November 25th, 2003

Donald S. Clark
Office of the Secretary
Federal Trade Commission
600 Pennsylvania Avenue NW
Washington, DC 20580

RE: Comments Regarding Health Care and Competition Law and Policy

Dear Special Counsel Hyman:

The National Women's Law Center is a Washington, D.C. based, nonprofit, public interest advocacy group. For over thirty years, the Center has worked to end discrimination against women and girls in all aspects of their lives. In an effort to protect access to health care in rural, urban, low-income and minority communities, the Center has developed innovative and practical responses to the problem of health care provider mergers and sales that threaten to eliminate women's reproductive and other health services. The Center also identifies barriers to services resulting from religiously affiliated providers, and solutions to increase access, and has issued reports on these legal strategies, including consumer protection, charitable assets, and antitrust theories.[1] The Center has assisted communities in protecting access to affordable, high-quality, comprehensive health care, and works with a wide range of partners in these efforts, including providers, local, state and national advocates, and governmental officials.

Additional endorsers of these comments and recommendations include the Citizen Advocacy Center, Community Catalyst, Consumer's Union, MergerWatch, and the National Health Law Program. A description of each of these organizations and their respective interests in these hearings is attached as an Appendix.

Center staff had the opportunity to attend the Federal Trade Commission and Department of Justice Hearings on Health Care and Competition Law and Policy ("the Hearings") held throughout 2003, and are encouraged by the efforts of the Federal Trade Commission and Department of Justice ("the Agencies") to revisit some key issues in

[1] *Truth or Consequences: Using Consumer Protection Laws to Expose Institutional Restrictions on Reproductive and Other Health Care* (2003); *Hospital Mergers and the Threat to Women's Reproductive Health Services: Using Charitable Assets Laws to Fight Back* (2001); *Hospital Mergers and the Threat to Women's Reproductive Health Services: Using Antitrust Laws to Fight Back* (1998). All are available at www.nwlc.org.

health care competition. We share the Agencies' concern that consolidation is resulting in increased costs and decreased competition, and reducing consumer access and the quality of care. We also agree with the Agencies' focus on patient-centered care and consumer information as ways to improve consumer decision-making and health care delivery. We submit these comments to highlight certain issues of interest to our organization and others on health care access, consumer information and quality of care. Some of these issues were touched upon during the Hearings, but many were not. We thank you in advance for your consideration and incorporation of these comments in drawing conclusions from the Hearings of the past year. We hope to assist you in any way possible in moving forward to protect and advance the interests of our nation's health care consumers.

Our comments and recommendations are summarized as follows:

1. The growth of religiously affiliated providers, including hospitals and insurance companies, is resulting in reduced access to reproductive health care, and contributing to serious health disparities. The Agencies should pay special attention in the course of reviewing proposed mergers and sales to restrictions on services used by most women for almost half of their lives, and seek to preserve consumer choice and access. Communities are also in need of greater post-transaction enforcement of hospitals' assurances regarding service access and availability that were made in order to get approval from state and federal authorities and gain community support.

2. Restrictions on access to reproductive health care present a serious barrier to women, hinder informed decision-making, diminish the quality of care provided, and result in health care fragmentation. The Agencies should seek to improve information on reproductive health service restrictions among health care providers, and in both the Medicaid program and private insurance markets.

3. The impact that the growth of large, religiously affiliated health care systems is having on women's ability to access reproductive health care and other services must be assessed. Five of the nation's ten largest nonprofit health systems (ranked by patient revenue) are Catholic sponsored, and ban the provision of basic reproductive health services that are used by the majority of women. The market power held by these large systems is straining unaffiliated hospitals' ability to remain competitive and to access low-cost capital. Unable to compete effectively, nonsectarian, unaffiliated hospitals are increasingly finding it necessary to join these religious systems, with the result being a loss of services.

4. Reproductive health care provides an important lens through which to consider issues of consumer information, quality care and patient-centered care. Data collection, quality surveys and research on patient interactions should include reproductive health care information and indicators in order to advance the Agencies' understanding of patient-centered care and health care decision-making.

I. Our Interest in the Hearings

A. Health care competition and the impact on access to reproductive and other health care

Rapid consolidation of hospitals and health plans in the 1990s dramatically changed health care in this nation. Religiously affiliated hospitals and health care systems were, and remain, influential players in the shifting market. When religiously owned hospitals, HMOs, or other health care entities merge with secular institutions, reproductive and other health services are often eliminated because of conflict with religious doctrine. While many religious denominations operate health care facilities, the largest number of hospitals, and those with the broadest restrictions on procedures are Catholic affiliated. Catholic hospitals constitute twelve percent of all U.S. hospitals, serving twenty percent of all Americans, according to the Catholic Health Association of the United States. Half of the ten largest health care systems are Catholic, as of 2002 (the most recent data available from Modern Healthcare). While the largest number of these transactions occurred during the "merger mania" of the 1990s, restricted systems continue to merge and purchase hospitals and are still growing larger. The merger wave also contributed to many hospital closures, as some systems could not sustain their growth. This left many communities, disproportionately urban and minority, without access to a nearby hospital.

Restrictions on services are set forth in the *Ethical and Religious Directives for Catholic Health Care Services* ("the *Directives*"), issued by the United States Conference of Catholic Bishops.[2] The *Directives* restrict contraceptive services and counseling, male and female sterilization, and access to emergency contraception for rape victims seeking treatment in emergency rooms.[3] Other reproductive health services that are not as commonly provided in hospitals but are also forbidden include fetal or stem cell research or treatment, and abortion. Because infertility treatments are forbidden, cancer patients of reproductive age may not be able to receive fertility-preserving treatments, such as sperm or egg harvesting. The patient may not be counseled about these options or referred to alternative providers, as the *Directives* forbid assisting in the procurement of banned services. Women's access to clinical trials and research is also limited, because many protocols require the use of contraception, which is forbidden by the *Directives*. The *Directives* also prohibit counseling individuals with HIV/AIDS or STDs on the use

[2] The *Directives* can be found at http://www.usccb.org/bishops/directives.htm.

[3] When taken within 72 hours of unprotected sex or birth control failure, Emergency Contraception can reduce the risk of pregnancy by up to 89 percent. Currently, the U.S. Food and Drug Administration (FDA) has approved two prepackaged forms (Plan B and Preven), though various combinations of ordinary oral contraceptives can also be used. The drug has no effect on an established pregnancy, and should not be confused with medical abortion.

While *Directive* 36 appears to allow the treatment for rape victims, surveys indicate that the vast majority of Catholic hospitals refuse to provide it or inform victims of it. Other hospitals will give a woman an ovulation test to see if she is likely to get pregnant at that time. If she <u>is</u> ovulating, then they will <u>not</u> give her Emergency Contraception. Of course, this is when the rape victim would be at the highest risk of pregnancy and most in need of the treatment.

of condoms to prevent the spread of disease. The *Directives* require providers to ignore any patients' end-of-life wishes that conflict with the *Directives*. These restrictions extend to the medical staff at these hospitals, with hospitals often requiring staff to sign a statement agreeing to abide by the restrictions.

The wide scope of these restrictions, their role in limiting access to health care, and their impact on women's health is largely unknown to the general public, and even those familiar with the hospital industry. One presenter at the Hearings dismissed the issue of structuring affiliations between religious and non-sectarian hospitals in a manner that would save reproductive health services, concluding that it was easier to just fully merge the hospitals. The presenter stated, "what it really means is that the merged entity couldn't involve itself in sterilizations and abortions and probably most hospitals in this country can get away with that, without doing that and still live."[4] The common misconception is that restrictions only extend to sterilization and abortion. Health care restrictions by religious providers forbid a whole host of commonly used services, leaving many women without access to basic health care. For a woman who chooses post-partum sterilization, not having access to a hospital that will provide this service is no mere inconvenience. If she is unable to have the procedure after delivery, she is subject to additional anesthesia, another recovery period, and time away from her family, including her new infant. A woman receiving Medicaid typically loses eligibility 60 days after giving birth, so she may find herself without insurance coverage for the surgery if she is not able to have it at the time of her delivery. The impact of restrictions on reproductive health is broad, and felt most harshly by low-income, minority and young women.

B. The importance of reproductive health care access to women's health

Women's reproductive health is important to women's overall health, and is recognized as a national priority. Family planning services, including contraception and access to surgical sterilization, are given preferred status in our nation's Medicaid program. These services are reimbursed at a higher rate than other services, and the federal government has established programs, such as the Medicaid Family Planning Waiver, to ensure that Medicaid eligibility is expanded to women who want these services but who do not otherwise qualify for Medicaid. Family planning has been recognized as a crucial component in improving the nation's health by Healthy People 2010, an effort by U.S. Department of Health and Human Services to reduce health disparities, as well as the U.S. Preventive Services Task Force, and the Institute of Medicine. Racial and ethnic disparities in key health indicators including maternal and infant mortality, STDs and HIV, and unplanned pregnancy are directly linked to reproductive health care access.

[4] Hearings on Health Care and Competition Law and Policy, Hospital Joint Ventures and Joint Operating Agreements, remarks of William G. Kopit, Epstein, Becker & Green (Apr. 10, 2003). While it is true that abortion is not typically a hospital based service, women with severe and life threatening health complications still require access to a hospital that will allow the procedure.

It is well established that family planning benefits women's health, as well as infant health. Pregnancy spacing, management of conditions impacting mother and child, and improved prenatal care all result from access to reproductive health care and family planning. Use of contraception greatly reduces unplanned pregnancies and abortions. Furthermore, without some use of contraceptives, a woman could expect to bear 13-15 children in her lifetime, presenting a tremendous toll on her physical health and the well-being of the family. According to the Alan Guttmacher Institute, over 65 million women in the United States are between the ages of 13 and 44, are sexually active and do not wish to become pregnant, providing some indication of the need and use of family planning services.

National efforts to allow women to designate an obstetrician/gynecologist as a primary care provider, or to provide direct access to an obstetrician/gynecologist without approval from a primary care provider illustrate that for almost half a woman's lifespan, reproductive health care is her entrance to health care. A visit to the gynecologist may be a woman's one opportunity to receive screenings for cholesterol and blood pressure, a breast exam, and counseling on preventive measures such as smoking cessation, better nutrition and physical activity. This contact is an important step in reducing the leading killers of women, including cardiovascular disease and cancer.

II. Hospital Mergers, Sales and Other Transactions and the Impact on Reproductive Health

The imposition of religiously based restrictions on reproductive health care is limiting access to health care and consumer choice in selecting physicians, hospitals, and insurance companies. Advocates are concerned with the same issues that drove the development of these Hearings: increased prices, limited consumer choice, and hospital closures that leave communities without care. The growth of Catholic health care systems has allowed their hospitals to drive out or purchase independent competitors, because they are supported by large systems that can absorb the losses of one financially weak hospital until the system is able to gain market power in that area and increase prices. This not only reduces competition, but it presents severe limitations on access for communities, and disproportionately these communities are low-income and minority communities. Furthermore, some Catholic hospital systems will refuse to sell their hospitals to any buyer who does not commit to limiting access to services as required by the *Directives*.[5] This precludes an open and competitive bidding process in which the community can be sure they are getting full fair market value for their nonprofit charitable hospital.

[5] The Carondelet Health System required Tenet Healthcare Inc. to abide by the *Directives* in its 2001 sale of Daniel Freeman Memorial Hospital in Inglewood, California. Also in 2001, the Intracoastal Health System required bidders for St. Mary's Hospital in West Palm Beach to adhere to the *Directives*, and chose Tenet as the purchaser.

A. Hospitals are getting increasingly creative in structuring transactions to avoid state and federal oversight

Hospitals and health care systems are becoming more creative in structuring their transactions for the specific purpose of avoiding routine state and federal review under antitrust laws and other laws regulating hospitals and nonprofit institutions. In addition to not wanting the delays and expense that come with such reviews, hospitals are denying communities legally required opportunities for notice and input that are also a part of these reviews.[6] As communities, women's groups, civil rights organizations and health care advocates become aware of the impact of these transactions and organize resistance, there will likely be an even greater incentive to avoid federal and state oversight and public notice of these transactions. This is to the detriment of competitors and consumers, whom such oversight is intended to protect. Agencies charged with reviewing these transactions and enforcing the laws must respond aggressively in order to intervene when hospitals and health care systems devise measures to avoid oversight.

B. Joint ventures remain an important solution for hospitals wishing to reduce costs and maintain their institutional identities

The panel of March 27th, 2003, focused on contracting practices, including joint ventures and the potential for anticompetitive conduct. Joint ventures have been used specifically to preserve services while allowing religious and nonsectarian hospitals to streamline other functions to improve efficiency and reduce costs. One panelist cited the Vassar/St. Francis joint operating agreement (JOA),[7] a case of special interest to the Center and its allies. In 1992, Vassar and St. Francis hospitals in upstate New York entered a JOA to provide certain cardiac and diagnostic services. This arrangement, labeled a "virtual merger," also allowed the secular hospital to continue providing reproductive health services. The community viewed this as an excellent solution.

This "virtual merger" was challenged for reasons unrelated to the compromise worked out regarding services. In July 2000, the state Attorney General obtained a court order dissolving the collaboration because the hospitals had gone beyond the scope of the JOA, fixing prices and allocating other services in violation of antitrust laws. Neither the Attorney General nor the court challenged the agreement to continue reproductive health services.

Clearly, joint ventures involving nonprofit hospitals require special oversight, including assurances that nonprofits are not being converted to for-profit businesses, transferring assets from their designated charitable use and away from the community while still being allowed to reap the tax benefits. We encourage the Agencies to provide

[6] Such requirements are often contained in state Certificate of Need laws, Department of Health regulations, and conversion statutes.

[7] New York v. Saint Francis Hosp., 94 F. Supp. 2d 399 (S.D.N.Y. 2000); *see also* State of New York ex rel. Spitzer v. Saint Francis Hosp., 2000-2 Trade Cas. (CCH) ¶ 72,960 (S.D.N.Y. 2000) (final consent judgment entered June 20, 2000).

appropriate review of proposed joint ventures, and trust that they will continue to support arrangements that save services. We hope that the Agencies do not look unfavorably among such arrangements when the hospitals comply with the terms of their agreement, maintain their function as nonprofit charitable institutions, and follow the Agencies' Guidelines on such arrangements.

C. Post-merger behavior

The Hearing's session on post-merger behavior was of special interest to the Center and its allies. We have observed that hospitals make promises to maintain services in order to gain state and federal approval and assuage communities, but often do not keep these promises. Religious and nonsectarian hospitals have specifically stated to communities that they would affiliate–but would not consolidate departments or restrict services—in order to avoid community opposition or evade close governmental scrutiny. There have been several cases where affiliated hospitals have consolidated obstetrics/gynecology departments, leaving the religiously restricted partner in charge of those departments and eliminating access to routine services. These consolidations came after the hospitals assured communities that women's access to comprehensive reproductive health care was secure.[8] Hospitals have merged, assuring communities that they would notice no change in the operation of the hospitals, yet confusion over services and policies eventually had a devastating impact on the lives of patients.[9]

Hospitals often rely on community presumptions made about their nonprofit status when trying to lessen resistance to mergers or purchases. One incorrect presumption, raised during the April 10th, 2003 session, is that nonprofits act in the interest of communities and the poor, and do not exhibit the same profit maximizing behavior as for-profits. Another common misconception, also raised during that session, is that a nonprofit hospital is locally owned and controlled by board members with a real understanding of

[8] MergerWatch, an advocacy group that follows such transactions, has documented consolidations or the elimination of services in Niagara Falls, New York (attempt to consolidate services to restricted partner after an affiliation); Paris, Texas (attempt to remove maternity ward from unrestricted partner in an affiliation); West Palm Beach, Florida (plan to close maternity ward at non-restricted partner); and Long Beach, California (eliminated emergency contraception and sterilization after the purchase of a community hospital).

[9] In Manchester, New Hampshire, the 1994 merger of Catholic Medical Center and Elliot Hospital into Optima Health resulted in confusion over what services were allowed at Elliot. This conflict ultimately resulted in a patient being denied an emergency abortion required by severe fetal complications because the patient was not yet suffering from an infection, although that was the inevitable progression of her condition. She was put in a cab by her treating physician and sent 80 miles away to have the procedure. Ralph Jimenez, *Abortion Dispute Hits N.H. Hospital*, BOSTON GLOBE, May 23, 1998, at B1.

These concerns resulted in a 1998 Attorney General investigation, which found that the hospitals' failure to consider the impact of the merger on their respective charitable missions, and failure to consider the community impact or seek input required the hospitals to revisit these issues. Independent boards of the hospitals determined that they could not maintain the merger and still meet their individual missions. The hospitals separated in 2000. New Hampshire Attorney General's Report on Optima Health (Mar. 10, 1998), available at http://doj.nh.gov/publications/optima1.html.

community needs. This is often not the case due to nonprofit systems' ownership of hospitals that may be located in another state or on the opposite coast. In fact, shortly after this issue was addressed at the Hearings, the South Dakota Supreme Court found that the sale of a system's non-profit hospitals to an out-of-state system resulted in the transfer of its assets outside of the community, resulting in a breach of the nonprofit's charitable trust and duty to use its assets to serve the local community.[10] Religiously owned hospitals enjoy an even higher degree of public trust, confidence and good-will, and the presumption that they are locally owned and controlled.

By the time communities become aware of the hospitals' actual plans and the potential impact on access, federal and state authorities have completed their reviews of the transaction or no longer have the authority to intervene. Fortunately, increased community awareness is resulting in greater input and communication with hospitals on the terms and impact of mergers and sales. Authorities should find a way to insure that promises made to temporarily appease communities are actually kept. Hospitals rely on the fact that limited state and federal resources do not allow for vigorous review and enforcement of post-merger conduct, and their broken promises are taking a toll on access to health care. The efforts of the Agencies to take a second look at some of these transactions presents a great step forward in putting hospitals on notice that they have a duty to keep the promises made to gain state and federal approval or community support.

III. Consumer Protection Concerns: Improving Information and Quality of Care

A. Women do not have the information they need to make important health care decisions

For women's health advocates, the focus on consumer information is an especially important aspect of the Hearings. The May 30th, 2003, discussion directly raised the issue of outside influences standing between patient information and high quality care. A well documented barrier to reproductive health services is lack of information about such services, including options for treatment. Providers are under both legal and ethical duties to provide informed consent. Other state and federal laws require disclosure of institutional restrictions, referrals to alternative providers when invoking moral or religious objections to services, and compliance with unfair and deceptive advertising laws.

The *Directives* (described in Part I.A.) virtually require providers to breach these legal and ethical duties. Because certain treatments and services cannot even be discussed—such as contraception, sterilization, HIV/STD prevention methods, and infertility services—when a patient presents with symptoms or concerns where such options may be medically indicated, a health care provider cannot fully inform a patient of his or her options. While the *Directives* do allow for rape victims to be treated with Emergency Contraception, surveys reveal that victims presenting in emergency rooms at Catholic

[10] Banner Health System v. Lawrence E. Long, 663 N.W.2d 242 (S.D., 2003).

hospitals are often not told about the treatment and its effectiveness at reducing the risk of pregnancy, or where they could possibly receive it.[11]

Moreover, numerous studies reveal that individuals are not aware of the scope of these restrictions, or that the religious affiliation of their hospital or health plan may mean that they are not told of the full range of treatment options. Indeed, the religious affiliation of some hospitals is not apparent. After a merger or sale, the newly-religious entity may continue to use the name of the nonsectarian facility or may adopt a new name that gives no hint of a religious affiliation. Most troubling, a woman may not choose which hospital she is taken to by ambulance when she is sexually assaulted, leaving the quality of her treatment completely to chance. Surveys indicate that while up to 68% of women are aware of emergency contraception, young women and minority women are far less aware of the treatment, with one study finding that only five percent of teens at an urban clinic had such knowledge. These young women are therefore relying on providers to tell them of its availability, or be placed at an increased risk of pregnancy resulting from rape.

Another concern about consumer education in health care is the selection of health insurance plans and managed care. Advocates are especially concerned with restricted managed care plans' participation in Medicaid managed care. Medicaid serves predominately women of childbearing age. Catholic owned health plans participate in Medicaid managed care, but many plans do not provide the services that the Medicaid program requires be covered. Instead, women in these plans must use their Medicaid cards to get reproductive health services from a provider that accepts Medicaid. This requires knowledge about their ability to go "out of network," and a degree of health system literacy which many beneficiaries do not have. Transportation, work schedules, child care and language present additional barriers. Even when a woman manages to get these services, this still represents a fragmentation of health care, requiring her to see more than one provider.

Furthermore, many Medicaid managed care beneficiaries are automatically assigned to health plans that do not provide reproductive health services, and changing plans once enrolled is not a simple matter. Because religiously affiliated plans are nonprofit, they are given advantages by the state, and get more than their fair share of default enrollees (Medicaid beneficiaries who do not select a plan). Two measures would go far in assisting these women in getting accurate information and making more informed choices for themselves and their families: federally imposed clear disclosure about health plans' restrictions on services, and the elimination of state's default enrollment preferences for insurance plans that refuse to provide services required for participation in the Medicaid program.

Consumers within private insurance markets may not fare much better. Many women presume that if their health plan covers a service, then the health plan also includes somewhere within its network a provider where they can receive the service. This is not always the case. Women may find themselves locked into a health plan or committed to

[11] See note 3.

a hospital or physician that does not provide them with the care that they need, and that their insurance covers. While it cannot be expected that a provider directory would list every service that is or is not provided, reproductive health services are used by over half of the population for almost half of their life spans. It is essential that health plans let women know if certain providers will deny them access to these basic services.

B. Federal efforts to improve data collection, health care quality and consumer satisfaction should include basic preventive reproductive health services

The May sessions highlighted many efforts underway to increase the Agencies' understanding of how consumers receive information and use it to make health care decisions. Speakers also highlighted the consumers' role in assisting the government in developing measures of quality health care. We would encourage that these efforts incorporate surveys, indicators and data collection on women's reproductive health services, and the extent to which people are aware of any restrictions on their access to care, including religiously based restrictions.

The availability and accessibility of such services, and the consumer information available to women to make decisions about their reproductive health care, are of paramount importance to women's health. Just as the Hearings included specific areas of specialty care and services such as assisted living, end-of-life and vision correction surgery, women's health care also provides another lens through which to view the impact of consumer information on quality and access.

An obstetrician/gynecologist is allowed to be a woman's primary care provider in her managed care plan in the majority of states. This means that the reproductive health care provider is many women's entry into the health care system. Any tools developed to compare health plans should include specific information on access to reproductive health care providers and routine services, including gynecological screenings and family planning. In order to improve quality and access to care, it is essential that the Agencies identify barriers to women's access to reproductive health care, including plans, systems and providers that refuse to perform these common services.

As the primary health care decision-makers for their families, an analysis of women's information, processing and selection of health plans with regard to reproductive health services could provide much needed information on consumer behavior generally. Additionally, the development of quality measures on reproductive health care would enhance women's and children's health. Quality measures would also ensure that the one contact that many women have with a provider enhances her health.

The reproductive health visit is also an ideal interaction in which to analyze issues of communication, exchange of information and listening, all identified by experts at the Hearings as key components in evaluating the provider/patient relationship. The discussion of May 30th, 2003, touched upon ways to improve quality and patient focus. Because many gynecological and obstetrical visits are for preventive care and routine

screenings, and not to address a particular illness, these exchanges could possibly shed light on interactions that are patient-focused, rather than illness-focused. Experts have clearly identified a need for patient-centered care, so the reproductive health care visit may provide some useful information for other types of health care interactions. We would encourage the further study of these interactions to improve the quality of reproductive health services, and in turn, women's overall health.

Conclusion

We are encouraged by the Agencies' greater attention to the behavior of nonprofit hospitals, assumptions made when reviewing transactions involving nonprofits, and their impact on health care markets. We believe that greater attention must be paid to the impact of the aforementioned restrictions on services, the resulting limitations on access to reproductive health care in communities, and the impact on women's health. The growth of Catholic health care systems is severely curtailing access to services used by women for almost half of their lives. Lack of information about these restrictions impacts a woman's ability to make informed decisions about her health care.

We thank you for your efforts to seek input from a diverse array of stakeholders and look forward to findings that reflect a wide range of concerns on access and quality. If you would like to discuss these comments further, or seek any supporting documentation, please do not hesitate to contact us.

Sincerely,

/s/

Judith Waxman
Vice President for Health and Reproductive Rights

/s/

Jill C. Morrison
Senior Counsel

On behalf of these additional organizational endorsers:

David A. Swankin
President and CEO
Citizen Advocacy Center

Dawn Touzin
Director, Community Health Assets Project
Community Catalyst

Laurie Sobel
Senior Attorney
Consumers Union

Lois Uttley
Vice President and Director
MergerWatch

Lourdes Rivera
Managing Attorney
National Health Law Program

APPENDIX
DESCRIPTION OF ENDORSING ORGANIZATIONS AND THEIR INTEREST IN THE HEARINGS

The Citizen Advocacy Center

The Citizen Advocacy Center is a nonprofit training and support program for public members serving on health care regulatory agencies, governing boards and advisory bodies as representatives of the consumer interest. While CAC was created to maximize the leverage of public members, our services and publications are available to and valued by all members of health care regulatory and governing boards and by the executives and attorneys who staff these institutions. CAC's is interested in the hearing's role in improving consumer information and input in the health care system.

Community Catalyst

Community Catalyst is a national advocacy organization that builds consumer and community participation in the shaping of our health system to ensure quality, affordable health care for all. We work with state and local advocacy groups to expand health care access, especially for the uninsured and medically underserved. We help advocates analyze public policy; educate the public; influence regulators and other public officials; negotiate with health care institutions; and secure public policy changes. Through our Community Health Assets Project (CHAP) we help advocacy groups protect health care services and community health assets when hospitals and health plans become for-profit, or otherwise change hands. Ensuring that access to needed services is not limited or eliminated is an important community asset we seek to preserve.

Consumers Union

Consumers Union is a national nonprofit membership organization chartered in 1936 to provide consumers with information, education, and counsel about goods, services, health, and personal finance. We work to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union has been monitoring the sale and conversion of nonprofit health care corporations for over seventeen years. Over the past six years, Consumers Union, along with its partner organization Community Catalyst, has assisted consumer groups, legislators, regulators, courts, and Attorneys General reviewing these transactions in more than 40 states.

MergerWatch

MergerWatch is a project of the Education Fund of Family Planning Advocates of New York State. MergerWatch monitors the threats to reproductive health care from mergers and other health care industry transactions through which restrictive religious rules are placed on previously secular providers and services are banned. MergerWatch works to educate the public and policy makers about the threats posed by religious health

restrictions and provides assistance to community groups working to preserve reproductive health services when their community hospital proposes adopting such restrictions in order to enter into an affiliation with a religious hospital or system.

National Health Law Program

The National Health Law Program is a non-profit law firm that provides legal and policy analysis to health advocates, policy makers, and the public, focusing on improving health care access for low and limited income people. Our Reproductive Health Project concentrates on assuring that appropriate services are available to individuals on a timely basis, regardless of the setting where those services are being provided. As such, we have a great interest in the hearings.