of the lack of specificity in the Guidelines, it is clear that continuing clarification of the Merger Guidelines is warranted. However, Justice and FTC have agreed to continue to speak with th hospital industry and the health care bar to provide clarification of their policies. Indeed, Justice and FTC just assisted the American Hospital Association (AHA) in the preparation of the first issue of an AHA membership periodical on antitru issues. We support these cooperative efforts.

Question 2:

In your written testimony you note that "over the past decade, certain regulatory requirements have been eliminated..." Furthermore, you observe that "hospitals remain largely unregulated in the very activities that the antitrust laws were intended to constrain; in their ability to set prices and determine the supply of services to non-public purchasers of health care."

Is it the opinion of HHS that the enforcement of Federal antitrust laws by FTC and Justice is sufficient to protect against monopolistic behavior and to eliminate hospital bed over supply and duplication of high technology services, or do you support additional measures as well?

Answer:

We do not believe that Congress ever intended for the antitrust laws to eliminat the oversupply of hospital beds and the duplication of high technology. We do believe that the overcapacity and inefficiency in the hospital industry must end. The Secretary and the Department have endeavored to promote competition an efficiency without dictating the specific actions that should be taken. These specific business decisions are best made by hospital administrators, their boards and their communities.

Question 3:

What is the time-line for the Working Group that you discussed? What is the goal of the Working Group? When are your findings due to be completed?

Answer:

The working group which was discussed in testimony is intended to be an on-going, staff-level group that will address issues of common interest to our Department, the Department of Justice and the Federal Trade Commission including joint ventures and managed care. We envision that the group will meet several times a year, or more frequently if necessary, to discuss emerging health policy issues, issues of common concern, and to share research related to health care and the antitrust laws. The working group will not produce findings or a report but rather the members will disseminate information to their respective agencies.

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