FTC/DOJ Hearings on Health Care and

Competition Law and Policy

Statement of the Federation of American Hospitals

February 27, 2003

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Introduction:

The Federation of American Hospitals ("FAH") is the national representative of privately owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of the United States. FAH members are market-oriented and believe that competition plays a valuable role in health care markets.

FAH's goal is to assist the Federal Trade Commission ("FTC") and the Antitrust Division of the United States Department of Justice ("DOJ") (collectively referred to as the "Antitrust Agencies") in better understanding how to apply the antitrust laws to health care markets. FAH believes that these hearings provide an important opportunity for industry participants to share their experiences and insights into the operation of health care markets with the Antitrust Agencies, which will assist the Antitrust Agencies in applying the antitrust laws in a manner that recognizes the unique characteristics of hospital markets, encourages procompetitive and efficient behavior, and prevents abuses of true market power and anticompetitive conduct.

One of the important issues facing health care markets and health care policy-makers is rapidly increasing costs. The Centers for Medicare and Medicaid Services ("CMS") predicts that national health spending will grow an average of 7.3 percent annually over the next ten years, and that health spending will account for 17.7 percent of the country's Gross Domestic Product by the year 2012.[1] The projected increases and rate of increase in national health spending have spawned significant public debate. Unfortunately, much of the public debate aimed at addressing the problem of rising health care costs has consisted of finger-pointing, with each segment of the health care industry seeking exoneration – and what better way to do that than by placing blame on your negotiating partner? One example of this is that certain groups have associated health care cost inflation with hospital consolidation, while obscuring fundamental cost drivers. More specifically, these groups focus on short-term market changes and disregard long-term trends. In fact, increases or decreases in health care costs result from a combination of factors involving providers, payors, employers, and individual consumers and patients, as well as the particular pressures and market circumstances each faces.

The Federation believes that finger-pointing is counterproductive. Instead, let us closely examine the experience of industry participants such as Federation members, which can provide practical assistance to the FTC and DOJ in applying the antitrust laws to health care markets. Federation members believe that competition and antitrust law, when appropriately applied, will continue to play a significant role in ensuring high-quality, affordable health care for Americans and controlling their health care costs.

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[1] Stephen Heffler, et al., *Health Spending Projections for 2000 – 2012*. Health Tracking, (Feb, 7, 2003).

The Complexity of Hospital and Health Care Markets:

Overview:

Hospitals and hospital markets are part of a series of related health care markets that interact with one another in varied and often complex ways. It has often been said that, "When you've seen one health care market, you've seen one health care market." The same holds true for hospital markets. Nevertheless, hospital and health care markets in general certainly share some common features. Health care markets share three basic characteristics. First, the demand for most health care services is relatively inelastic. Second, the price, or cost, of health care is shared by at least five different groups: providers; insurers (or payors); employers; individual consumers and patients, and taxpayers. Third, governmental entities are the most significant buyers of health care services.

The costs of health care are shared by several groups. Providers, and hospitals in particular, share the costs of health care in that the actual cost of providing some services, such as emergency services and services for the uninsured, is not always reimbursed fully, or reimbursed at all. Employers also share in the costs of health care because they almost always absorb at least a part of the cost of providing health care coverage to their employees. Individual consumers and patients also shoulder a portion of the costs through premiums, deductibles, co-payments and other mechanisms. Finally, taxpayers share in the costs of caring for the uninsured.

The third common characteristic of health care markets is that the most significant payors (buyers) in health care markets are usually governmental entities such as the federal and state governments. Government payors unilaterally determine how much they will pay, or reimburse, providers for the services they provide. That amount may have little relationship to the actual cost of providing the services. One of the effects of these three basic characteristics is that the relationship between costs and prices that exists in many market is less direct in health care markets; i.e., the ability of price (or revenue) to respond to changes in costs is limited. Moreover, the complex relationships among the four primary participants in health care markets (providers, payors, employers, and individual consumers and patients), affect each participant's ability to respond to, or effect, changes in the market.

Understanding the relationships among health care market participants is critical to understanding competition in any particular market. Clearly, competition and pricing in health care markets is not merely a function of consolidation or concentration among providers or payors. Rather, it depends on the particular circumstances in which employers, payors, providers and individual consumers and patients find themselves, and the ways in which the circumstances faced by one affect the others.

A number of interdependent factors faced by employers, payors, providers and individual consumers and patients affect, in varying degrees, health care costs and competition. One of these factors concerns the costs of production. The costs of production for hospitals are significant and have grown substantially in recent years. Hospitals' labor costs increased an

average of almost 39% from 1997 to 2001.[2] Hospitals have experienced substantial labor shortages, particularly nurses. While hospitals provide health care services to employers and individuals generally, they also compete with employers for the best employees. The provision of hospital services is very labor-intensive, with wages and benefits accounting for almost 60% of a hospital's costs. Hospital labor costs in particular have increased significantly.

Another important factor is the characteristics of area employers. Although the particular characteristics of employers and the manner in which they affect health care costs and competition differs from one market to another, their relevance is universal. The employers' and employees' sensitivity to differences in cost and accessibility, the health status or needs of the work force, and the flexibility in designing or modifying health benefits all may be affected by the nature of the industry in which area employers participate (e.g., service industry, manufacturing industry, blue-collar or white collar industry), and the size of area employers. A similar factor is the labor market conditions, both generally and within the health care markets. Are employees unionized? Is the labor market strong such that employees have substantial mobility? The answers to these questions and others may have a significant bearing on how competition works, and how it may work in a particular market.

Of course, the competitiveness of providers and payors in a market is an important factor; as is the extent to which there has been consolidation, market entry or exit. Consolidation can cut both ways; it may create market power, but it also likely increases the efficiency of the remaining competitors, particularly in the case of hospitals. It also is important to consider the issue of excess capacity or capacity constraints on the part of hospitals and other facilities. Capacity may affect efficiency as well as the ability and incentive for hospitals to offer discounts for volume.

In areas of the country where they exist, Certificate of Need ("CON") laws and the way in which they apply may play a significant role in shaping local hospital markets. It also is important to examine how CON laws have been applied. It is not uncommon for the application of CON rules or restrictions to vary among different types of providers. Either way, the presence of CON laws often affects the ability of providers to respond to market conditions.

The nature of managed care reimbursement methods also should be considered. The mechanism by which payors reimburse providers may affect the economic incentives of both payors and providers, and may influence how payors and providers affect the other's behavior. Moreover, reimbursement mechanisms may provide insight into the relative bargaining strength of payors and providers. The size of the uninsured or underinsured population is another important factor. It not only affects a hospital's financial position by consuming services without a corresponding payment, but also is an indicator of labor and employer conditions in an area. A large uninsured or underinsured population may signal a depressed economy, but may also provide information about the amount of competition among employers for employees and the economic importance of commercially insured patients. The relative sizes of the publicly and commercially (or privately) insured populations also is significant in assessing competitive conditions.

[2] PricewaterhouseCoopers, *Cost of Caring: Key Drivers of Growth in Spending on Hospital Care* (Feb. 19, 2003) (Prepared for the Federation of American Hospitals and the American Hospital Association).

Finally, another important factor in understanding competition in health care markets is the existence of outpatient and ancillary services providers, and physician-owned specialty hospitals. In some markets, outpatient facilities are few, or provide only a small range of services. However, in other markets there are significant numbers of facilities competing with nearly every service provided by hospitals. Moreover, regulations in some states permit outpatient facilities to provide some inpatient (i.e., requiring an overnight stay) services. In such markets, outpatient and physician-owned specialty facilities may provide as much competition to a hospital, if not more, than other hospitals do.

There exists a type of cause and effect relationship among providers, payors, employers, and individual consumers and patients. Providers respond or react to the payors' business strategies and decisions. Payors, in turn, respond or react to employers' business strategies and decisions. And employers must respond or react to their employees' expectations and employment alternatives, as well as to general economic conditions.

Employer Factors:

One of the biggest assets an employer has is its employees, and competition among employers to hire and retain the best employees increases and decreases depending, in part, on the state of the economy. One way employers compete for employees is by offering greater benefits, especially health care benefits. However, the importance or prevalence of this aspect of competition for employees depends to a significant extent on the strength of the economy, which affects the mobility of an employer's work force. Generally, individuals have fewer alternatives for employment in a weak economy, so employers do not need to compete as aggressively to retain employees. The experience of the last ten to twelve years provides a good illustration of how the actions and circumstances of employers, payors, and providers affect each other.

In the early nineties, the economy was rather sluggish and health care costs were increasing rapidly.[3] Generally, this meant that revenue and profits grew slowly, and that competition for employees was relatively mild because employees had fewer alternatives for employment and there was a readily available labor pool from which employers were able to draw to replace employees who left. In this environment, employers sought to reduce their costs. One way to do this was to reduce the level of health care coverage provided to employees, and/or reduce the cost of that coverage. Thus, in the early to mid-nineties, restrictive forms of managed care that reduced costs were popular with employers because the general economic conditions made cost savings a more immediate need than offering more generous health care benefits or access to employees.[4]

As the economy began to accelerate in the late nineties, finding and retaining good employees became more difficult and a more immediate need for many employers than reducing health care costs. Employers began to seek greater access and coverage in health plans, and generally became less concerned over low cost.[5] Payors responded to changing preferences and

[3] Stephen Heffler, et al., *Health Spending Projections for 2000 – 2012*. Health Tracking, (Feb, 7, 2003).
[4] Id.
[5] Id.

priorities by offering health plans that expanded benefits and increased access to providers, and that minimized cost containment mechanisms.[6]

This trend in health benefits has often been referred to as the "managed care backlash." While "backlash" may accurately describe how people reacted, what made the "backlash" economically feasible was that as the economy accelerated, employers believed that they could afford to offer more generous/less restrictive health care coverage to employees more than they could afford to lose good employees to other employers. In other words, when the economy is good, employers are forced to compete more vigorously for employees. When the economy is lagging, competition for employees slackens and saving on costs becomes more imperative. Recognizing the managed care backlash as a cyclical relationship between the state of the economy and the popularity (or acceptability) of particular forms of managed care may provide important insights as the agencies attempt to predict future effects of changes in health care market structures.

Commercial Payor Factors:

Commercial payors compete, generally, on two levels: for inclusion in the health plans offered by employers to employees; and for being chosen by individual employees. Generally, commercial payors distinguish themselves to employers and employees by offering a mix of breadth of coverage, access to providers, and price. Two important factors in determining a health plan's attractiveness to employers and employees are the quality and inclusiveness of its panel of participating providers, and the cost of coverage (premium). Health plans that exclude some of the providers in a market are generally able to lower the cost of health insurance coverage by offering providers the potential for greater volume in exchange for lower reimbursement. However, excluding some qualified providers reduces the accessibility of services to enrollees of the health plan, which may make the plan less attractive to some potential customers.

Commercial payors design their health plans to meet the needs and preferences of employers and employees in a given market; i.e., the most desirable balance of cost and accessibility. The balance that sells best varies from market to market and from year to year, depending on the characteristics of the market and economic conditions. Some employers may prefer a balance that substantially lowers cost, even if at the expense of some accessibility, while other employers will pay more for more options/greater accessibility. Payors, thus, compete with one another to develop and offer health plans that achieve the optimal balance of accessibility and cost for the greatest number of employers in a given market. This interplay between what employers and individuals want, and what payors offer in the form of health plans has direct effects on how hospitals and other providers compete with each other.

[6] "Between 1997 and 1998, we started to see the spike in utilization. Every one of the insurers in our community dramatically reduced their utilization management activities." Statement by Greg Poulsen, Vice President of Strategic Planning, Intermountain Health Care, Salt Lake City, Utah, cited in PricewaterhouseCoopers, *Cost of Caring: Key Drivers of Growth in Spending on Hospital Care* (Feb. 19, 2003) (Prepared for the Federation of American Hospitals and the American Hospital Association).

Provider factors:

There are a great many compelling reasons to provide a wide range of hospital services to the community. First and foremost, hospitals exist to provide quality health care. In order to do that, hospitals must function as businesses, managing revenue and costs. This is what some call the "business of health care." Like all businesses, hospitals must produce a positive cash flow, whether expressed as profit or as net excess of revenue over expenses, over the long-term to be able to remain in operation. A positive cash flow is necessary to invest in new technology, maintain and upgrade facilities, and expand services or operations.

Three key variables are revenue, volume, and costs. Providers, particularly hospitals, operate in one of the most heavily regulated industries in the country. Nearly every aspect of a hospital's operations is covered by both state and federal regulations. Importantly, regulations cover not only operations, but also hospitals' financial relationships and structures. A hospital's control over its payments, volume, and, to a lesser extent, its costs is limited.

Revenue:

Unlike most business enterprises, hospitals have limited ability to control the amount of revenue they receive for their services. In most industries, the amount of revenue a company receives is a relatively simple equation consisting of volume of sales multiplied by the price for its goods or services. However, for a number of reasons, a hospital's prices often bear little relation to the revenue it receives. Some of these reasons include the fact that governmental payors unilaterally decide the reimbursement rates they will pay, the significant amount of charity care hospitals provide, and the fact that health plans may retroactively deny payment for services the hospital has already rendered.

A substantial portion of hospitals' patients are covered by federal and state government programs (e.g., Medicare and Medicaid), which unilaterally determine the prices they will pay. These payments may, or may not, correlate with a hospital's costs of providing the services. Moreover, most hospitals have honored their moral obligation to provide services to patients irrespective of their ability to pay. In addition, Congress and the courts have imposed legal obligations on hospitals to provide emergency care without regard to a patient's ability to pay. Hospitals must provide these services to immigrants as well as U.S. citizens, and the costs of providing such care continue to increase as immigrant populations continue to grow. There are few other industries, if any, in which businesses routinely provide costly services for little or no compensation. The provision of uncompensated, or "under-compensated" care is significant from an antitrust perspective because it affects a hospital's overall cost structure and ability to price its services competitively. Thus, hospitals are effectively precluded from adjusting payment or controlling revenue for a substantial portion of their patients.

Hospitals are often required to make substantial payment concessions to managed care plans in order for those plans to include the hospital in a payor's panel of participating providers. In many markets, hospitals cannot afford to be excluded from any significant payor's panel of participating providers. Although participation in managed care plans may result in higher volume, the concessions often are not tied to any guarantee of higher volume. Moreover, most

contracts between hospitals and health plans give health plans significant discretion to deny coverage (i.e., not pay) for services the hospital has already provided.

Volume:

Given the restrictions hospitals face in controlling the revenue they receive for providing services, volume assumes an important role in the economic equation. Higher volume provides a hospital with a greater number of revenue sources and revenue, and the ability to spread its fixed costs among more patients. However, because demand for services (particularly inpatient services) is relatively inelastic, hospitals (and other providers) have limited ability to increase overall demand for their services. For example, no one is likely to decide to have a child because hospitals in the area are offering "a deal" on obstetric services. Similarly, someone will not induce a coronary blockage because a hospital is offering a "two-for-one sale" on new drug-eluting stents.

Hospital volume may increase in two ways. First, a hospital may be able to increase the number of patients to whom current services are offered, i.e., increase its market share. This is the type of volume increase that is the rationale for giving discounts to managed care. Second, a hospital may diversify or expand the range of services it offers.

The provision of non-inpatient services has become an increasingly important source of revenue to many hospitals. However, many of a hospital's competitors for non-inpatient services are not regulated as extensively, and are not required to incur the substantial fixed costs associated with a hospital. These facts place acute care hospitals at a significant competitive disadvantage in competing for patients.

Costs:

Hospitals have substantial fixed costs. Not long ago, many hospitals had excess inpatient capacity, having been built when many more services and procedures required an inpatient stay, and patients who were hospitalized stayed longer. As lengths of stay decreased, and fewer patients were hospitalized, hospitals had to spread those fixed costs among fewer and fewer patients. Many hospitals have implemented aggressive programs to decrease their costs and increase their efficiency in order to produce a positive cash flow. However, a hospital's ability to reduce costs is often limited by regulatory restrictions and market forces, such as labor shortages.

While it is true that in some instances hospital consolidations do increase market power, most mergers and acquisitions among hospitals have as their principal aim the reduction of costs and realization of efficiencies. Moreover, even where a merger appears to create substantial market power, a detailed analysis of many factors is needed to determine whether traditional measures such as market share or use of the Herfindahl-Hirschman Index (HHI) accurately reflect the amount of actual market power created by a merger or acquisition.

FAH's Recommendations:

The complexity and variability of health care markets do not minimize the relevance of, or need for, antitrust enforcement. Rather, they highlight the importance of developing a robust and sophisticated analytical framework that is capable of incorporating a "real-world," adaptable and targeted approach to analyzing health care markets. FAH believes that our collective experience in the industry allows us to identify some factors that the agencies should consider in developing and refining their framework for analyzing health care markets.

- **Examine Markets on a Case-by-Case Basis:**
  First, given the complexity and variability of health care markets, there are few absolutes that should be applied as a matter of course. However, while they are few, there are some rules that should apply universally. Application of traditional *per se* rules in health care markets is appropriate and should be continued. Naked price-fixing and market allocation agreements should not be tolerated, or pursued less vigorously than in other industries. Similarly, sham mergers are no less problematic in health care markets than in other markets, and should be prosecuted vigorously.

- **Go Beyond Traditional Antitrust Analysis:**
  Second, traditional measures of market power such as market shares and HHIs are helpful, but cannot accurately represent the competitive impact of structural changes in health care markets. The analysis reflected in the Antitrust Agencies' Merger Guidelines recognizes that such data are only a starting point. However, the Antitrust Agencies' analysis, particularly in hospital merger cases, has been criticized for relying too much on market shares and HHIs. Indeed, if there is one common theme that can be found in most of the Antitrust Agencies' unsuccessful challenges to hospital mergers over the last few years, it is that the courts have consistently criticized the Antitrust Agencies for relying too heavily on statistical or static market data, and ignoring the kind of dynamic analysis that would incorporate many of the factors discussed herein. One cannot accurately evaluate the extent of a hospital's market power, or its ability to wield its market power without also closely examining payor markets, employer markets, and outpatient and ancillary services markets; and analyzing how the interaction of those markets is likely to affect competition in the future.

- **Examine Each Hospital's Circumstances:**
  Third, not all hospitals are created equal. Some hospitals are more important (or marketable) to payors than other hospitals. Participation of some hospitals is much more important to a health plan's marketability and success than is the participation of other hospitals. Differences in medical staff, geographic location of the hospital, and any unique services or characteristics of a particular hospital are among the many reasons that two apparently equal hospitals may not have the same degree of market power or competitive significance.

- **Consider Competitive Effects of Outpatient and Ancillary Service Providers and Physician-Owned Specialty Hospitals:**
  Fourth, do not underestimate the potential competitive constraint posed by providers of outpatient and ancillary services and physician-owned specialty hospitals. While the services themselves may not be competitive with, or an alternative to, a hospital's inpatient services;

the potential disciplining effect on a hospital of excluding its outpatient services from a health plan, or steering away from those services can be significant under the right market conditions. If employers in a particular market will allow payors to steer people away from a hospital's outpatient and ancillary services, the impact on the hospital could be significant enough to prevent the hospital from exercising its market power in the inpatient services market. Of course, while such a tactic may not be feasible or effective in some markets, that fact should not prevent the Antitrust Agencies from considering the possibility of outpatient and ancillary services competition constraining pricing for inpatient services. Although it is necessary to identify distinct product markets in antitrust analysis to determine whether a hospital possesses market power, hospitals operate as integrated businesses, not independent service lines. The challenges and constraints a hospital faces in all of its operations should be considered in analyzing the ability or likelihood of a hospital to exercise market power.

- **Consider the Power of Payors:**
  Fifth, do not underestimate or discount the power of large payors to constrain hospital payments. In some markets, a particular payor has such a large market share that hospital market power is irrelevant. In markets where both a payor and a provider possess market power, it is not clear that provider market power would trump payor market power. Nevertheless, payors have several tools or strategies at their disposal that may allow them, in some situations, to constrain payments to a hospital with substantial market power. For example, threats of excluding a sister hospital in a competitive market from participation in the payor's health plans may constrain a hospital's exercise of market power. Similarly, a payor may threaten to forgo a contract with the hospital and pay insureds directly for hospital services. The administrative and public relations costs to the hospital from having to collect from its patients can, in some circumstances, have a significant deterrent effect. The feasibility or effectiveness of any such strategy depends on a number of factors, including considerations of employers' desires and other market conditions.

- **Be Mindful of Unintended Consequences on Legislative/Regulatory Process:**
  Sixth, keep in mind that antitrust enforcement actions or programs may affect legislative and/or regulatory policies in unintended ways. Antitrust analysis tends to take a long-term perspective on market conditions and corrections. Enforcement decisions and actions are intended to protect or preserve the ability of relatively slow-moving market forces to identify and correct errors, misallocations of resources, etc.

  Legislative and policy perspectives, on the other hand, often focus on short-term solutions to real or perceived crises. Thus, FTC or DOJ actions intended to allow market forces to work over the course of years, may be interpreted as evidence of a need for immediate corrective action by legislative or regulatory bodies. For example, FTC and DOJ concerns about how antitrust law may help control rising health care costs could be viewed erroneously from a legislative or regulatory perspective as evidence of an immediate need to reduce reimbursement levels to providers. Such actions by legislators and regulators would be very harmful to hospitals.

Conclusion:

As national health care spending has increased recently, there has been much focus on the "cause" of the increase. There has been a great deal of finger pointing, which has been counterproductive. Complex factors faced by employers, payors, providers and individual consumers and patients affect health care costs and competition. FAH looks forward to continuing to engage in a dialogue with the FTC as it examines issues related to health care competition law and policy. Thank you for the opportunity to present FAH's analysis and recommendations.