FTC/DOJ Hearings on Health Care and Competition Law and Policy

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Good morning, my name is Eugene Anthony Fay. I am the Vice President, Government Affairs of Province Healthcare Company, located in Brentwood, Tennessee. Province Healthcare Company owns and operates 20 proprietary rural hospitals and manages another 35 not-for-profit and governmental rural hospitals in a total of seventeen states.

Today I am here on behalf of the Federation of American Hospitals, which is the national representative of privately owned or managed community hospitals and health systems throughout the United States. The Federation's members encompass a broad range of facilities, located across the country and in Puerto Rico, including tertiary centers, general acute care hospitals in metropolitan and urban areas, sole community and rural hospitals, teaching hospitals, psychiatric hospitals, long-term acute care hospitals, rehabilitation hospitals, and children's and women's hospitals. In addition, the Federation's members manage hundreds of non-profit hospitals. I am pleased to be here today to talk about hospital ownership types, and thank the FTC and DOJ for inviting the Federation of American Hospitals to participate on the panel.

As background, there are several forms of hospital ownership within the United States. These range from public hospitals (owned by state, county and district governments); non-profit hospitals, such as university, community-owned, and religiously sponsored hospitals; and investor-owned hospitals, including privately owned and publicly traded hospitals. Currently, about 25% of all general acute care hospitals are public hospitals, 60% are non-profit hospitals, and 15% are investor-owned hospitals. These numbers have remained relatively constant throughout the years.

Notwithstanding this seemingly broad array of types of hospital ownership, a more in depth analysis reveals that these ownership variations are distinctions without any significant difference. All hospitals, irrespective of ownership, and whether located in urban or rural markets, have the same mission: to provide the highest quality, appropriate medical care possible to the patients they serve, irrespective of the patient's ability to pay for such care. In fact, all hospitals are more alike than dissimilar.

For example, with respect to indigent care, recent data available from the Medicare Payment Advisory Commission (MedPAC) illustrates that investor-owned and non-profit hospitals provide substantially the same amount of uncompensated care. In 1999, according to the data, the uncompensated care burden for voluntary non-profit hospitals was 4.6% of total hospital costs, and 4.2% of total hospital costs for investor-owned hospitals.

In addition, all hospitals reinvest the vast majority of their cash flow back into capital equipment. Such reinvestment is a priority for investor-owned and non-profit hospitals alike. Both investor-owned and non-profit hospitals must maintain a positive bottom line in order to maintain capital.

All hospitals are highly regulated at both the federal and state levels. In addition, they are reviewed and certified by the same bodies, such as the Joint Commission on Accreditation of Health Care Organizations (JCAHO). All hospitals within a given state are subject to their state's legal requirements with respect to their licensing and operational requirements, including the admission and credentialing of their medical staffs; the operation of their emergency departments; the mandate to follow certificate-of-need requirements; and the requirements for specialized services such as neo-natal intensive care, adult intensive care, cardiac care, and infectious diseases. In addition, the operation of hospitals' laboratories, radiation and x-ray

facilities, pharmacies, nursing staff and participation in their state's Medicaid and related programs, among others, are mandated under their state's laws and regulations irrespective of ownership type.

All hospitals within a particular state receive generally the same reimbursement for their Medicaid services, compete with one another for managed care contracts from third party payers; and are subject to the state's wage and hour laws, workers' compensation, tort and other liability laws, and unfair competition laws, among a host of other laws and regulations.

Similarly, many hospitals, irrespective of ownership, are organized into systems. Both investor-owned and non-profit hospitals organize in this fashion to achieve substantially the same purposes – efficiency and cost savings, without sacrificing quality of care. Often these systems consolidate their operations and legal support, JCAHO activities, information technology infrastructures, design and construction, quality assurance, and tax and accounting functions at the highest level of the system (national, regional or state). These systems operate similarly whether investor-owned or non-profit. Consolidation of operations brings efficiencies and cost savings to the systems.

At the federal level, all hospitals that participate in the Medicare program are subject to a vast array of laws and regulations governing this entitlement, including the payments they receive for Medicare services (subject to certain adjustments, not related to the ownership of the hospital). All hospitals receive similar payments under the Medicare program, which at one time paid investor-owned facilities a "return-on-equity capital" add-on to their usual payments. However, in recognition of the fact that there is not a substantial difference among or between hospitals, that add-on was phased out and expired on October 1, 1989.

All hospitals are subject to various federal laws, including labor laws, antitrust laws and fraud and abuse laws. The great majority of hospitals have compliance programs as recommended by the HHS Office of Inspector General and are required to comply with the federal laws prohibiting false claims and anti-kickback schemes. The enforcement of these and other laws, the court decisions which have emanated from civil and criminal prosecutions of violation of these laws, and settlements entered into do not distinguish between investor-owned and non-profit hospitals, nor were the laws promulgated with that intent.

All hospitals that participate in the Medicare program are subject to the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA requires that all hospitals provide a medical screening exam and necessary stabilizing treatment to all individuals who go to a hospital's emergency department. EMTALA applies to all Medicare-participating hospitals and applies to all individuals, regardless of their ability to pay or insurance status. Investor-owned and non-profit hospitals are treated the same under this law.

Obviously, there are also some differences among different forms of hospital ownership. We submit, however, that those differences are differences without a distinction and do not rise to the same level of consequence or importance as do their similarities. Some of the differences are as follows:

Financial reporting for investor-owned hospitals is more transparent than for non-profit hospitals. Investor-owned hospitals are subject to the same federal laws and regulations applicable to all public companies including the recently enacted Sarbanes-Oxley Act, requirements for filing for initial public and secondary offerings of their securities, and annual, quarterly, and special filings required by those laws. Thus, the complete financial information pertaining to hospital management companies is readily available to the public as a result of the

requirements of the Securities and Exchange Commission (SEC), which has jurisdiction over these companies. In contrast, non-profit hospitals are exempt from SEC registration requirements. They are, however, required to file annual corporate income tax returns at the state and federal levels. Those returns do not contain the same degree of disclosure as required by the SEC.

Non-profit hospitals also are eligible for federal and state grants, loan guarantees, and interest rate subsidies which generally are not available to investor-owned facilities. Non-profit facilities also have access to tax-exempt financing, which is not available to investor-owned hospitals. As a result, investor-owned hospitals borrow money at a rate that is approximately 100 to 200 basis points higher than tax-exempt financing. However, because investor-owned hospitals have access to the equity markets, they may be able to raise capital more quickly, and thereby fund projects that are not always readily available to their non-profit counterparts, such as the construction of sole community or rural hospitals, or the rapid deployment of new technology, equipment or procedures to multiple sites.

In addition, non-profit hospitals enjoy special privileges under an exemption to the Robinson-Patman Act, which allows those institutions to purchase certain goods for their own use and consumption, most often pharmaceuticals, at favorable prices with immunity from the antitrust laws. The Federal Trade Commission has jurisdiction under the Clayton Act to challenge mergers and acquisitions by non-profit institutions, however it does not have jurisdiction to challenge anticompetitive conduct by non-profit institutions. In those circumstances, the Department of Justice asserts jurisdiction over those matters. With this exception, and the exception for state-owned institutions, in general, the federal antitrust laws apply to all other hospitals, non-profit and investor-owned alike.

Perhaps the most distinguishing difference between investor-owned and non-profit hospitals is the fact that by virtue of their exemptions, non-profit hospitals do not pay federal or state taxes. As a consequence, to the extent that the hospital experiences a "surplus" from operations (after providing for set-asides for future growth and the replacement of facilities and equipment) – which fewer and fewer hospitals earn in this increasingly challenging operating environment – a portion of that "surplus" is passed on to the community in which the facility or system is located, through various community benefits afforded to each locale's residents. Investor-owned hospitals do pay federal and state taxes, which are another form of community benefit, in that those tax payments fund federal, state and local agencies that provide a wide variety of programs among which are Medicare and Medicaid, and other community benefits (police, fire protection, emergency response and other governmental functions) to their respective citizens.

Until recently, investor-owned hospitals have been foreclosed from participating in certain federal programs such as those under the Hill Burton Act, and the Federal Emergency Management Administration. However, as Congress reexamines these historical distinctions and recognizes how few differences actually exist, it seems more inclined to remove artificial barriers and establish parity among all hospitals. A case in point is the Nurse Reinvestment Act, signed into law last year, which allows nurses who receive federal aid to work at any hospital, regardless of its ownership status. FAH will continue to encourage Congress and others, including the FTC and DOJ, to follow suit, as the similarities among investor-owned and non-profit hospitals far outweigh their differences.

SUMMARY

In short, and from a broad overview, investor-owned and non-profit hospitals and health systems operate in relatively the same environments, subject only to their locale, size, and the array of services that they offer. All hospitals operate in a highly regulated environment. All are required to and do render their services at the same levels of care as required by applicable law including the custom and practice of providing such care in their respective communities. With limited exceptions all hospitals are governed under the same federal and state laws, rules and regulations. And as a consequence, we believe that all the federal laws, rules and regulations addressing competition should apply equally to both investor-owned and non-profit hospitals and systems.