Written Comments of National Surgical Hospitals

Federal Trade Commission & U. S. Department of Justice Joint Hearing On Health Care and Competition Law and Policy
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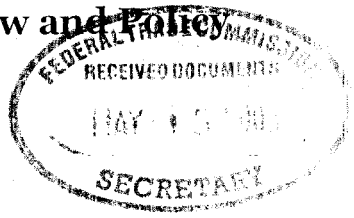

Single Specialty Hospitals

I. Introduction

National Surgical Hospitals expresses its appreciation to the Department of Justice and Federal Trade Commission staff for organizing joint hearings on health care and competition law and policy. We are pleased with the FTC's and Department of Justice' interest in competition in the burgeoning specialty hospital industry. While we are yet a relatively small part of the $1.3 trillion per year US health care marketplace, we are on the leading edge of health care innovation and will be, in my opinion, an integral part of the solution to the health care crisis in the United States. Given the opportunity to participate on a level playing field, free from unfair trade practices, specialty surgical hospitals create choice and competition in the health care marketplace.

II. Definition and Background

Defining a specialty hospital is challenging, and a single definition is impossible. Attempts have been made to define the specialty hospital as single specialty (e.g. orthopedic, or cardiac), or by type of service (e.g. surgical), or by ownership (e.g. physicians) or by location (e.g. freestanding). All of these categorizations fall short as there is a matrix of all of these and multiple examples can be found in every cell of the matrix.

Whatever form they take, the case for specialty surgical hospitals is compelling. These facilities have arisen from a demand from physicians, patients, and payers for more efficient, patient friendly and cost effective locations to provide medical care than has been traditionally provided in the full service hospital. Although perceived as a "new" phenomenon, these hospitals are simply another manifestation of trends that have been evident for decades. No single factor can be said to be the cause of the unbundling of surgical care from the full service hospital. Rather it is the confluence of the following factors that caused the emergence of the ambulatory surgery 25 years ago and that continues to drive the growth in surgical hospitals today.

1. *Inpatient to outpatient* . Today in excess of 80% of all surgical cases are done in an outpatient setting. This is up from less than 20% in 1980. On average 85% of the cases in our surgical hospitals are outpatient. In the past few decades surgery has been transformed and surgeons and their patients have migrated to ambulatory surgery centers and more recently their close cousins – surgical hospitals. This has been driven by:
   - technological advances, particularly in endoscopic surgical techniques and advanced anesthetic agents
   - physician demand for efficient surgical facilities and specialized staff dedicated to elective procedures

- patient demand for a non-institutional, friendly, convenient setting for their surgical care; and
- payer demand for cost efficiencies.

2. *Patients as consumers.* The single largest growth sector within the managed care industry is the *point of service plan*, which allows the patient their choice of provider. Patients are voting with their feet, moving to plans that give them freedom of choice. What patients want is more control, more personal attention, a less institutional environment and better value – all of which are provided in a specialty surgical hospital.

3. *Physician input and control.* Physicians feel a loss of control of their practices and are demanding to regain control of their work environment. The physicians' ownership stake in the specialty surgical hospital is essential to inspiring the critical leadership and commitment necessary for the hospital to meet the needs of physicians and patients. An environment where patients are happier, staff is friendlier, and the surgical day runs more smoothly is an enormous psychic benefit for harried physicians. A facility that allows surgeons to start on time, do more cases in a given period, and get back to their office on time has a huge impact on their practice efficiency. It has been our experience that, almost without exception, specialty surgical hospitals are developed in response to demand from local surgeons. A demand borne of frustration with local acute care hospital management that is unresponsive and unable (or unwilling) to meet surgeon and patient requirements. Surgeons, exasperated with long waits for operating room time (sometimes up to several months for elective surgery) and delays in purchasing necessary equipment, have decided to put their own money and reputations at risk to develop surgical facilities which will be less bureaucratic, less political and more accountable.

4. *Employee satisfaction*. Nurses are the principal employees of a hospital. The working environment in a large hospital (or in any larger institution) distances employees from their customers and administration. Nurses are unhappy with their work environment and have abandoned the profession in droves leading to a chronic nursing shortage. Smaller work settings offer a better, more customer focused, service orientation and a smaller, flatter administrative structure. This makes the specialty hospital a better work environment. Hopefully the growth of smaller, friendlier facilities will encourage nurses to return to this very noble profession.

III. Threats to Competition

National Surgical Hospitals holds great optimism for the future of specialty surgical hospitals. This optimism is based on the fundamental soundness of this model of surgical care delivery and on the superior patient care results we are seeing. Surgical hospitals are the right thing at the right time for quality patient care. Unfortunately, there are a few dark clouds on the horizon that temper our optimism. Specialty hospital owners and management are witnessing an increase in the frequency and intensity of hostile anti-competitive behavior aimed at our facilities and our physician partners. We are not referring to the kind of vigorous and healthy competition one would expect as

the new business in town. Rather, to conduct that is best described as "exclusionary" or "predatory". We see behavior we believe violates the legal standard established by the U.S. Supreme Court as that of monopolists trying to maintain market power through unfair or predatory means or abuse of power. (See *Aspen Skiing Co. v. Aspen Highlands Skiing Corp. 472 U.S. 585 (1985)*.

These abuses include

- Exclusionary contracting;
- Economic credentialing;
- Abuse of CON process;
- Regulatory/legislative efforts to encumber specialty facilities with unnecessary regulation and mandatory services;
- Direction of cases through hospital ownership of captive physicians and health plans, a clear conflict of interest;
- Threats and actions against surgeons in allocation of prime operating room times;
- Threats, actions and interference in referral patterns of primary care physicians to specialists.

We are not so naïve as to expect that when we announce to a community the development of a new competing surgical hospital that we will be greeted by a warm handshake and a smile from the existing acute care hospital. But we have been surprised and disappointed by the antagonistic and sometimes irrational conduct we have encountered. For example:

- Logan, Utah – Logan Regional Hospital is an Intermountain Healthcare ("IHC) hospital located in northern Utah. When faced with competition from a new surgical hospital, Logan Regional used its size and contracting power as a member of IHC to confront the competitive threat. Logan Regional and IHC, with control of approximately 75% of the HMO plan non-governmental enrollees in the state, became very punitive in contracting with payers that dared contract with the surgical hospital. IHC restricted access to its primary care network, which effectively limited payers to one hospital in the Logan market – Logan Regional Hospital. The surgical hospital is now denied access to the enrollees under contract with the IHC health plans and has few independent payers which are willing to forego the exclusive IHC contract in order to contract with the surgical hospital. This has meant increased costs for payers contracting with the surgical hospital, an increase in the payers' rates and ultimately has led to IHC Health Plans capturing m ore market share through their less expensive products. [1] IHC is also heavily involved in the employment of primary care physicians and specialists in an effort to control the referral base for its hospitals. They employ over 67% of the internal medicine physicians, 58% of the family practice physicians and 57% of the pediatric physicians in the Logan area. Non-

[1] Intermountain Healthcare is the dominant healthcare provider in the Utah and engages in an aggressive vertical integration model of health care delivery. IHC Health Plans control 60.3% of the total HMO enrollees in the state and through affiliated plans control an additional 15.5% of the market. These plans enter exclusive contracts with the local IHC hospitals and structure benefits in such a way as to make out-of-network utilization very onerous on the enrollees.

IHC primary care physicians have great difficulty contracting with IHC Health Plans unless they support the IHC system.

- Coeur d'Alene, Idaho – When Kootenai Medical Center learned that several physicians on it medical staff intended to partner in development of a surgical hospital the reaction was open hostility. The Board, acting under questionable authority, passed "resolutions" and adopted "conditions to maintain privileges" threatening physicians with expulsion from the medical staff because of their investment decisions with no regard to their professional performance. Physicians have been ordered by hospital administration to disclose all financial relationships with competing facilities so that the hospital may use this information in its credentialing process. The threat and loss of privileges at the only hospital in the community (the next closest general acute care hospital is in Spokane, Washington) could have a devastating impact on a physician's practice. In the meantime, the hospital is aggressively recruiting its own specialists into the community to compete directly with certain of those specialists who have invested in the surgical hospital.
- Durham, North Carolina – Duke University Medical Center controls over 98% of the surgical market in the Durham, North Carolina area. The sole competitor is a small privately owned specialty surgical hospital which operates within a 77 year old leased facility. The owners of the specialty surgical hospital, seeking to deliver existing surgical services in a replacement facility that will meet current health and building codes, applied to the state CON authority for permission to relocate existing operations. The specialty hospital sought permission to provide the same services at approximately the same capacity level (one additional OR was requested) in a new location and facility. The response from Duke University Medical Center was open aggression. Duke marshaled its resources to contest this facility upgrade knowing that if it could lock the specialty hospital into its existing 77 year-old facility it may eventually suffocate this remaining source of competition. Duke University Medical Center then sought to exert more economic pressure on orthopedic surgeons who own an interest in the specialty surgical hospital by threatening to cancel their staff privileges at Durham Regional Hospital. (Durham Regional operates under the control of Duke.) No reason was given for the cancellation of privileges other than the surgeons' ownership in a competing facility. Additionally, Duke University Health System hired five orthopedic surgeons to directly compete with, and as Duke stated, close the practice of the orthopedic surgeon owners. Finally, Duke has provided in their lease agreement with the county that they can relocate any services from Durham Regional Hospital to Duke University Medical Center. If this occurs for surgical services, the community surgeons will be forced to pay 12% of their gross revenue to Duke as an "educational fee" if they want to perform surgery in a Duke facility.

This opposition to specialty hospitals and their physician owners is not isolated to a few local anomalies. Opposition has become an intense and public effort by such large and well-funded organizations as the California Healthcare Association and the American Hospital Association. For example, the 2003 State Advocacy Priorities of the California Healthcare Association include an effort to, "*Sponsor legislation to restrict future physician investment in specialty hospitals in California.*" This is legislation that has

now been introduced, along with another bill to saddle a surgical hospital that sees only elective (non-emergency) cases with a full service (whatever that means) emergency room. The American Hospital Association approach is an attempt to artfully regulate and encumber specialty hospitals such that operational and ownership efficiencies and freedoms are eliminated. The AHA, waving the rather disingenuous banner of "patient safety and quality care" advocates a regulatory constriction upon specialty hospitals which, if successful, will burden us with the same costly and resource consuming inefficiencies as they now bear.

The harsh reality for the large hospitals and their trade associations is that the healthcare marketplace is changing. For years they have been protected by state laws and other economic barriers to entry. Fortunately for consumers, specialty hospitals have worked through many of those barriers and offer a viable alternative for at least some healthcare services. As FTC Chairman Timothy Muris has said, "Vigorous competition can be quite unpleasant for competitors. Indeed, as Judge Easterbrook noted in *Ball Memorial*, 'competition is a ruthless process.' Yet ruthless competition is exactly what the drafters of the Sherman, Clayton, and FTC Acts mandated when they wrote these three statutory charters of economic freedom."

National Surgical Hospitals hopes that the Department of Justice and Federal Trade Commission will take note of these concerted efforts by large hospitals and associations to impede, if not eliminate, the development of specialty surgical hospitals. Just as the development of the ambulatory surgery center industry was at first opposed (but later embraced) by hospitals, they are now opposing the next innovation in the delivery of surgical care, unless of course it is they and not a new competitor who are developing the specialty surgical hospital. The old-line establishment of health care cannot be so parochial as to believe that blocking progressive forms of health care delivery is in the best interests of our nation, our communities or our patients.

IV. Specialty Hospital Fact and Fiction

The spirited debate over specialty hospitals has led to the propagation of much misinformation and half-truths about these facilities and their owners by those opposed to their proliferation. Some of these topics have been addressed at the FTC/DOJ hearings and so it is appropriate that they are mentioned here. These are the more prevalent of the specialty hospital "myths" and misconceptions that opponents promulgate.

1. The "De Facto" Exclusive Contract. Specialty hospitals opponents suggest that physician ownership in specialty hospitals creates a de facto exclusive contract requiring the physician-investor to bring all of his/her cases to the specialty hospital. No such contract exists. Rare is the physician that could bring all of their cases to a specialty surgical hospital. Certainly some cases do leave the existing acute care hospital but almost all surgical hospital physicians continue to do a large percentage (often more than 50%) of their inpatient cases at the incumbent hospital. In fact, some physician-investors never bring a case to the specialty surgical hospital. The specialty surgical hospital has no legal means of compelling physician-investors to bring cases. Those decisions are made by the

physician and patient based on clinical and patient care and/or convenience factors.

2. Physician Ownership Creates Unacceptable Conflicts of Interest. Physician ownership of healthcare facilities has a long and productive history in medicine. Who better to own a hospital and participate in its operation and governance than physicians that provide services there? Federal law explicitly allows for physician ownership of hospitals and ambulatory surgery centers, so long as it is properly structured and managed. While there is some evidence of past over-utilization abuses by a small minority of physicians, the perception has been far worse than the problem. Historically these problems have been limited to ancillary healthcare services in facilities in which physicians held an ownership interest. These problems have been addressed quite well by the existing Stark laws. There is little or no basis to claim that the same kind of abuses have occurred in facilities in which the physician personally performs surgery or like procedures.

   The arguments advanced by large acute care hospitals for stopping physician ownership is greatly undermined by the practices of many hospitals in using physician self-referral to their advantage. These hospitals conveniently ignore the inherent conflict of interest they create when they employ physicians, or own physician practice groups. They aggressively incentivize and seek to control the referral patterns of physicians in their employ or under their ownership to assure that the physicians are referring patients exclusively to their hospital or to other physicians that use their hospital. Is there a greater conflict of interest then that created by the acute care hospitals in "owning" physicians, manipulating their referrals and controlling their compensation?

3. Physician Ownership is Inherently Bad. While the AHA and other hospital associations are preaching the ills associated with physician ownerships, their members are participating in joint ventures which provide physicians ownership in specialty hospitals and ambulatory surgery centers. The large acute care hospitals live a double standard by claiming that physician ownership is fraught with problems of self-referral and unsavory influence yet actually participating in joint ownership with physicians in healthcare facilities. Approximately 10% of specialty hospitals are jointly owned by hospitals and physicians. Apparently there is "bad" physician ownership and "good" physician ownership and the sole differentiating factor is whether the acute care hospital can profit by the arrangement.

4. Community Hospitals Are Failing Because of Specialty Hospitals. Specialty hospital opponents claim that specialty hospitals are taking only the profitable cases out of community hospitals and leaving them to suffer financially. This is a re-tread argument intended to scare policy makers into protecting the community hospitals from competition. It has been used in the past to argue against ambulatory surgery centers. The problem with this argument is that it is simply not supported by facts. The acute care hospitals' claims are usually worded in terms of what "might" or "could" harm community hospitals and cause

them to restrict services and fail. The potential threats that are conjured by specialty hospital opponents are many but their factual support is nil. Opponents are unable to bring forth evidence of actual adverse occurrences despite the fact that there are nearly 100 specialty hospitals operating in the U.S. and some have been around for decades.

V. Support of FTC Position on Competition in Health Care

In November 2002 FTC Chairman Muris reaffirmed the Commission's "*commitment to vigorous competition*" in the health care field. We of the specialty surgical hospital industry agree with Chairman Muris' position that, "*the FTC's basic task remains the same as it has always been. [E]nsuring that the approximately 15% of our nation's GDP devoted to health care,...is spent in robustly competitive markets. Aggressive competition promotes lower prices, higher quality, greater innovation and enhanced access.*" Specialty surgical hospitals are at the forefront of health care innovation and we are delivering on the promise of high quality surgical care at lower overall costs.

The anticompetitive position of the large established acute care hospitals is counter to the established policy the both the FTC and Department of Justice to protect competition, not competitors. These hospitals ask that the US government be complicit in their favored form of market allocation. They want to block entry of new competitors in their profitable market lines so that they can subsidize their unprofitable operations. This would not be tolerated in any other industry and should not be sanctioned in health care. The fact that existing hospitals operate in a broken reimbursement system that favors some medical services over others does not justify ignoring basic and essential laws of competition.

We believe the enforcement and policy decisions of the Commission and the Department of Justice should be guided by words of former FTC Commissioner Roscoe B. Starek, III. He said, "[T]*he Commission does not favor one type of health care delivery system over another. Rather, we work to keep markets open to new and existing competition so that consumers and providers can make their economic decision.... The Commission seeks to ensure that delivery systems may develop and grow if they meet the preferences and needs of consumers, and that anticompetitive behavior does not impede the development of health care alternatives."(Emphasis added)* This must be the position of federal and state policy and enforcement agencies if we are to realize the full promise of specialty surgical hospitals. We encourage the FTC and Department of Justice to actively promote innovation in the delivery of surgical care by doing everything possible to stop anticompetitive conduct that threatens the viability of specialty surgical hospitals.

Thank you

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