AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

HEALTHCARE CONSOLIDATION AND COMPETITION AFTER PPACA

HEARING

BEFORE THE

SUBCOMMITTEE ON
INTELLECTUAL PROPERTY,
COMPETITION, AND THE INTERNET

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

MAY 18, 2012

Serial No. 112–121

Printed for the use of the Committee on the Judiciary

Available via the World Wide Web: http://judiciary.house.gov

U.S. GOVERNMENT PRINTING OFFICE

74–262 PDF WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON THE JUDICIARY

LAMAR SMITH, Texas, *Chairman*

F. JAMES SENSENBRENNER, JR., Wisconsin
HOWARD COBLE, North Carolina
ELTON GALLEGLY, California
BOB GOODLATTE, Virginia
DANIEL E. LUNGREN, California
STEVE CHABOT, Ohio
DARRELL E. ISSA, California
MIKE PENCE, Indiana
J. RANDY FORBES, Virginia
STEVE KING, Iowa
TRENT FRANKS, Arizona
LOUIE GOHMERT, Texas
JIM JORDAN, Ohio
TED POE, Texas
JASON CHAFFETZ, Utah
TIM GRIFFIN, Arkansas
TOM MARINO, Pennsylvania
TREY GOWDY, South Carolina
DENNIS ROSS, Florida
SANDY ADAMS, Florida
BEN QUAYLE, Arizona
MARK AMODEI, Nevada

JOHN CONYERS, JR., Michigan
HOWARD L. BERMAN, California
JERROLD NADLER, New York
ROBERT C. "BOBBY" SCOTT, Virginia
MELVIN L. WATT, North Carolina
ZOE LOFGREN, California
SHEILA JACKSON LEE, Texas
MAXINE WATERS, California
STEVE COHEN, Tennessee
HENRY C. "HANK" JOHNSON, JR., Georgia
PEDRO R. PIERLUISI, Puerto Rico
MIKE QUIGLEY, Illinois
JUDY CHU, California
TED DEUTCH, Florida
LINDA T. SÁNCHEZ, California
JARED POLIS, Colorado

RICHARD HERTLING, *Staff Director and Chief Counsel*
PERRY APELBAUM, *Minority Staff Director and Chief Counsel*

SUBCOMMITTEE ON INTELLECTUAL PROPERTY, COMPETITION, AND THE INTERNET

BOB GOODLATTE, Virginia, *Chairman*
BEN QUAYLE, Arizona, *Vice-Chairman*

F. JAMES SENSENBRENNER, JR., Wisconsin
HOWARD COBLE, North Carolina
STEVE CHABOT, Ohio
DARRELL E. ISSA, California
MIKE PENCE, Indiana
JIM JORDAN, Ohio
TED POE, Texas
JASON CHAFFETZ, Utah
TIM GRIFFIN, Arkansas
TOM MARINO, Pennsylvania
SANDY ADAMS, Florida
MARK AMODEI, Nevada

MELVIN L. WATT, North Carolina
JOHN CONYERS, JR., Michigan
HOWARD L. BERMAN, California
JUDY CHU, California
TED DEUTCH, Florida
LINDA T. SÁNCHEZ, California
JERROLD NADLER, New York
ZOE LOFGREN, California
SHEILA JACKSON LEE, Texas
MAXINE WATERS, California
HENRY C. "HANK" JOHNSON, JR., Georgia

BLAINE MERRITT, *Chief Counsel*
STEPHANIE MOORE, *Minority Counsel*

CONTENTS

MAY 18, 2012

Page

OPENING STATEMENTS

Honorable Melvin L. Watt, a Representative in Congress from the State of North Carolina, and Ranking Member, Subcommittee on Intellectual Property, Competition, and the Internet 1
Honorable John Conyers, Jr., a Representative in Congress from the State of Michigan, and Ranking Member, Committee on the Judiciary, and Member, Subcommittee on Intellectual Property, Competition, and the Internet . 6
Honorable Lamar Smith, a Representative in Congress from the State of Texas, and Chairman, Committee on the Judiciary 7

WITNESSES

Edmund F. Haislmaier, Senior Research Fellow, Center for Health Policy Studies, The Heritage Foundation
Oral Testimony 9
Prepared Statement 10
Thomas L. Greaney, Chester A. Myers Professor of Law, Co-Director, Center for Health Law Studies, Saint Louis University School of Law
Oral Testimony 15
Prepared Statement 17
Scott Gottlieb, M.D., Clinical Assistant Professor, New York University, Resident Fellow, American Enterprise Institute
Oral Testimony 79
Prepared Statement 80

LETTERS, STATEMENTS, ETC., SUBMITTED FOR THE HEARING

Prepared Statement of the Honorable Melvin L. Watt, a Representative in Congress from the State of North Carolina, and Ranking Member, Subcommittee on Intellectual Property, Competition, and the Internet 3
Prepared Statement of the Honorable Lamar Smith, a Representative in Congress from the State of Texas, and Chairman, Committee on the Judiciary 5

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Prepared Statement of the Honorable Bob Goodlatte, a Representative in Congress from the State of Virginia, and Chairman, Subcommittee on Intellectual Property, Competition, and the Internet 89
Prepared Statement of the Honorable John Conyers, Jr., a Representative in Congress from the State of Michigan, and Ranking Member, Committee on the Judiciary, and Member, Subcommittee on Intellectual Property, Competition, and the Internet 90
Prepared Statement of the Honorable Howard Coble, a Representative in Congress from the State of North Carolina, and Member, Subcommittee on Intellectual Property, Competition, and the Internet 91
Material submitted by the Honorable Melvin L. Watt, a Representative in Congress from the State of North Carolina, and Ranking Member, Subcommittee on Intellectual Property, Competition, and the Internet 92

Page

Prepared Statement of The Academy Advisors 199
Prepared Statement of Joel C. White, Executive Director, Coalition for Affordable Health Coverage 202
Prepared Statement of the American Medical Group Association (AMGA) 208
Prepared Statement of the Association of American Medical Colleges 210
Prepared Statement of the American Hospital Association 211

HEALTHCARE CONSOLIDATION AND COMPETITION AFTER PPACA

FRIDAY, MAY 18, 2012

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON INTELLECTUAL PROPERTY,
COMPETITION, AND THE INTERNET,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to call, at 11:15 a.m., in room 2141, Rayburn House Office Building, the Honorable Bob Goodlatte (Chairman of the Subcommittee) presiding.

Present: Representatives Goodlatte, Smith, Coble, Adams, Watt, Conyers, Chu, and Johnson.

Staff Present: (Majority) Holt Lackey, Counsel; Olivia Lee, Clerk; (Minority) Stephanie Moore, Subcommittee Chief Counsel.

Mr. GOODLATTE. Good morning. The Subcommittee will come to order.

I want to begin by apologizing for being late getting here and the votes delaying us even further. But I will dispense with my opening statement and incorporate some of those remarks perhaps later when we get to the questioning so we can get right to the testimony of the witnesses.

But first I want to recognize the gentleman from North Carolina, whose son is getting married this weekend. And our full congratulations to him and his family. And it is now my pleasure to recognize him for his opening statement.

Mr. WATT. Thank you, Mr. Chairman.

And I would dispense with my opening statement, but I am a little unhappy with the title to this hearing. It is like the newspaper headline. Maybe the content of the hearing itself will be about something substantive, but I am a little concerned about the title that we put on it. So let me just say a few things.

Consolidation in health care is of utmost importance to me and to my constituents, both in the provider and insurance markets. In North Carolina, a recent investigation by the News and Observer, the Raleigh newspaper, the statewide newspaper, and the Charlotte Observer, the second statewide newspaper, revealed that hospital consolidation has led to huge profits and market dominance for UNC Hospitals, Duke University Health System, and, to a lesser extent, Wake Medical Center.

Hospital prices for patients have soared, while charity services have declined or pale in comparison to the hospital systems' profit margins. According to these news reports, the profits are poured

into fancy facilities, generous compensation packages for executives, and advanced technology that experts say don't always translate into superior health outcomes for patients. And reserves in the billions have been set aside for future purchases, which, according to the investigation, has solidified the market power of these merged entities.

Another side effect of hospital concentration and consolidation is increased bargaining power with insurance providers, because the hospitals are so big they are in a position to negotiate higher reimbursement rates. In North Carolina, Blue Cross has 75 percent of the health insurance market. It reports that its cost per hospital admission surged by almost 40 percent in 3 years, between 2007 and 2010, but the costs are passed on in higher premiums to customers, individuals and businesses alike.

In fact, earlier this month, a prominent attorney filed a class action antitrust lawsuit against Blue Cross Blue Shield of North Carolina, charging that noncompetition practices among its affiliates blocks rival insurers, resulting in accumulation of market power which they exert to demand discounts with hospitals. The Department of Justice is also reportedly investigating whether Blue Cross plans in North Carolina raise health insurance premiums by cutting deals with hospitals to stifle its competitors from negotiating better rates.

So, Mr. Chairman, there is much to examine in the area of healthcare consolidation and competition, but to link examination of these issues to the Affordable Care Act threatens to unnecessarily politicize a crisis that is gripping our communities across the country. And to do so when a decision from the Supreme Court on the constitutionality of the healthcare reform law is expected next month seems misguided and not befitting to the bipartisanship that has characterized this Subcommittee in particular.

I guess the good news for the Obama administration is that even some of those in Congress who oppose the individual mandate and hope that it will be invalidated as unconstitutional believe that the government's severability argument is sound and that the remainder of the law will survive.

The fact of the matter is that hospital consolidation began long before the Affordable Care Act. The market muscle of insurers, including healthcare insurers, has been made possible in part due to the McCarran-Ferguson exemption from antitrust laws, which, of course, was in place long before healthcare reform. The trend in hospitals merging with other hospitals, hospitals acquiring physician practices, physicians banding together, and, more recently, plans buying physician practices, has been under way for some time and is not unique to North Carolina. And, as of 2007, in 21 States, one insurance carrier controls more than half of the market.

The Affordable Care Act, which I supported, will make dramatic changes in health insurance and health care to be phased in between 2010 and 2018. It is expected to expand health insurance to 32 million more Americans. And the medical loss ratio, which requires health insurers to spend a specified percentage of their premiums on payment for medical services or on activities that improve healthcare quality—something which apparently some of my colleagues find to be a radical idea—is designed to ensure that

health insurance premium dollars are not consumed by salaries, marketing, and overhead.

Providing more Americans with better-quality insurance is a step in the right direction, and ensuring that health insurance premiums serve that purpose rather than making executives rich is equally important.

So, Mr. Chairman, I have a lot more on my chest. I guess to expedite getting to the witnesses so that maybe we can talk about the consolidation issue, I will put the rest of my statement in the record.

But I just—I am not happy, because we have tried to connect a subject here with something that I don't think is really related to it. We have a problem. We ought to try to solve it, but we ought to try to do it without being partisan about this. That is the policy we have followed in this Subcommittee in the past, and I hope we will get back to it after this hearing.

With that, Mr. Chairman, I ask unanimous consent to put into the record a copy of the State of North Carolina report that was generated by the North Carolina director of economic research, North Carolina Hospital Association, which reflects some of the things that I referenced, and a copy of Professor Greaney's article that he cites in his testimony. I ask unanimous consent that those two things be put in the record.*

And I yield back the balance of my time.

Mr. GOODLATTE. Without objection, the gentleman's request that the documents cited be put in the record will be granted.

[The prepared statement of Mr. Watt follows:]

Prepared Statement of the Honorable Melvin L. Watt, a Representative in Congress from the State of North Carolina, and Ranking Member, Subcommittee on Intellectual Property, Competition, and the Internet

Thank you, Chairman Goodlatte.

Consolidation in health care is of utmost importance to me and to my constituents, both in the provider and insurance markets. In North Carolina, a recent investigation by "The News and Observer" and "The Charlotte Observer" revealed that hospital consolidation has led to huge profits and market dominance for UNC Hospitals, Duke University Health System, and to a lesser extent WakeMed. Hospital prices for patients have soared while charity services have declined or pale in comparison to the hospital systems profit margins. According to these news reports, profits are poured into fancy facilities, generous compensation packages for executives, and advanced technology that experts say don't always translate into superior health outcomes for patients and reserves in the billions have been set-aside for future purchases, which according to the investigation, has solidified the market power of these merged entities.

Another side-effect of hospital concentration and consolidation is increased bargaining power with insurance providers. Because the hospitals are so big, they are in a position to negotiate higher reimbursement rates. In North Carolina, Blue Cross has 75% of the health insurance market. It reports that it's cost per hospital admission surged by almost 40 per cent in a three year period, between 2007 and 2010. But the costs are passed on in higher premiums to customers—individuals and businesses alike.

In fact, earlier this month prominent attorney David Boies filed a class action antitrust lawsuit against Blue Cross and Blue Shield of North Carolina charging that the non-competition practice among its affiliates blocks rival insurers, resulting in an accumulation of market power which they exert to demand discounts with hospitals. The Department of Justice is also reportedly investigating whether Blue Cross plans in North Carolina raise health insurance premiums by cutting deals with hospitals that stifle its competitors from negotiating better rates.

*The material referred to is available in the Appendix.

So, Mr. Chairman, there is much to examine in the area of health care consolidation and competition. But to link examination of these issues to the Affordable Care Act threatens to unnecessarily politicize a crisis that is gripping our communities across the country. And to do so when a decision from the Supreme Court on the constitutionality of the health reform law is expected next month seems misguided and is not befitting of the bipartisanship that has characterized this Subcommittee. I guess the good news for the Obama Administration is that even some of those in Congress who oppose the individual mandate and hope that it will be invalidated as constitutional believe that the government's severability argument is sound and that the remainder of the law will survive.

The fact of the matter is that hospital consolidation began long before the Affordable Care Act. The market muscle of insurers, including health care insurers, has been made possible in part due to the McCarran-Ferguson exemption from the antitrust laws which, of course, was in place long before health care reform. The trend in hospitals merging with other hospitals, hospitals acquiring physician practices, physicians banding together and more recently, plans buying physician practices, has been underway for some time and is not unique to North Carolina. And, as of 2007, in 21 states, one insurance carrier controls more than half the market.

The Affordable Care Act, which I supported, will make dramatic changes in health insurance and health care to be phased in between 2010 and 2018. It is expected to expand health insurance to 32 million more Americans and the medical loss ratio which requires health insurers to spend a specified percentage of their premiums on payment for medical services or on activities that improve health care quality (which some find a radical idea), is designed to ensure that health insurance premium dollars are not consumed by salaries, marketing and overhead. Providing more Americans with better quality insurance is a step in the right direction and insuring that health insurance premiums serve that purpose rather than making executives rich is equally important. Critics argue that the MLR will drive insurers out of the market, but our antitrust laws protect competition, not competitors.

Although the reports of hospital consolidation in North Carolina are alarming, there are benefits to consolidation in health care markets including better integration of care and improved quality and accountability. The downside occurs when the consolidated entity becomes so large, squeezes out competition, and can dictate unjustifiably high rates from insurers. Equally problematic is when merged entities become so entrenched they are impossible to undo. Some critics maintain that the Accountable Care Organizations authorized by the health reform law will lead to greater consolidation. But again, despite my concerns about consolidation in my home state, not all consolidation is anticompetitive. Health providers are encouraged to form Accountable Care Organizations in order to deliver integrated, efficient and seamless services to patients. The Accountable Care Organizations are intended to eliminate duplication of services and coordinate patient care.

But the enforcement agencies are prepared to provide robust examination of Accountable Care Organizations. In October 2011, the FTC and DOJ issued a joint "Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program." The statement acknowledges that "under certain conditions ACOs could reduce competition and harm consumers through higher prices or lower quality of care," and lays out the roadmap the agencies will follow in assessing whether a formed ACO or one that seeks guidance pre-establishment is likely to operate consistent with antitrust law and policy.

Mr. Chairman, the legislative process leading to the passage of the Affordable Care Act was protracted and often ugly, and certainly did not produce a perfect law. And the trends toward consolidation are legitimate areas of inquiry. But an examination of whether the Affordable Care Act, in its embryonic stages, is driving consolidation among health care providers and insurance companies is misleading, premature and inconsistent with the bipartisan way in which we have sought to operate this Subcommittee.

I hope that our panel will provide us with meaningful input on a problem that has plagued our healthcare system for decades and not be misled by the partisan, political headline and title the Republicans have chosen to put on this hearing.

I yield back.

Mr. GOODLATTE. And, similarly, the opening statement of the Chairman of the full Committee, Chairman Smith, will also be made part of the record.

[The prepared statement of Mr. Smith follows:]

Prepared Statement of the Honorable Lamar Smith, a Representative in Congress from the State of Texas, and Chairman, Committee on the Judiciary

I am proud of the work that the Judiciary Committee has done to protect Americans' rights from being threatened by the Obama administration's so-called Affordable Care Act.

This Committee has helped expose the unprecedented and unconstitutional individual mandate, which requires every American to buy health insurance. This Committee also has worked to protect Americans' religious liberty from Obamacare mandates that would violate their faith.

I signed Amicus briefs with the Supreme Court urging them to recognize that the Act is unconstitutional and to strike down the entire law. And I have joined my Republican colleagues in voting 26 times to defund all or part of Obamacare.

Setting the constitutional concerns aside, today's hearing focuses on a different sort of problem with Obamacare. The law is not only unconstitutional, but it also scrambles the economics of America's health care system in a way that reduces competition. And when competition is reduced, higher prices, less innovation, and lower quality care follows.

Obamacare is not just bad policy, it is bad economics as well.

We know that centralized, top-down, government run systems do not work as well as competitive markets. In a government run system, businesses respond mostly to government mandates. In a free market system, businesses respond mostly to the needs and wants of their customers.

But Obamacare places government decision making over free market competition.

Under Obamacare, the government not only tells Americans that they have to buy health insurance; it also tells them what that insurance must cover.

Rather than leaving medical professionals free to care for patients as they see best, and compete with each other to offer better care, the new law buries doctors under a mountain of regulatory paperwork.

I expect the testimony at today's hearing will demonstrate how the Administration's regulatory approach reduces competition and leads to higher medical costs and lower quality care.

The first victim of Obamacare's regulations will be the small, independent and innovative insurance companies and health care providers.

The new law already stifles the ability of smaller, more innovative insurance companies and medical practices to offer innovative business models that might improve on current practices.

The second victim of Obamacare will be competition as these small businesses either go out of business, consolidate into larger businesses, or are never started at all.

The ultimate victim will be the American people who will receive higher cost, lower quality care. And to add insult to injury, taxpayers are the ones who are forced to foot the bill.

Competition and innovation benefit patients. Overregulation benefits only the largest incumbent companies and the status quo.

During the debate over Obamacare, Jeffrey Flier, Dean of Harvard Medical School, wrote that it:

> "would undermine any potential for real innovation in insurance and the provision of care. It would do so by overregulating the health-care system in the service of special interests such as insurance companies, hospitals, professional organizations and pharmaceutical companies, rather than the patients who should be our primary concern."

Accordingly, Dr. Flier gave the bill "a failing grade." I agree.

Obamacare violates both the Constitution and common sense. Unfortunately, if it is not declared unconstitutional, repealed, or modified, the worst is yet to come.

Ideally, Obamacare would be repealed and replaced with a system that promotes competition, innovation and the best interests of the American people.

Mr. GOODLATTE. Before we turn to the Ranking Member, Mr. Conyers, I do want to respond to the gentleman. I think it is important that we examine the effects of the general competitive state of the healthcare industry as well as the competitive effects of a very important new law, which, as you know, is controversial, is

being reviewed by the Supreme Court, but as of now is in the process of being implemented. And we should examine the competitive effects of that law on the general state of competition in the healthcare industry.

And I now am pleased to turn to the gentleman from Michigan, the Ranking Member of the Judiciary Committee, Mr. Conyers.

Mr. CONYERS. Thank you, Chairman Goodlatte.

I won't be able to get all of this off my chest either, so I will just try to make a couple points.

To begin with, the hearing might be considered premature because the forces promoting hospital consolidation have all been going on long before the Affordable Care Act that is called demeaningly by some "ObamaCare," but I call it ObamaCare because it is the first health bill named after a President in my memory. It is a little early for this.

Secondly, the DOJ, the Trade Commission, State attorneys general across the country have made attempts to challenge hospital and insurance consolidation, which, as Mr. Watt has indicated, has been going on for decades. This is not new stuff.

And frequently I think we have to concede—and I am doing a further study on it—that the Federal system, the DOJ, has not been up on it; they haven't been suing as much as it seems to me that they could. And the Federal Court system seems not to be proconsumer, and sometimes they seem to be even anticompetitive. Now, I am going to develop that out over the fall, and maybe we can come back to this again.

And then the examination of the State exchanges in the Obama health bill, still under court scrutiny, will compete with existing insurers. And these exchanges may allow for innovators to enter the market, but the fact of the matter is, they don't come into effect until 2014. So that is why there is going to be a little bit of theory involved in this.

And I would just close by letting our colleagues know that I have reintroduced a bill that ends the huge antitrust exemption made in 1945, which was even before I got to the Congress, about exempting insurance companies from the antitrust provisions. I have done this before in other Congresses, and guess what? In 2010, on a recorded vote of 406–19, my ending the exemption passed.

And so I would just close by summarizing one of our witnesses' assertions, that the Affordable Care Act in fact depends on and promotes competition in provider and insurance markets and that competitive bargaining between payers and providers and a healthy rivalry are good ways to drive prices down and keep them at levels that best serve the public.

So I thank you for allowing these opening comments, sir.

Mr. GOODLATTE. And we thank you for those opening comments.

Briefly in response, before I turn to the Chairman of the Judiciary Committee, who has now arrived, I do want to say that, while the main portion, if you will, of the ACA does not take effect until 2014, numerous portions of it are already in effect, already operating, and they have had already identifiable impacts on the healthcare industry. Mergers, for example, among healthcare providers have increased by 50 percent since the passage of the ACA.

And we will turn to our experts in a moment to hear their views on what may be the cause of that.

But first let's recognize the Chairman of the Committee, the gentleman from Texas, Mr. Smith, whose statement is in the record but now will be exemplified.

Mr. SMITH. Thank you, Mr. Chairman.

Mr. Chairman, I am proud of the work that the Judiciary Committee has done to protect Americans' rights from being threatened by the Obama administration's so-called Affordable Care Act. This Committee has helped expose the unprecedented and, to me, unconstitutional individual mandate, which requires every American to buy health insurance. This Committee also has worked to protect Americans' religious liberty from ObamaCare mandates that would violate their faith.

I signed Amicus briefs with the Supreme Court urging them to recognize that the Act is unconstitutional and to strike down the entire law. And I have joined my Republican colleagues in voting 26 times to defund all or part of ObamaCare.

Setting the constitutional concerns aside, today's hearing concentrates on a different sort of problem with ObamaCare. The law is not only unconstitutional, but it also scrambles the economics of America's healthcare system in a way that reduces competition. And when competition is reduced, higher prices, less innovation, and lower-quality care inevitably follows.

ObamaCare is not just bad policy, it is bad economics as well. We know that centralized, top-down, government-run systems do not work as well as competitive markets. In a government-run system, businesses respond mostly to government mandates. In a free market system, businesses respond mostly to the needs and wants of their customers.

But ObamaCare places government decision-making above free market competition. Under ObamaCare, the government not only tells Americans that they have to buy health insurance, it also tells them what that insurance must cover. Rather than leaving medical professionals free to care for patients as they see best and compete with each other to offer better care, the new law buries doctors under a mountain of regulatory paperwork.

I expect the testimony at today's hearing will demonstrate how the Administration's regulatory approach reduces competition and leads to higher medical costs and lower-quality care. The first victim of ObamaCare's regulations will be the small, independent, and innovative insurance companies and healthcare providers. The new law already stifles the ability of smaller, more innovative insurance companies and medical practices to offer innovative business models that might improve on current practices. The second victim of ObamaCare will be competition, as these small businesses either go out of business, consolidate into larger businesses, or are never started at all. The ultimate victims will be the American people, who will receive higher-cost, lower-quality care. And to add insult to injury, taxpayers are the ones who are forced to foot the bill.

Competition and innovation benefits patients. Overregulation benefits only the largest incumbent companies and the status quo.

During the debate over ObamaCare, Jeffrey Flier, Dean of Harvard Medical School, wrote that it, quote, "would undermine any

potential for real innovation in insurance and the provision of care. It would do so by overregulating the healthcare system in the service of special interests, such as insurance companies, hospitals, professional organizations, and pharmaceutical companies, rather than the patients, who should be our primary concern," end quote. Accordingly, Dr. Flier gave the bill "a failing grade," and I agree.

ObamaCare violates both the Constitution and common sense. Unfortunately, if it is not declared unconstitutional, repealed, or modified, the worst is yet to come. Ideally, ObamaCare would be replaced with a system that promotes competition, innovation, and the best interests of the American people.

Thank you, Mr. Chairman. I yield back.

Mr. CONYERS. Chairman Goodlatte, might I be permitted to——

Mr. GOODLATTE. Thank you, Mr. Chairman.

And the Chair recognizes the gentleman from Michigan.

Mr. CONYERS. Just a 1-minute response to my friend, the full Committee Chair, Mr. Smith, who rarely——

Mr. GOODLATTE. Without objection, we will dispense with regular order, since I dispensed with it for myself, and give the gentleman a minute.

Mr. CONYERS. Your fairness is greatly appreciated.

All I wanted to do as the author for a number of years of the universal single-payer healthcare bill, which I want you to know has shaped my attitudes about this subject that we are in, I want to just send a memo to our full Committee Chair pointing out what I would like to consider inadvertent errors of fact that he might want to take note of and maybe even reply back to me in writing, as well.

And I thank the Chair for allowing that intervention.

Mr. GOODLATTE. I thank the gentleman.

And we now can turn to our very distinguished panel of witnesses today. Each witness' written statements will be entered into the record in its entirety.

I ask that each witness summarize their testimony in 5 minutes or less. To help you stay within that time, there is a timing light on your table. When the light switches from green to yellow, you will have 1 minute to conclude your testimony. When the light turns red, it signals the witness' 5 minutes have expired.

And as is the custom with this Committee, before I introduce our witnesses, I would like them to stand and be sworn.

[Witnesses sworn.]

Mr. GOODLATTE. Thank you very much.

Our first witness is—you are going to have to help me—Mr. Haislmaier? Okay. Our first witness is Edmund Haislmaier, who is a Senior Research Fellow with The Heritage Foundation Center of Health Policy Studies and a member of the Board of Directors of the National Center for Public Policy Research. Earlier in his career, Mr. Haislmaier was the director of healthcare policy for Pfizer, Incorporated.

Our second witness is Thomas L. Greaney, who is the co-director of the Center for Health Law Studies and the Chester A. Myers Professor of Law at Saint Louis University School of Law. He is also an associate professor of hospital and healthcare administration at the St. Louis University School of Public Health.

Our third witness is Dr. Scott Gottlieb, who is a clinical assistant professor at New York University School of Medicine and a resident fellow at the American Enterprise Institute. Dr. Gottlieb has served in various capacities at the Food and Drug Administration and as a senior policy advisor at the Centers for Medicare and Medicaid Services.

And we will turn first to Mr. Haislmaier.

TESTIMONY OF EDMUND F. HAISLMAIER, SENIOR RESEARCH FELLOW, CENTER FOR HEALTH POLICY STUDIES, THE HERITAGE FOUNDATION

Mr. HAISLMAIER. Thank you, Mr. Chairman and Members of the Committee, for inviting me to testify. You have my written testimony. I will just in the few minutes briefly summarize some of the high points of that.

You asked me to speak on the subject of health insurance markets, as opposed to my colleagues who will be speaking more about the provider markets. The area of health insurance is where I have spent more of my work.

Essentially, what I lay out in the testimony is that there are indeed a number of provisions in the PPACA that will, in my view, lead to reduced competition and some consolidation in the insurance market. As noted, some of those have not yet taken effect, while some of those have already taken effect.

Essentially, I can see the market unfolding in a way that reduces competition and increases consolidation because of the provisions that, first of all, standardize coverage; secondly, increase premiums; third, raise barriers to market entry for new competitors; and, fourth, encourage industry consolidation.

I have identified for you in the testimony five specific provisions in this legislation that will not only result in standardization of coverage—and that was intentional by the authors—but will also result, to some degree or another, in increased costs.

The point is simply that when you standardize a product, you make it more like a commodity, and you force competition away from product differentiation and into simply competing on price. And the tendency in that market is to see a consolidation in the market into a few large firms. And for other policy reasons, I think Congress deliberately chose in the PPACA to provide this kind of level of increased standardization in this legislation, so it is not that surprising that you would see that result.

My point on cost is simply that, as the costs of the standardized package increases, the interest in holding down costs by reducing coverage or reducing payments for those things that are not required will also increase. And I point out that this is, in fact, a dynamic that played out while the legislation was being considered, with respect to preventive services such as mammography screening.

So, for a number of reasons, I see that the market will become increasingly commoditized. Again, some of that was deliberate and intentional. I think it will go beyond the level that was intended. But that dynamic has been set in place.

The other point that I make in here is that the minimum loss ratio regulations have a number of effects that could be deemed

anticompetitive. The first is that they create a barrier to market entry for new carriers. It makes it much more difficult to finance a new startup health insurer under this, and I do not expect to see new ones come into the market as a result.

Secondly, the various standardizations of products and also the minimum loss ratio regulation is, in my estimation, going to lead to companies for whom they have multiple lines of insurance getting out of the health insurance business and selling it off. We have already seen some of that occur in the market.

And, finally, that system will favor for-profit insurers at the expense of not-for-profit insurers, because for-profit insurers can raise the capital to engage in expansion and acquisition of rivals, whereas nonprofits won't. And so I would envision that that would result in additional reductions in competition.

There are a couple of other provisions also that I see having an effect. One is the Multi-State Plan provisions that were put in the legislation, which will, again, favor national health insurers over regional ones, and the insurer rate review provisions.

In closing, let me point out that what this has collectively unleashed is a dynamic that treats health insurance like a regulated public utility. And, therefore, an insurer really has the choice of do you want to stay in that market, in which case you want to become a big insurer so that you can resist being pushed around by the regulators, or do you want to simply get out of that market. And that is, I think, the business decision that insurers will face.

Two final points. One is that I do not see this consolidation really taking effect until after the industry has more certainty following the Court's ruling and following the elections. Right now, it is being done in bits and pieces, so I would not expect to see any big mergers until they have more certainty as to what the landscape looks like. So that probably wouldn't happen for a year or 2.

And then, finally, I would simply point out that sometimes McCarran-Ferguson is inaccurately described. It is not that insurers are exempt from antitrust; it is that the division between Federal and State is defined there.

Thank you, Mr. Chairman. I think my time has expired.

Mr. GOODLATTE. It has. I hate to cut people short, but we are facing votes, and we want to give both Professor Greaney and Dr. Gottlieb the ability to give their testimony.

[The prepared statement of Mr. Haislmaier follows:]

Prepared Statement of Edmund F. Haislmaier, Senior Research Fellow, Center for Health Studies, The Heritage Foundation

Mr. Chairman and members of the Committee, thank you for inviting me to testify on the subject of "Health Care Consolidation and Competition after PPACA."

My name is Edmund F. Haislmaier. I am Senior Research Fellow in Health Policy at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

My testimony today focuses on how I expect competition and consolidation to play out in the health insurance sector under the new rules and regulations established in the Patient Protection and Affordable Care Act (PPACA).

The PPACA significantly expands, both in scope and in detail, the federal regulation of commercial health insurers. A number of its provisions are likely, over time, to reduce competition in that sector. The reduction in competition will result from provisions in the PPACA that standardize coverage, increase premiums, raise barriers to market entry, and encourage industry consolidation.

STANDARDIZING COVERAGE

The first set of relevant provisions are those that have the effect of standardizing health insurance coverage.

When government imposes regulations that standardize a product, producers of the item are, obviously, less able to compete on the basis of product differentiation. The product becomes more of a commodity and competition among suppliers becomes focused mainly on price. Other factors, such as convenience or brand identity, may enable some producers to charge marginally higher prices, but even that pricing power is fairly limited in a commoditized market.

At least five provisions of the PPACA will intentionally standardize health insurance to varying degrees:

1. Section 1302 instructs the Department of Health and Human Services (HHS) to set, and periodically update, an "essential health benefits package" of minimum health insurance coverage requirements.
2. Section 1302 also limits deductibles for employer plans in the small-group market and limits total enrollee cost-sharing for all health plans to the levels specified in the tax code for qualified High Deductible Health Savings Account plans.
3. Section 1201(4) requires all individual and small group health insurance policies to provide coverage for the essential health benefits package.
4. Section 1001(5) requires health insurers and employer plans to cover numerous preventive services with no enrollee cost-sharing.
5. Section 1001(5) prohibits health insurers and employer plans from setting annual or lifetime coverage limits "on the dollar value of benefits."

In a commodity market where competition is focused principally on price, firms that are able to reduce their costs through economies of scale can generally offer better prices and thus gain market share at the expense of their competitors. As a result, markets for commodities tend to be dominated by a few, large firms. Those firms achieve their dominant size by either under-pricing smaller rivals or acquiring competitors. The provisions of the PPACA that standardize and commoditize coverage are likely to drive a similar dynamic in the health insurance market. Furthermore, because these are new, federal standards, the effects will be national in scope. Even carriers that have long been dominant in a particular state or region will find it harder to maintain their position and keep larger, national players at bay.

INCREASING COVERAGE COSTS

The above provisions will not only standardize coverage, but in many cases will increase coverage costs as well. For example:

- The Administration conducted an economic analysis of the effects of their regulations implementing the PPACA's preventive services coverage requirement. They concluded that, "The Departments estimate that premiums will increase by approximately 1.5 percent on average for enrollees in non-grandfathered plans. This estimate assumes that any changes in insurance benefits will be directly passed on to the consumer in the form of changes in premiums."[1]
- In its regulations implementing the PPACA's provision that prohibits plans imposing annual limits on the dollar value of benefits after 2014, and sets minimum annual limits for prior years, HHS established a waiver process for years before 2014, "if compliance with these interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums."[2] HHS has granted temporary waivers of the annual limits provision to plans with a total of over 4 million enrollees.[3] Thus, when the complete prohibition on annual limits takes effect in 2014, at least 4 million individuals will be priced out of their current coverage, and it is likely that this provision will increase premiums for millions more.

[1] Federal Register, Vol. 75, No. 137, July 19, 2010, p. 41738.
[2] Federal Register, Vol. 75, No. 123, June 28, 2010, p. 37191.
[3] Total enrollment in plans granted waivers is 4,039,774. Lists of those waiver recipients, with enrollment figures, can be found at *Annual Limits Policy: Protecting Consumers, Maintaining Options, and Building a Bridge to 2014,* U.S. Department of Health and Human Services, at *http://cciio.cms.gov/resources/files/approved*__applications__for__waiver.html.

- Congress instructed HHS to define and periodically update an "essential health benefits package." HHS has not yet proposed regulations specifying the initial design of the essential health benefits package and has only issued "bulletins" outlining the approaches that it is considering. Given that the statute requires coverage for some categories of benefits not typically included in most current health plans—such as "habilitative" services—it is likely that the eventual package of required benefits will increase premiums.

The significance of these increased costs is that they generate a dynamic for further plan standardization. The more expensive the required coverage becomes the more insurers will look to keep premiums in check by limiting or cutting benefits that are not required. Indeed, State governments have behaved exactly this way in managing their Medicaid programs. As the cost to states of paying for mandatory Medicaid benefits has increased, states have responded by limiting or discontinuing optional Medicaid benefits.

Similarly, it was fear of this same dynamic occurring that led Congress to amend the PPACA provision requiring coverage of preventive services so as to overrule the US Preventive Services Task Force's recommendation on breast cancer screening. At that time the USPSTF had just revised its recommendation on breast cancer screening from starting at age 40 to starting at age 50. Breast cancer groups were concerned that making coverage mandatory at age 50 would induce plans to no longer pay for screening for women between the ages of 40 and 50. Congress responded by amending the PPACA to require coverage of breast cancer screening using the prior recommendation of age 40.[4]

The foregoing example also illustrates another effect of the benefit mandates in the PPACA. Over time there is likely to be ever more detailed standardization of health insurance coverage as provider and patient groups lobby HHS and Congress to expand coverage requirements, while insurers and employers, looking to control rising plan costs, seek greater regulatory certainty with respect to the limits they may impose on required benefits.

Thus, by giving HHS authority that is both broad and discretionary to define what constitutes "essential benefits," Congress set in motion a dynamic that will result in increasing standardization of health insurance coverage. That increasing standardization shrinks the scope for competition among insurers and is likely to result in industry consolidation, as the regulated product becomes more of an undifferentiated commodity.

THE "MINIMUM LOSS RATIO" REGULATION

Another provision of the PPACA that will likely have a major effect in reducing insurer competition and driving consolidation within the health insurance industry is the so-called "minimum loss ratio" (MLR) regulation. [5] This provision established, effective January 1, 2011, new federal rules governing how health insurers spend premium dollars. These rules are commonly referred to as "minimum loss ratio" regulations—meaning that they specify the minimum share of premium income that an insurer must spend on claims costs and "activities that improve health care quality."

The minimum levels are set in the PPACA at 85 percent for large group plans and 80 percent for small group and individual plans. The PPACA further stipulates that if an insurer spends less than the required minimum in a given year, then the insurer must refund the difference to policyholders. Thus, for example, if an insurer is required to spend 80 percent of premium income on claims costs for a particular product but only spends 75 percent, the insurer is required to rebate five percent of the premium collected to policyholders.

NEW BARRIER TO MARKET ENTRY

One of the effects of the minimum loss ratio regulations is that they create a barrier to market entry for new carriers. As with many start-up companies, a substantial initial capital investment is required to create a new insurer. That investment is needed to fund initial marketing and sales efforts to attract paying customers, and to build-out the operational and administrative infrastructure for billing customers, paying claims, etc. Similar to other new businesses, a new insurer initially operates at a loss until it achieves enough "scale"—that is, it acquires enough customers—that revenues exceed expenses, and it become profitable.

---

[4] New Section 2713(a)(5) of the Public Health Service Act (42 U.S. Code § 300gg-13(a)(5)) as added by PL 111–148 § 1001(5).

[5] New § 2718 of the Public Health Service Act (42 U.S. Code § 300gg–18) as added by PL 111–148 § 1001(5) and then amended by § 10101(f).

The MLR regulations effectively constrain the amount, and delay the timing, of any excess premium revenues that a start-up health insurer could plan to either reinvest in growing its business (say, through additional marketing) or repaying its initial investors. Thus, the MLR regulations push further into the future a new company's projected "break-even" point, and may also necessitate additional start-up capital beyond what was previously projected.

Of course, it is uncertain whether a particular start-up insurer would succeed, even without having to deal with the constraints imposed by the MLR regulations. However, what is certain is that imposing the new MLR regulations raises the bar for an "in-process" start-up, and increases the risk and initial capital requirements for an "in-planning" start-up venture.

In at least one reported case investors decided to terminate an "in-process" start-up health insurer, at least in part, due to the effects of the new MLR regulations on its business plan.[6] What is unknowable are how many attempts to create new health insurers that were still in the planning stage were simply abandoned once investors determined that the added burden of complying with the new minimum loss ratio regulations make it too expensive or too risky to go forward.

MARKET CONSOLIDATION

A number of established companies that currently provide health insurance can also be expected to exit the market over the next several years. The ones most likely to leave are those with multiple lines of coverage, for which offering health insurance is just part of their larger business. In general, the minimum loss ratio regulations will make offering health insurance less profitable while, as previously noted, the benefit requirements will also make it more of a commodity business. Companies offering multiple lines of insurance will be inclined to discontinue, or sell to competitors, their health plans and focus instead on the other lines of insurance that they offer—such as life, auto, property, or liability coverage—or on non-insurance business opportunities.

The smaller the company, or the smaller the share of a company's total business represented by health insurance, the more likely it is that the company will exit the post-PPACA health insurance market.

For example, on September 30, 2010, Principal Financial Group, Inc. announced that it was exiting the major medical health insurance market and transferring its existing book of business to UnitedHealth Group.[7] Principal will instead focus on its other lines of business, which include managing retirement and investment plans, and offering life, disability, dental and vision insurance products (none of which are subject to the PPACA's new federal insurance regulations).

To be sure, such business decisions are often the product of multiple considerations, but the MLR provisions in the PPACA will certainly discourage companies with other options from continuing to offer health plans.

FAVORING FOR-PROFIT INSURERS

Still another unintended consequence of the minimum loss ratio regulations is that they will increase the competitive advantage of for-profit insurers over their non-profit rivals. Because the MLR requirement constrains the share of premium income that an insurer can "retain," it limits an insurer's ability to accumulate the capital needed to expand, either through increased marketing and sales efforts or by purchasing business from other carriers. Non-profit insurers have no other source of investment capital beyond whatever excess premium income they can accumulate after paying claims costs and administrative expenses. However, for-profit insurers can finance their capital needs by issuing equity shares. Since the proceeds of a share offering are not premium income, the MLR restrictions do not apply.

Thus, the minimum loss ratio regulation is likely to not only spur increased consolidation in the health insurance industry, but to also drive that consolidation toward a market dominated by a few, very large, for-profit, insurers. It is easy to envision large, for profit health insurers applying the same "roll-up" strategy of raising capital through equity offerings and then using the proceeds to buy smaller competi-

[6] Michael Schwartz, "Startup health insurer shutting," *Richmond BizSense,* June 4, 2010, at: http://www.richmondbizsense.com/2010/06/04/startup-health-insurer-shutting and Michael Schwartz, "With healthcare reform looming, nHealth was losing millions," *Richmond BizSense,* June 11, 2010, at: http://www.richmondbizsense.com/2010/06/11/with-healthcare-reform-looming-nhealth-was-losing-millions/.

[7] Principal Financial Group, "The Principal Financial Group to Exit Medical Insurance Business," press release, September 30, 2010, at: http://phx.corporate-ir.net/phoenix.zhtml?c=125598&p=irol-newsArticle&ID=1477633&highlight=.

tors that has been successfully applied in other sectors. Such an outcome is probably not something that the authors of the PPACA either intended or envisioned.

MULTI-STATE PLANS

Another provision in the PPACA that favors large, national health insurers over smaller or regional ones is the requirement in Section 1334 that the Office of Personnel Management directly contract with a select number of insurers to offer "multi-state" plans. Section 1334 sets a four year schedule for offering multi-state plans in all the states, and specifies that multi-state plans are "deemed to be certified by an Exchange" as qualified plans. That deeming provision gives the multi-state plans a guarantee of access to the subsidized coverage market, while their competitors have no such guarantee.

RATE REVIEW

The insurer rate review provisions in Section 1003 of the PPACA offer yet another reason for smaller carriers to exit the health insurance market and big carriers to get bigger. While Congress did not give HHS authority to deny insurer rate increases, HHS has shown that it is willing to use its new rate review powers to "name and shame" insurers if they significantly increase premiums. Secretary Sebelius has also threatened to deny uncooperative insurers access to the federally subsidized exchange markets that are scheduled to open in 2014.[8]

The logical business strategy for surviving in that kind of a market is for a carrier to become big enough that it can retain some level of pricing power in the face of persistent government attempts to impose price regulations. Becoming "too big" or "too important" to fail will be the best strategy for a company seeking to protect itself against the threat that government price regulation could make its business unprofitable.

COMBINED EFFECTS

Collectively, these regulations mean that the PPACA has unleashed a market dynamic that will drive toward greater consolidation in the health insurance industry, eventually resulting in fewer and larger carriers dominating the market—with a consequent reduction in choice and competition for consumers. How this new market dynamic will likely play out can be seen from past experience in other sectors where "consolidators"—such as Staples and Office Depot—built market-dominating firms through a strategy of raising investment capital and then deploying it to acquire small and mid-sized competitors. Indeed, a prominent supporter of the PPACA explicitly, and correctly, wrote that the legislation "fundamentally transforms health insurance" into "a regulated industry . . . that, in its restructured form, will therefore take on certain characteristics of a public utility."[9]

What was left unsaid is that the characteristics of public utility economics are markets dominated by a few large firms, with low rates of return and captive customers, in which the firms' pricing power is constrained by government regulation, but government's exercise of regulatory power is constrained by the need to keep the remaining firms profitable to avoid the widespread social and economic dislocation that would occur should they be driven out of existence. In essence, this is a prescription for achieving market equilibrium through an economic "mutually assured destruction" stand off—with little or no remaining consumer choice or product innovation.

Mr. Chairman, this concludes my prepared testimony. I thank you and the rest of the Committee for inviting me to testify before you on this issue. I will be happy to answer any questions that you or members of the Committee may have.

Mr. GOODLATTE. Professor Greaney, welcome. You might want to turn that microphone on and pull it close to you.

---

[8] Letter of Health and Human Services Secretary Kathleen Sebelius to Karen Ignagni, President and CEO of America's Health Insurance Plans, September 9, 2010.

[9] Sara Rosenbaum, J.D., *A "Broader Regulatory Scheme"—The Constitutionality of Health Care Reform,* New England Journal of Medicine, 10.1056/NEJMp1010850, October 27, 2010, at NEJM.org.

TESTIMONY OF THOMAS L. GREANEY, CHESTER A. MYERS PROFESSOR OF LAW, CO-DIRECTOR, CENTER FOR HEALTH LAW STUDIES, SAINT LOUIS UNIVERSITY SCHOOL OF LAW

Mr. GREANEY. Thank you, Chairman Goodlatte,

Ranking Member Watt, Committee Ranking Member Conyers. It is an honor to be here to address this important subject.

Issues involving competition, healthcare concentration, and antitrust have been the center of my research and teaching for the last 24 years. Before that, I had a career at the Justice Department, Antitrust Division, working on healthcare competition issues.

Let me summarize my testimony with five key points.

First of all, the Affordable Care Act depends on and promotes competition in provider and payer markets.

Secondly, hospital market concentration is the product of merger waves that have been going on for 20 years. And they were sort of fomented by erroneous court decisions, lax antitrust enforcement, and they were exacerbated by government policies that limited entry and restricted competition.

The third point is that there is both good consolidation and bad consolidation. Problematic consolidation occurs principally among horizontal combinations of hospitals forming monopolies and getting dominant systems, as well as on the insurance side. By contrast, vertical combinations between hospitals and physicians can reduce fragmentation and help fix the problems of the system and encourage more competition.

The Affordable Care Act, I believe, encourages the pro-competitive consolidations. And I think it is erroneous to claim that it is somehow responsible for anticompetitive consolidations when the consolidations that are going on are designed precisely to avoid the competitive benefits of competition that the act sponsors.

Finally, there has been a big resurgence, I think, in antitrust enforcement in recent years, and that is all for the good. Going forward, I think the FTC and DOJ are committed to holding the line on consolidations, and that is the good news. That is not to say that consolidation isn't a problem. There is concentration out there, and we may reach the point at some point where some regulation is needed to deal with dominance, because the market may not.

Just to go through each of those points briefly, I mentioned that the Affordable Care Act depends on and promotes competition. Many ask, well, why do you need government involvement to make healthcare markets more competitive? And the answer I point out in my testimony is, there is what I call the witch's broth of history: provider dominance, ill-conceived payment systems and regulatory policies, and, most importantly, market imperfections that make health care different and make it sometimes less serving of the consumer interest.

And we find ourselves with the worst of both worlds. We have fragmentation on the one hand. We have doctors operating in silos, unconnected to specialists, not communicating and not integrating their care. On the other hand, we have concentration in pockets of dominant hospitals and some dominant physician groups.

Let me just point out, I summarize this in my testimony, but the Affordable Care Act tackles this in various ways. The health insur-

ance exchanges are perhaps the most important pro-competitive instrument that is out there.

Secondly, don't forget that Medicare payment reform has an important effect on competition in private markets. And that happens because Medicare delivery reform can promote competitive markets. Many of the changes contained in the Affordable Care Act contain innovations such as value-based purchasing. And remember, private payers often follow the lead of Medicare, and I think the organizational changes coming out of the Affordable Care Act, particularly with accountable care organizations, are going to promote the kind of integration that serves competition.

A couple of points briefly on concentration. It is a problem for competition, but it is not just a problem for the Affordable Care Act. It is a problem for those who would rely on laissez faire proposals, who rely on health savings accounts. It is a problem for the Wyden plan that is going to rely on competition in Medicare markets.

There was a merger wave, as Chairman Watt mentioned, but it occurred in the mid-1990's, and that is when the great bulk of consolidation occurred. It had disastrous results for the American public. Prices went up 5 to 40 percent after mergers. The Massachusetts attorney general just did a report a year ago that summarizes the price increases that flow from market dominance.

There is some good news on the antitrust enforcement side. The FTC, DOJ are moving aggressively on hospital mergers and market dominance, especially where we see the dominant payers confronting the dominant hospitals. That is a big problem. And I think there is a glimmer of hope in the potential coming out of affordable care organizations that can promote some competition, can induce some additional competition.

That is not to say we have solved the problem. And my testimony goes on to discuss some pro-competitive things that can be done, including lessening barriers to entry, such as certificate-of-need laws, perhaps loosening up the opportunities for physician-controlled hospitals.

Mr. GOODLATTE. Thank you, Professor Greaney.

[The prepared statement of Mr. Greaney follows:]

Prepared Statement of
Professor Thomas L. Greaney

Before the

Committee on the Judiciary
United States House of Representatives

Subcommittee on Intellectual Property, Competition, and the Internet
on
"Health Care Consolidation and Competition After PPACA"

May 18, 2012

Chairman Goodlatte, Ranking Member Watt, Committee Ranking Member Conyers and Members of the Subcommittee, I much appreciate the opportunity to testify on the important issue of health care consolidation and competition policy in the context of health reform. By way of introduction, I am the Chester A. Myers Professor of Law and Director of the Center for Health Law Studies at Saint Louis University School of Law. I have devoted most of my 24-year academic career to studying issues related to competition and regulation in the health care sector, writing numerous articles on the subject and co-authoring the leading casebook in health law. Before that I served as Assistant Chief in the Antitrust Division of the United States Department of Justice, litigating and supervising cases involving health care. My professional affiliations include membership in the American Health Lawyers Associations and I serve on the Advisory Board of the American Antitrust Institute.

Let me summarize the key points of my analysis of the market concentration problem:

- The Affordable Care Act depends on and promotes competition in provider and payor markets.

- Hospital market concentration is the result of various "merger waves" over the last twenty years facilitated by erroneous court decisions and lax antitrust enforcement, and exacerbated by government policies limiting entry and competition.

- Problematic concentration is largely caused by horizontal combinations—mergers and joint ventures among rivals. By contrast, vertical integration, such as combinations of hospitals with physicians, is generally procompetitive, because reducing fragmentation improves both the quality of care and the capacity of providers to eliminate wasteful services.

- The Affordable Care Act encourages procompetitive consolidations through payment reforms and incentives to form efficient delivery systems such as accountable care organizations.

- It would be erroneous to claim that the Affordable Care Act is somehow responsible for anticompetitive consolidation when in fact such mergers and joint ventures are efforts to *avoid* the procompetitive aspects of the Act.

- The recent resurgence in antitrust law enforcement should limit future increases in concentration and curb the exercise of market power, but will not unwind most prior consolidations.

- The provider monopoly problem calls for countermeasures such as encouraging development of accountable care organizations organized in competitive structures and reducing barriers to entry.

Competition Policy and the Affordable Care Act

I'd like to begin with an important proposition that is sometimes lost in the rhetoric about health reform. The Affordable Care Act both *depends on* and *promotes* competition in provider and insurance markets. A key point is that the new law does not regulate prices for commercial health insurance or prices in the hospital, physician, pharmaceutical, or medical device markets. Instead the law relies on (1) competitive bargaining *between* payers and providers and (2) rivalry *within* each sector to drive price and quality to levels that best serve the public.

Why do we need government intervention to make health care markets perform more efficiently? The answer lies in a witches' broth of history, provider dominance, ill-conceived government payment and regulatory policies, and perhaps most importantly, market imperfections that are endemic to delivery of services, insurance, and third party payment. Justification for regulation to promote competition can be found in virtually every economic analysis of health care. Markets for providing and financing care are beset with myriad market imperfections: inadequate information, agency, moral hazard, monopoly and selection in insurance markets that greatly distort markets. Add to that governmental failures— payment systems that reward intensity and volume but not accountability for resources or outcomes; restrictions on referrals that impede efficient cooperation among providers; and entry impediments in the form of licensure and CON, to name a few. Finally, toss in a strain of professional norms that are highly resistant to marketplace incentives-- and you have the root causes of our broken system.

Looking at the result in health care markets, we find the worst of two worlds: *both* fragmentation and concentration. As I'll discuss in a minute, hospital and specialty provider markets are highly concentrated while most primary care physicians remain in "silos" of solo or small practice groups. In most places, there is scant "vertical integration" among providers of different services—a phenomenon that impedes effective bargaining to reduce costs and prevent overutilization of services, and also has adverse effects on the quality of health services patients receive because it inhibits coordination of care.

The Affordable Care Act tackles these problems on many fronts. My article, *The Affordable Care Act and Competition Policy: Antidote or Placebo?,*[1] describes these measures in some detail, but I will focus on a few of the most important. Although it may be counterintuitive to those who dichotomize between competition and regulation, law can *foster* competition by imposing rules and standards, and even by mandating purchasing or creating competition-

[1] Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?,* 89 Or. L. Rev. 811 (2011).

enabling institutions. As I have argued since the early days of the "competitive revolution" in health care, this kind of regulation is a condition precedent for effective markets.[2]

To briefly recap some of the ACA's competition-improving steps:

First, a centerpiece of reform is the Health Insurance Exchange. At bottom, exchanges are really just efficient markets for offering and purchasing health insurance analogous to farmers markets or travel websites. The ACA adopts regulations that are necessary to make insurance products comparable and understandable, that require basic minimums of coverage, and that protect against the insurance industry's long-standing practice of chasing down only good risks-- all textbook efforts to make competition work efficiently in the insurance market.

Second, Medicare payment and delivery reform plays a critical—and generally unappreciated—role in promoting competitive markets both private and public. Underlying the myriad changes in payment policy and the ACA's pilot programs and other innovations, such as value based purchasing, accountable care organizations and reforms to bidding in the Medicare Advantage program, is the understanding that Medicare policy strongly influences the private sector. Private payors often follow Medicare's lead on payment methods and depend on the program to set quality standards. Moreover, the incentives it creates in the way medicine is delivered has unquestioned spillover effects on commercial health plans. Most notable in this regard are the prodigious efforts undertaken by the ACA to redirect federal payment *away* from fee-for-service payment.

Third, the ACA seeks to create incentives for providers to develop innovative organizational structures that can respond to payment mechanisms that rely on competition to drive cost containment and quality improvement. The watchword here is *integration*. Congress recognized that it was essential to stimulate formation of organizations that could receive and distribute reimbursement and be responsible for the quality of care under the new payment arrangements contained in the ACA and developing in the private sector such as bundled payments and global reimbursements. Given the badly fragmented structure of health delivery, a critical innovation is the Medicare Shared Savings Program which fosters development of Accountable Care Organizations to serve *both* Medicare beneficiaries and private payers and employers.

Finally, the new law deals with a very significant public goods market failure—the underproduction of research and the inadequate dissemination of information concerning the effectiveness and quality of health care services and procedures. The Act does so by subsidizing research and creating new entities to support such research and to disseminate information about outcome and medically-effective treatments. Numerous other provisions attempt to correct flaws in Medicare and Medicaid reimbursement methodologies and add incentives to improve quality by using "evidence based medicine."

---

[2] *See* Thomas L. Greaney, *Competitive Reform in Health Care: The Vulnerable Revolution*, 5 Yale. J. on Reg. 179 (1988)(predicting that competition in health care would not succeed if regulation and infrastructure do not support it).

The important take-away is that much of the extensive regulation contained in the new law is explicitly designed to promote competition. It aims to encourage the redesign of payment and delivery systems so that private payers and providers can interact in the marketplace to provide the best mix of cost and quality in health care. As I'll discuss in a moment, however, there are obstacles to realizing the potential benefits of the competitive strategy for health care reform.

Concentration and Antitrust Enforcement

So, what could possibly go wrong? Many observers, including myself, have pointed to the extensive concentration that pervades health care markets and constitute a serious impediment to effective competition. It is important however to put this phenomenon into context-- both as to how it came about and what can be done about it.

First it should be understood that although we have experienced a "merger wave" in recent years, it is not the first, nor is it responsible for the widespread concentration we see in many markets today. Hospital consolidation has proceeded in spurts several times over the past twenty years, with the biggest wave occurring in the mid-1990s. The Robert Woods Johnson Synthesis Project analysis summarized this phenomenon

> In 1990, the typical person living in a metropolitan statistical area (MSA) faced a concentrated hospital market with an HHI [the index of concentration used in antitrust cases] of 1,576. By 2003, however, the typical MSA resident faced a hospital market with an HHI of 2,323. This change is equivalent to a reduction from six to four competing local hospital systems. [3]

Notably, the largest number of hospital mergers was undertaken *after* the defeat of the Clinton Health Reform proposal and during a time when managed care was at its zenith. While academics disagree on what caused the sharp increase in mergers, recent studies suggest that hospitals' anticipation of increased cost pressures from managed care led them to consolidate. Moreover, one thing is clear: a series of unsuccessful antitrust challenges to hospital mergers in federal court gave a green light to consolidation. And, as the government antitrust agencies themselves admit, these decisions caused federal and state enforcers to back away from challenging hospital mergers for almost seven years.[4] Adding to this tale of misfortune is the widely-held opinion that the courts got it wrong: the majority of judicial decisions allowing hospital mergers found unrealistically large geographic markets that did not conform with sound economic analysis.[5]

---

[3] Robert Vogt & Robert Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* (2006) http://www.rwjf.org/files/research/no9researchreport.pdf.

[4] An Assistant Director of the FTC's Bureau of Competition acknowledged, "Both the FTC and the DOJ left the hospital merger business and determined that these cases were unwinnable in federal district court." Victoria Stagg Elliot, *FTC, in Turnabout, Takes a Closer Look at Hospital Mergers*, AmericanMedicalNews (April 9, 2012).

[5] See e.g., Cory S. Capps, *The Silent Majority Fallacy of the Elzinga Hogarty Criteria: A Critique and New Approach to Analyzing Hospital Mergers* (2001), available at http://www.nber.org/papers/w8216.

The result of this spike in hospital concentration was disastrous for the American public. A large body of literature documents the existence, scope and effects of market concentration. One well-regarded compilation of the numerous studies of this issue spells out the link between hospital market concentration and escalating costs of health insurance: hospital consolidation in the 1990s raised overall inpatient prices by at least 5%, and by 40% or more when merging hospitals were located close to one another.[6] Another important study, undertaken by the Massachusetts Attorney General, documents the effects of "provider leverage" on health care costs and insurance premiums, notably finding prices for health services are uncorrelated with quality, complexity, proportion of government patients, or academic status but instead are positively correlated with provider market power. [7] A leading economist summarized the impetus to merge with rivals in the face of pressure from payers to compete:

> I have asked many providers why they wanted to merge. Although publicly they all invoked the synergies mantra, virtually everyone stated privately that the main reason for merging was to avoid competition and/or obtain market power.[8]

Provider concentration has a double effect-- one in commercial markets the second on government payers, especially Medicare. The most obvious effect as described above is to increase dominant providers' ability to command higher prices and resist efforts to limit unnecessary procedures. A second effect, often overlooked, is the cost-elevating impact of provider market concentration upon government payers. Examining the effect of hospital concentration on Medicare payments, the Medicare Payment Advisory Commission (MedPAC) has found that high hospital margins on private-payer patients tend to induce more construction and higher hospital costs and that, "when non-Medicare margins are high, hospitals face less pressure to constrain costs, [and] costs rise."[9] These factors, MedPAC observes, explain the counterintuitive phenomenon that hospital Medicare margins tend to be low in markets in which concentration is highest, while margins are higher in more competitively structured markets.

The key point to be derived from the past twenty years of experience with hospital consolidation is that, if not checked by vigilant antitrust enforcement, it can undermine the benefits that competition offers. Further, mergers that concentrate local markets have largely been driven by a desire to gain bargaining leverage. (It is important to note of course that not all consolidation is harmful: many hospital mergers do not affect local markets as they substitute a

---

[6] Vogt & Town supra note 3.

[7] Massachusetts Attorney General, *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 6½(b)* (March 16, 2010), *available at:* *http://www.mass.gov/Cago/docs/healthcare/final_report_w_cover_appendices_glossary.pdf*

[8] David Dranove, THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE: FROM MARCUS WELBY TO MANAGED CARE 122 (2000).

[9] MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: IMPROVING INCENTIVES IN THE MEDICARE PROGRAM xiv (2009) *available at* http://www.medpac .gov/documents/mar09_entirereport.pdf.

stronger, more efficient owner not currently competing in the market or they involve relatively small competitors in the same market.) In sum, it would be highly misleading to suggest that the Affordable Care Act is somehow responsible for a new wave of attempted anticompetitive provider mergers, when in fact those mergers are an effort to *avoid* the very pro-competitive policies the new law puts in place.

Turning to the payer side, health insurance markets have a long history of consolidation and increasing concentration in the individual and small group market, where, according to some data, two firms have greater than fifty percent of the market in twenty-two states, and one firm has more than fifty percent in seventeen states.[10] The results in these markets appear to confirm what economic theory predicts: higher premiums for consumers and high profits for the insurance industry. Summarizing studies indicating that private insurance revenue increased even faster than medical costs, economists at the Urban Institute concluded that "the market power of insurers meant that they were not only able to pass on health care costs to purchasers but to increase profitability at the same time."[11] While some studies question the extent of insurers' exercise of market power, bilateral market power is unlikely to serve consumer interests. Finally, experience suggests that entry into concentrated insurance markets is far from easy and may be unlikely to occur in markets with few insurers. A recent study by the Antitrust Division of the Department of Justice found that entry in such insurance markets was impeded by the difficulty of securing provider contracts.[12] Congress addressed the problem in several ways: encouraging formation of new competition via nonprofit insurance cooperatives and multi-state health plans. Although the proposal to include a public option plan in every market was rejected, by improving insurance markets, reducing risks of adverse selection, and establishing health insurance exchanges, the ACA took steps designed to induce de novo entry into concentrated insurance markets.

The Resurgence of Antitrust Enforcement

In recent years the Federal Trade Commission, the Antitrust Division, and a number of State Attorneys General have stepped up antitrust enforcement. The federal antitrust agencies' cases, along with competition advocacy in the legislative and regulatory arenas, have focused on (1) stopping anticompetitive mergers, (2) challenging the exercise of market power by dominant providers and insurers, (3) urging legislators to reject or remove barriers to competition or legislative exemptions from the antitrust laws, and (4) attacking competitor collusion, most notably between manufacturers of branded pharmaceuticals and generic

---

[10] Karen Davenport & Sonia Sekhar, *Interactive Map: Insurance Market Concentration Creates Fewer Choices*, CTR. FOR AM. PROGRESS (Nov. 5, 2009), http://www .americanprogress.org/issues/2009/11/insurance_market.html.

[11] John Holahan & Linda Blumberg, Urban Inst., Health Policy Ctr., CAN A PUBLIC INSURANCE PLAN INCREASE COMPETITION AND LOWER THE COSTS OF HEALTH CARE REFORM? 3 (2008), *available at* http://www.urban.org/health_policy/url.cfm?ID =411762.

[12] The Department of Justice's study concluded:

> [T]he biggest obstacle to an insurer's entry or expansion in the small- or mid-sized-employer market is scale. New insurers cannot compete with incumbents for enrollees without provider discounts, but they cannot negotiate for discounts without a large number of enrollees. This circularity problem makes entry risky and difficult, helping to secure the position of existing incumbents.

Christine A. Varney, Assistant Att'y Gen., Antitrust Div., U.S. Dep't of Justice, Remarks as Prepared for the American Bar Association/American Health Lawyers Association Antitrust and Healthcare Conference (May 24, 2009), *available at* http://www.justice.gov /atr/public/speeches/258898.pdf.

entrants and provider collusion in managed care negotiations. In addition, state attorneys general and private litigants have brought a number of important antitrust cases principally in the merger area.[13] (A description of the leading antitrust cases of the last two years, prepared for the biannual Antitrust in the Health Care Conference sponsored by the American Bar Association and the American Health Lawyers Association, is submitted as an appendix to this testimony).

These cases and legislative comments constitute a significant and necessary step toward protecting the competitive policies that undergird the Affordable Care Act. In the merger area, for example, the FTC succeeded in obtaining a federal court injunction blocking a hospital merger in Rockford, Illinois[14] and stopped another highly concentrative merger of hospitals in Toledo, Ohio via an administrative proceeding.[15] The Department of Justice challenged, and settled by consent decree requiring divestitures, a merger of health insurers that would reduce competition in Medicare Advantage contracting[16] and forced another health plan to abandon its plan to acquire its leading rival.[17] Together these cases should send a strong signal that consolidations will be closely scrutinized. However, the FTC suffered a notable setback in a challenge to a merger to monopoly between two hospitals in Albany Georgia in which the Court of Appeals allowed the merger to go forward based on a controversial application of the State Action Doctrine.[18]

A second series of cases involve challenges to the actions of dominant providers or dominant payers. These cases represent a marked departure from the posture of the agencies over the last two decades in which the government agencies have rarely taken on cases of monopolization or abuse of dominant position. The conduct at issue involves a variety of "exclusionary" actions: vertical arrangements that foreclose rivals without significant efficiency justifications. For example, the Antitrust Division challenged a dominant insurer's insistence on "most favored nations" clauses from contracting hospitals that severely disadvantaged rival

---

[13] Because my testimony today focuses on provider and payor competition, I am omitting what is undoubtedly the most significant antitrust enforcement effort in health care, the challenge to pay-for-delay agreements in the pharmaceutical sector. These cases, currently tangled in a series of conflicting decisions from federal appellate costs, are estimated to involve potential costs of $3.5 billion per year.

[14] *In the Matter of* OSF Healthcare System and Rockford Health System, FTC Docket No. 9349 (Nov. 17, 2011) available at www.ftc.gov/os/adjpro/d9349/111118rockfordcmpt.pdf

[15] *In the Matter of* ProMedica Health System, Inc., FTC Docket No. 9346 (March 28, 2012) available at www.ftc.gov/os/adjpro/d9346/120328promedicabriffopinion.pdf

[16] United States v. Humana Inc. and Arcadian Management Services, (D.D.C. March 28, 2012) available at www.justice.gov/atr/cases/humana.html.

[17] Press Release, U.S. Dep't of Justice, Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans (Mar. 8, 2010), *available at* http://www.justice.gov/atr/public/press_releases/2010/256259.pdf.

[18] Federal Trade Commission v. Phoebe Putney Health System, Inc., 663 F.3d 1369 (11th Cir. Aug. 9, 2011). The Solicitor General has filed a petition for certiorari in this case.

insurers.[19] In another case, settled by consent decree, the Division challenged a near-monopoly hospital's demands for exclusionary discounts from insurers.[20]

Preserving the Potentially Pro-competitive Effects of Accountable Care Organizations

Of the many important innovations contained in the Affordable Care Act, the Medicare Shared Savings Program (MSSP), which promotes the development of accountable care organizations, has undoubtedly garnered the most attention. The ACO strategy takes direct aim at the twin problems of the health care system: fragmented delivery and payments that reward volume rather than performance. Because they will be accountable for the full range of care needed by beneficiaries, ACOs need to establish integrated networks of providers that can monitor quality and provide seamless, cost-effective care. The Affordable Care Act explicitly encourages Medicare ACOs to also serve the commercially-insured sector and self-funded employers.

From the standpoint of competition policy, ACOs offer an important opportunity for providers to align in entities capable of delivering care that consumers (employers, insurers and individuals) can compare and negotiate with to get the best bargain in price and quality. Thus *both* provider integration and rivalry are key to the success of the concept. CMS, the FTC and the Department of Justice have worked closely together to establish guidelines[21] that will help providers assess the antitrust boundaries when forming ACOs. CMS has approved 27 ACOs and is reviewing another 150 applicants under the MSSP program. Together with 32 ACOs previously approved under the Pioneer ACO program (designed for integrated systems), over 1 million Medicare beneficiaries will be served by ACOs. In addition, many private insurers have inaugurated ACO programs.

Several procompetitive aspects of the agencies' regulations and policy statements should be noted. First, the MSSP allows ACOs considerable flexibility in the way they organize themselves. ACOs may be formed by joint ventures among providers and exclusive contracting is permitted only to the extent it does not impair competition. Exceptions are established for rural providers that recognize the special competitive circumstances they face. Dominant providers are constrained to some extent and cautioned about specific practices that interfere with payers' ability to engage in competitive contracting. Finally, CMS will gather data and monitor carefully the performance of participating ACOs.

---

[19] United States v. Blue Cross Blue Shield of Michigan, No. 2:10-14155-DPH-MKM (filed Oct. 18, 2010) available at http://www.justice.gov/atr/public/press_releases/2010/263227.htm.

[20] United States v. United Regional Health Care System, Case No.: 7:11-cv-00030-O (September 29, 2012) available at http://www.justice.gov/atr/cases/unitedregional.html.

[21] Federal Trade Commission and U.S. Department of Justice, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (October 28, 2011) *available at* www.ftc.gov/os/fedreg/2011/10/111020aco.pdf.

There are, to be sure, legitimate concerns that ACOs may form in a manner that allows providers to aggregate market power that can be exercised over private health plans and employers. At the same time, ACOs offer a distinct opportunity to increase the competitiveness (and hence the quality and cost-effectiveness) of the delivery system. The antitrust agencies and CMS appear to have set out a framework capable of monitoring the competitive implications of ACOs as they develop.

Addressing the Concentration Problem

While the antitrust agencies' efforts to promote and protect competition in health care markets is commendable, it is also the case that antitrust law has little to say about monopolies lawfully acquired, or in the case of consummated mergers, entities that are impractical to successfully unwind. Given the high level of concentration in many hospital markets and a growing number of physician specialty markets, it is particularly important to encourage other measures that promote competition.

Although there is no single "silver bullet" to solve the problem posed by extant provider concentration, there are a number of steps that reduce the market power exercised in such markets. To begin with, hospital concentration may be lowered by reduction of government-imposed barriers to entry such as Certificate of Need laws and excessive restrictions on physician-controlled specialty hospitals. In addition allowing middle-level professionals, such as nurse practitioners and physician assistants to practice within the full scope of their professional license under state law may increase the number and viability of new organizational arrangements such as medical homes and accountable care organizations that may be able to exert pressure on dominant providers. Further, federal and state legislatures should stoutly resist pleas for immunity or special protections from competition laws; there is a strong consensus, based on the nation's experience, that such exemptions harm consumer welfare.[22]

A second means of dealing with provider concentration is to use the full measure of authority under the antitrust laws to challenge the abuse of market power by dominant hospitals, physician groups and pharmaceutical companies. Among the important issues on the antitrust agenda are resisting claims of "State action" where the state legislation does not follow the Supreme Court's requirement that the defense is available only where state law truly endorses anticompetitive conduct and the state actively supervises the effects on consumers. Other steps might include retrospective challenges to recent mergers where divestiture is feasible. Further, following some path breaking scholarship by Professors Havighurst and

[22] As the nonpartisan Antitrust Modernization Commission has explained, antitrust exemptions "should be recognized as a decision to sacrifice competition and consumer welfare" that benefits small, concentrated interest groups while imposing costs broadly upon consumers at large. Antitrust Modernization Comm'n, Report and Recommendations 350 (2007), *available at* http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

Richman, antitrust law may be deployed to charge dominant hospitals with illegal tying or bundling, so as to force them to compete on the services that they do not monopolize.[23]

Finally, it may be possible to strengthen private market participants' to negotiate with dominant providers. For example, state health insurance exchanges or state regulators might require unbundling of hospital services as Havighurst and Richman suggest. For its part, CMS should carefully review the performance of ACOs, and where appropriate, decline renewal of contracts if market power has been exercised over private payers. Likewise, regulations and payment policies that favor ACOs controlled by primary care providers rather than dominant hospitals could serve to reduce the impact of the latter's market power.

Conclusion

A core concern of the Affordable Care Act is promoting competition in health care. Responses to the law such as anticompetitive mergers and cartel activity should be understood as efforts to avoid the discipline the new market realities will impose. Vigorous enforcement of the antitrust laws is essential to dealing with those problems, but at the same time the law is of limited help in dealing with extant market power. Legislators and regulators should be alert to opportunities to improve the prospects for entry and increased competitive opportunities where monopoly power is present.

[23] Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care,* 89 Or. L. Rev. 847 (2011).

ATTACHMENT

SELECTED ANTITRUST DEVELOPMENTS IN HEALTH CARE

ABA Section of Antitrust Law
ABA Health Law Section
American Health Lawyers Association

ANTITRUST IN HEALTHCARE PROGRAM
May 3, 2012
Washington, D.C.

Thomas L. Greaney
Professor of Law and Director, Center for Health Law Studies
Saint Louis University School of Law

Douglas C. Ross
Davis Wright Tremaine LLP
Seattle, Washington

This paper reviews selected developments in antitrust health care. While the paper surveys some of the more important such developments since the last conference in May 2010, the principal focus is on matters that have taken place over the last year. The paper reviews developments in health care antitrust enforcement in Section I, developments in private litigation in Section II and concludes in Section III with a discussion of the agencies' guidelines, issued last year, on accountable care organizations.[1]

I. GOVERNMENT ACTIVITIES

The last two years have been among the busiest ever at the federal antitrust enforcement agencies with respect to health care matters and in particular mergers.

A. Hospital Mergers

1. FTC Wins a Hospital Merger on the Road: District Court Enjoins Rockford Merger[2]

In early April a federal court handed the FTC a win in a hospital merger being fought on the same battleground as the Department of Justice fought a hospital merger case nearly a quarter of a century ago: Rockford, Illinois.[3] The court enjoined OSF Healthcare System's proposed acquisition of Rockford Health System pending an administrative trial scheduled for later in the month. Judge Kapala of the Northern District of Illinois had "no trouble" finding that a combined OSF and Rockford would control an undue share of the market for acute care services in an area encompassing a 30-minute drive time around Rockford.

Rockford, a non-profit health care system, owns Rockford Memorial Hospital which is located in Rockford, Illinois. OSF, a health care system with several acute care hospitals throughout Illinois, owns St. Anthony Medical Center, another hospital in Rockford. St. Anthony's and Rockford Memorial compete with each other and with SwedishAmerican.

OSF's proposed acquisition of Rockford would combine the two hospitals and their physicians to form OSF Northern Region, a new health care system. The two non-profit systems entered an affiliation agreement in early 2011. The Illinois Health Facilities and Services Review Board approved the acquisition in May 2011, when it granted a Certificate of Exemption to OSF. The FTC parted ways with the State of Illinois and filed an administrative complaint against both systems in November 2011.[4] The complaint alleged the acquisition would create a dominant health system that would control 64% of the market for general acute care inpatient services and

---

[1] The authors would like to thank Charles Wright and Ryan Gist of Davis Wright Tremaine who authored numerous member alerts for the AHLA Antitrust Practice Group on which many of these summaries are based.

[2] FTC v. OSF Healthcare System and Rockford Health System, No. 3:11-cv-50344 (N.D. Ill. April 5, 2012) available at www.ftc.gov/os/caselist/1110102/120505rockfordmemo.pdf

[3] United States v. Rockford Memorial Corp., 898 F.2d 1278 (7th Cir. 1990).

[4] *In the Matter of* OSF Healthcare System and Rockford Health System, FTC Docket No. 9349 (Nov. 17, 2011) available at www.ftc.gov/os/adjpro/d9349/111118rockfordcmpt.pdf

would combine two of the three primary care physician groups in the area accounting for 37% of the relevant physician market.

The FTC simultaneously moved to enjoin the acquisition in federal court for the Northern District of Illinois. The agency expressed concern in a press release that the acquisition would end "decades of competition between the defendants' hospitals," leading to "significantly higher costs that would be passed on to employers and to health care consumers in Rockford."[5]

At the hearing on the requested injunction, FTC witnesses testified the acquisition would create a single system with nearly 65% of the market for general acute care inpatient services within a thirty-minute drive from Rockford. The "three to two" merger would, the FTC claimed, result in "a significant increase in the concentration of firms" in the market leading to an increased danger of collusion.

The court agreed and enjoined the acquisition. The court rejected the two systems' argument that SwedishAmerican, the remaining competitor and current market leader, would constrain any market power a combined OSF and Rockford might have. The court also expressed skepticism that – given the recent failures of single-hospital insurance networks in Rockford – insurance companies could defeat post-merger price increases by refusing to contract with a combined OSF and Rockford.

While taking pains not to express any opinion on the ultimate merits of the claim, the court observed "the FTC's likelihood of success on its claim involving the [primary care physician] market is distinctly lower than its claim involving the [general acute care inpatient] market." The post-merger market shares in the physician market would be lower than in the inpatient market, barriers to entry are lower, and payors have more bargaining leverage.

OSF and Rockford argued that the merger would reduce costs and increase the quality of care available to Rockford residents in a number of ways. Although Judge Kapala commended the two systems for "having the desirable goals of improving patient quality of care," he found the touted the efficiencies and improvements from the merger either were too speculative to rebut the FTC's case or could be realized even without the acquisition.

2. FTC Wins a Hospital Merger at Home: Commissioners Stop Toledo Hospitals From Forming Powerhouse[6]

In a widely anticipated decision following a contested hearing before an administrative law judge, the Federal Trade Commission in late March blocked ProMedica Health System's acquisition of St. Luke's Hospital in Toledo. The FTC found the acquisition would likely result in higher health care costs for patients, employers, and employees, in violation of Section 7 of the Clayton Act. The FTC ordered ProMedica to sell St. Luke's to a willing buyer for no minimum price. ProMedica has vowed to appeal to the Sixth Circuit Court of Appeals.

---

[5] "FTC Challenges OSF Healthcare System Proposed Acquisition of Rockford Health System as Anticompetitive," (Nov. 18, 2011) available at www.ftc.gov/opa/2011/11/rockford.shtm.
[6] *In the Matter of* ProMedica Health System, Inc., FTC Docket No. 9346 (March 28, 2012) available at www.ftc.gov/os/adjpro/d9346/120328promedicabrillopinion.pdf

ProMedica Health System is an integrated health care delivery system that owns three general acute care hospitals in Lucas County, Ohio (where Toledo is located). ProMedica also owns a health insurance company that operates in Lucas County. Evidence at trial showed the ProMedica hospitals enjoy the highest reimbursement rates in Lucas County.

St. Luke's is a stand-alone, community hospital in Toledo's suburbs. St. Luke's had the lowest reimbursement rates in the market and for years it had been losing money. In February 2010, Moody's downgraded its bond rating to two steps above junk-bond status. St. Luke's argued at trial that it operating expenses and looming capital needs could deplete its reserves by 2013.

Toledo's per capita bed ratio is higher than the national average. In addition to ProMedica and St. Luke's, the Mercy system operates three hospitals in Toledo and the University of Toledo operates a teaching hospital there. Toledo's economy lags the national average, with unemployment peaking in 2010 at over 13%.

Faced with these economics, St. Luke's sought shelter in the arms of a better-financed merger partner. In May 2010, St. Luke's and ProMedica signed a Joinder Agreement. The FTC opened an investigation in July of that year.

In January 2011, the FTC simultaneously issued an administrative complaint against the proposed merger and filed suit in federal district court, seeking an injunction that would keep the hospitals from integrating pending the outcome of the administrative hearing. A federal judge granted a preliminary injunction in March 2011. The parties then litigated the case before an administrative law judge in a hearing that included over 2,600 exhibits, testimony from 34 witnesses, and 7,955 pages of hearing transcripts.

In December 2011, the ALJ issued his initial decision concluding the transaction was likely to substantially lessen competition in violation of Section 7 of the Clayton Act. ProMedica and the FTC's Complaint Counsel both appealed separate aspects of that decision to the full Commission.

Commissioner Julie Brill wrote the opinion on behalf of three of the Commission's four members. Commissioner Thomas Rosch concurred in the result, but not in all of the majority's reasoning.[7] The primary points of contention involved the relevant product market and the trial staff's reliance on expert econometric analysis.

The majority's analysis began with an extended discussion of the relevant product market. At the administrative hearing, ProMedica argued the relevant product market should be the cluster of general acute care services provided by hospitals, without differentiation. Complaint Counsel argued the product market should exclude tertiary services (which St. Luke's generally does not offer), and that there should be a separate analysis of the market for obstetrical services. The ALJ agreed with ProMedica and analyzed the market for all general acute care services. The

[7] *In the Matter of* ProMedica Health System, Inc., FTC Docket No. 9346 (March 28, 2012) (concurring opinion of Commissioner Thomas Rosch) available at www.ftc.gov/os/adjpro/d9346/120328promedicaroschopinion.pdf.

trial staff appealed that portion of the ruling. Commissioner Brill's majority opinion reversed the ALJ on this issue.

The majority first found the product market should not include tertiary services, given that St. Luke's does not provide such services. As a result, the merger could not affect competition for such services: "Absent an overlap or potential overlap involving a given service line, there is no substantial lessening of competition, and, thus, no need to include the service in the relevant product market." The majority also reasoned that including tertiary service in the market might "obscure the analysis of competitive effects," given that patients might be willing to travel farther for such services and thus expand the geographic market accordingly.

Commissioner Rosch disagreed and would have included tertiary services in the market definition, in accordance with the FTC's approach in its *Evanston Northwestern Healthcare Corp.* decision from 2007. [8]

In the end, however, this debate had little practical effect: both the majority and Commissioner Rosch agreed with the ALJ that the competitive effects would be the same with or without the inclusion of tertiary services.

The majority then found evidence of a separate market for obstetrical services. That evidence included the fact that "no other services are interchangeable with OB services;" "obstetrics is recognized as a separate field of medicine with distinct providers of OB services;" the hospitals themselves "track OB services market shares separately from [general acute care] inpatient services;" at least one other hospital in the market did not provide OB services; and insurers separately negotiate reimbursement rates for OB services. For the majority, these "practical indicia" warranted examination of a separate market.

Again, Commissioner Rosch disagreed. Because OB services are already included in the cluster of general acute care services, Rosch reasoned, examining a separate market would be redundant. He found no judicial precedent for the majority's approach and concluded by warning the majority against "'gerrymandering' the relevant product market so as to make it more susceptible to a structural presumption of liability."

Turning to that structural presumption, the full Commission (joined by Commissioner Rosch) easily found a likelihood of competitive harm by examining market shares and concentration levels. The Commission found those data "exceed the thresholds for presumptive illegality provided in the 2010 Horizontal Merger Guidelines and the case law." Indeed, ProMedica did not dispute that presumption. As a result, the burden shifted to ProMedica "to cast doubt on the accuracy of the Government's evidence as predictive of future anticompetitive effects." The Commission rejected ProMedica's efforts.

ProMedica's primary effort at rebuttal focused on St. Luke's economic health. ProMedica faced a daunting challenge: as the FTC noted, courts have concluded that "financial weakness, while

---

[8] *In the Matter of* Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc., FTC Docket No. 9315, File No. 011 0234 (2007) available at www.ftc.gov/os/adjpro/d9315/index.shtm

perhaps relevant in some cases, is probably the weakest ground of all for justifying a merger, and certainly cannot be the primary justification for permitting one." Nor did the evidence help that task. The Commission found St. Luke's was actually turning its finances around in the year or so preceding the Joinder Agreement: it had hired a new CEO, it had begun implementing a new strategic plan, it had seen an increase in patient volumes, and by August 2010 it had realized a positive operating margin (albeit $7,000). The Commission concluded ProMedica "has not shown that St. Luke's financial condition so reduces its competitive significance as to undermine Complaint Counsel's prima facie case." Its "weakened competitor" evidence fell "far short of what the courts have demanded."

The full Commission then surveyed evidence buttressing the structural presumption of illegality. Perhaps most problematically, every insurer testified that "the Joinder would further increase ProMedica's bargaining leverage, thereby leading to even higher rates," and that the remaining hospitals in the market would not be sufficient substitutes in the insurers' opinions. The FTC did not discredit these opinions as biased, as ProMedica had argued.

Perhaps equally problematic were St. Luke's internal documents, which the Commission found predicted increased reimbursement rates for St. Luke's through enhanced bargaining leverage with insurers. Among other things, the documents noted the ProMedica affiliation could "harm the community by forcing higher hospital rates on them," and allow St. Luke's to "force high rates on employers and insurance companies."

The Commission then turned to the economic evidence the parties presented at trial. The FTC's economist predicted rates at St. Luke's would increase to supra-competitive levels as a result of the transaction. Finding ProMedica to be St. Luke's next-best substitute, the Commission agreed. The expert's prediction of a price increase at ProMedica's hospitals was not as clear-cut. The evidence showed St. Luke's is not ProMedica's closest substitute; instead, most ProMedica patients would choose to go to one of the Mercy hospitals after ProMedica. Nonetheless, the FTC's economist constructed an econometric model that attempted to calculate insurers' "willingness to pay" to include the various hospitals in their networks. From those calculations, the expert then predicted price increases of 16.2 percent in the aggregate, with prices rising 38 percent at St. Luke's and 10.75 percent at ProMedica's legacy hospitals. ProMedica and its economist strongly disputed the soundness of these conclusions. Nonetheless, the majority concluded this analysis "provides confirming evidence for the conclusion that the increased bargaining leverage created by the Joinder will lead to higher prices."

Commissioner Rosch saved his strongest criticism for the majority's reliance on this merger simulation evidence. First, he attacked the evidence as legally inappropriate, because St. Luke's was not ProMedica's next best substitute. As a result, he claimed, this evidence did not meet the courts' test that "customers accounting for a 'significant share of sales' in the market must view the merger parties as each other's closest substitutes." Second, Commissioner Rosch attacked the reliability of the econometric evidence, noting critics "have charged that such studies always predict a price increase if there is any degree of substitution between the merging parties' products." In other words, such evidence can lead to false positives in assessing competitive impact, regardless of the actual substitution between the merging parties. Finally, Commissioner Rosch found the economic evidence unnecessary, both in this case and generally:

> [T]he Commission has tried to persuade staff of the virtues of "telling a story" predominantly out of the mouths of the parties and their documents. This is how the top-flight plaintiff's lawyers try their cases. We have much to learn from them. The Commission should be reluctant to focus attention instead on economic models especially when the Commission has devoted so much time and effort to insisting that staff focus on the real world as contrasted with the theoretical world.

Finally, the Commission rejected ProMedica's evidence that insurers or other competitors might be able to constrain the combined entity from raising its prices. The Commission credited evidence that the insurers could not steer their customers to competitors and the other hospitals could not reposition themselves to capture market share from ProMedica/St. Luke's.

As it had argued to the ALJ, ProMedica argued to the full Commission that if there were a violation the appropriate remedy would be to permit the Joinder but require separate, walled-off bargaining units for the ProMedica hospitals and for St. Luke's. ProMedica argued this arrangement, which the FTC approved in the *Evanston* case, would allow St. Luke's to gain financial stability while preventing any perceived anticompetitive effects. Like the ALJ, the Commission rejected this argument and instead concluded that structural remedies like divestiture are preferred once the FTC has found an illegal merger. The Commission noted a conduct remedy was appropriate in *Evanston* only because the parties had merged seven years before the FTC's final decision and unscrambling the eggs would be nearly impossible, or at least very expensive. The Commission concluded the ProMedica/St. Luke's joinder was not such an omelet, in large part because the parties had entered a hold separate agreement that the district court had extended with its preliminary injunction.

Alternatively, ProMedica argued it should not be forced to sell St. Luke's but should be permitted simply to spin it off as an independent entity. The Commission disagreed, stating its order was broad enough to permit ProMedica to sell St. Luke's to its previously independent parent and thus restore its status as an independent hospital.

3. That's "Al-benny" to you: 11th Circuit Court Dismisses the FTC's Challenge to Georgia Hospital Merger Under State Action Doctrine; FTC Files for Certiorari to the Supreme Court[9]

In a ruling issued late in 2011, the Court of Appeals for the Eleventh Circuit dealt a serious blow to the Federal Trade Commission's effort to reign in the ability of hospitals to use the state action doctrine to protect otherwise anticompetitive mergers and acquisitions from attack under the antitrust laws. The FTC responded by filing a cert petition in late March 2012 with the Supreme Court.[10]

---

[9] Federal Trade Commission v. Phoebe Putney Health System, Inc., 663 F.3d 1369 (11th Cir. Aug. 9, 2011).

[10] Federal Trade Commission v. Phoebe Putney Health System, Inc. *Petition for Writ of Certiorari* (March 23, 2012) available at http://www.ftc.gov/opa/2012/03/phoebeputney.shtm.

The appellate court affirmed the dismissal, under the state action doctrine, of the FTC's complaint against the acquisition by Phoebe Putney Health System of Palmyra Park Hospital. The ruling immunizes from antitrust attack the consolidation of the only two acute care hospitals in a six-county region of rural southwestern Georgia.

For many years, the state-created Hospital Authority of Albany-Douglas County owned and operated Phoebe Putney Memorial Hospital in Albany, Georgia. In 1991, Phoebe Putney Health System and its subsidiary Phoebe Putney Memorial Hospital, Inc. – both nonprofit corporations created by the Authority – have leased Memorial Hospital from the Authority and operated the hospital semi-independently from the Authority.

Memorial Hospital's only competitor in a six-county geographic market was Palmyra Park Hospital, owned and operated by HCA, Inc. Between them, the two hospitals account for over 85% of acute care in their geographic market.

In April 2011, the Authority approved a plan by which it would acquire Palmyra Park Hospital. The Authority proposed to fund the acquisition with money provided by Phoebe Putney Health System, and then lease Palmyra Park back to the system or a subsidiary. The FTC attacked the structure of this transaction as a "strawman" designed for no reason other than to bring the transaction within the immunity of the state action doctrine.

The FTC sought to enjoin the transaction in federal court shortly after the Authority approved the deal. The agency claimed the deal would substantially lessen competition in the market for acute care hospital services in southwestern Georgia.

The hospitals moved to dismiss the complaint, asserting the transaction was immune from the antitrust laws under the state action doctrine. The district court agreed and dismissed the complaint with prejudice. The FTC sought an expedited appeal, and the Eleventh Circuit temporarily enjoined the transaction pending the outcome of that appeal.

Under the state action doctrine, courts consider whether state law authorizes the challenged conduct and whether state law "has clearly articulated a state policy authorizing anticompetitive conduct." The key inquiry under this standard is whether "anticompetitive conduct is a 'foreseeable result' of the legislation," that is, whether the anticompetitive conduct could be "reasonably anticipated" at the time of passage of the legislation. The Eleventh Circuit found both prongs of the standard were met.

Notably, the court assumed the merger would create a monopoly for acute care.

The court first surveyed the broad powers the Georgia legislature granted to public hospital authorities under the Georgia Hospital Authorities Law, passed in 1941. Through both expressly enumerated powers and a catch-all "necessary powers" clause in the statute, the court concluded "the Authority can in effect deploy any power a private corporation could in its stead," as well as deploy powers a private corporation could not (such as pricing its services below cost and making up the difference through tax revenues). Most importantly, the law expressly permits public hospital authorities to acquire other hospitals and to lease its hospitals to others for operation.

The court then reasoned it was foreseeable this broad grant of power to hospital authorities could have an effect on competition. According to the court, the economic realities of rural hospital districts made obvious the anticompetitive effects of hospital acquisitions within those districts:

> [T]he Georgia legislature must have anticipated anticompetitive harm when it authorized hospital acquisitions by the authorities. It defies imagination to suppose the legislature could have believed that every geographic market in Georgia was so replete with hospitals that authorizing acquisitions by the authorities could have no serious anticompetitive consequences. The legislature could hardly have thought that Georgia's more rural markets could support so many hospitals that acquisitions by an authority would not harm competition.

The court did not rely on legislative history or contemporaneous market studies from the time of passage of the Hospital Authorities Law. Instead, the court reasoned that if a rural hospital district in 1941 was authorized to acquire a hospital within its district, the effect on competition should have been obvious to the legislature.

In so ruling, the court declined to consider the FTC's "strawman" argument. As it had done before the district court, the FTC urged the Eleventh Circuit to find that the structure of the transaction did not involve any genuine state action, but that the Authority simply provided a rubber stamp of a private transaction.

Following the Supreme Court's decision in *City of Columbia v. Omni Outdoor Advertising, Inc.*,[11], the Eleventh Circuit declined to "deconstruct the governmental process or probe the official intent to determine whether the government's decision-making process has been usurped by private parties." Supreme Court precedent requires courts to take government approval at face value when considering the state-action doctrine, and not "look behind governmental actions for perceived conspiracies to restrain trade."

B. Payor Mergers

1. Advantage DOJ: Humana Agrees to Spin off Medicare Assets as Price of Acquiring Competitor[12]

The Antitrust Division of the Department of Justice announced in late March 2012 a proposed consent decree that would require Humana Inc. and Arcadian Management Services Inc. to divest assets relating to Arcadian's Medicare Advantage business in parts of Arizona, Arkansas, Louisiana, Oklahoma and Texas in order for Humana to proceed with its acquisition of Arcadian.

---

[11] 499 U.S. 365 (1991).

[12] United States v. Humana Inc. and Arcadian Management Services, (D.D.C. March 28, 2012) available at www.justice.gov/atr/cases/humana.html.

The Division claimed without the divestitures Medicare beneficiaries would likely have faced higher prices, fewer choices and lower quality options in the market for Medicare Advantage plans.

According to the complaint the Division filed simultaneously with the proposed consent decree, Humana and Arcadian are two of the few significant sellers of Medicare Advantage plans in 45 of counties and parishes in the five states where the divestitures will occur. The Division asserted the transaction would have created a combined company controlling between 40% and 100% of the Medicare Advantage health insurance market in these areas.

To avoid the perceived anticompetitive effects, Humana must promptly divest the Medicare Advantage plans in a slightly broader area of 51 counties and parishes to companies approved by the Division. The Division noted the divestitures encompassed a broader area than the 45 counties and parishes identified as presenting competitive concerns "to facilitate the divesture of the plans" and to "make those plans more administrable."

The proposed consent decree would require buyers of the divested Medicare Advantage plans contract with substantially all of the health care providers included in the Humana and Arcadian plans at substantially the same rates.

C. Other Mergers

1. No Benefit to Enforcement: FTC Passes on PBM Merger[13]

By a three-to-one vote, the Federal Trade Commission opted to close its investigation of the acquisition proposed by Medco Health Solutions of Express Scripts, Inc. The three commissioners in the majority found that the merged entity, despite enjoying a market share of at least 40% in the broadest possible market, nonetheless would be unlikely to raise prices unilaterally, to collude with others, or to exercise monopsony power when negotiating drug dispensing fees with pharmacists.

Medco and Express Scripts are pharmacy benefit managers. PBMs are third party administrators of prescription drug programs. They process and pay prescription drug claims, maintain drug formularies, contract with pharmacies, and negotiate discounts with manufacturers.

The Commission rejected the possibility that the acquisition might have an anticompetitive effect in the market for the provision of PBM services to health care benefit plan sponsors, including employers and unions. The Commission called this market "moderately concentrated," with at least ten significant competitors. The merged company would have a share of this market, wrote the Commission, of just over 40%.

"Medco and Express Scripts are not particularly close competitors" in this market, wrote the Commission majority. Medco focuses on large employers while Express Scripts historically has

[13] Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts, Inc., FTC File No. 111-0210 (April 2, 2012) available at www.ftc.gov/os/2012/04/120402expressmedcostatement.pdf.

targeted middle market plan sponsors and health plans. Interviews with customers and internal documents confirmed the conclusion that the two companies were not close competitors. CVS Caremark, along with Express Scripts and Medco, one of the "big three" in the PBM market, has provided robust competition to each of the merging parties. In fact, the Commission wrote, CVS Caremark was the closest competitor to each of Express Scripts and Medco. The Commission also noted that health plan owned and standalone PBMs have become stronger competitive threats over the last several years. Moreover, despite initial concerns that the big three PBMs might have a cost advantage over smaller companies, the Commission found the cost data submitted by PBMs did not support that conclusion.

"Ultimately," the Commission concluded "the evidence fails to demonstrate that the transaction is likely to produce unilateral anticompetitive effects." The Commission then turned to consider whether the merger may increase the likelihood that PBMs might collude, tacitly or explicitly, to raise price following the transaction.

The Commission concluded that the merger was unlikely to increase the possibility of anticompetitive collusion because coordination requires firms be able to reach agreements and monitor adherence to them. But because PBM contracts contain numerous pricing components and bids are rarely released, pricing terms for PBM services "are complicated and difficult to compare" and coordinated effects among PBMs would be difficult.

The Commission considered as well whether, as a result of the transaction, PBMs might be in a better position to allocate customers or refrain from bidding aggressively on each other's business. Again the Commission concluded this was unlikely. The success of CVS Caremark in the marketplace suggested to the Commission that this company, in particular, will find it profitable to continue to compete vigorously rather than "pull its punches and participate in a coordinated allocation of customers." The smaller, independent PBMs and PBMs owned by health plaintiffs also would have little incentive to collude because they have invested substantially in additional capacity and therefore need to grow.

Finally, the Commission turned to the question of whether the merger might permit the new firm to exercise monopsony power when it negotiates dispensing fees with retail pharmacies. The Commission found no such risk. The most significant factor on which the Commission relied to reach this result was market share. The merged firm would have a "smaller share of retail pharmacies' sales – approximately 29% – than is ordinarily considered necessary for the exercise of monopsony power." Moreover, the Commission wrote, "PBM size does not correlate to reimbursement rates paid to retail pharmacies." The Commission concluded that savings in dispensing fees likely would be passed through to PBM customers. As a result, the transaction could lower health care costs.

The Commission also considered and rejected the notion that the merger might lead to anticompetitive effects with respect to specialty drugs. Apparently, some opponents of the transaction argued the new firm would be in a better position to demand exclusive distribution arrangements from manufacturers of such drugs. But the specialty pharmacy market, the Commission found, is substantially less concentrated than the overall market for PBM services. Dozens of specialty pharmacies operate in the specialty market.

Significantly, manufacturers of specialty drugs indicated that they seek exclusive distribution arrangements on occasion. The fact the manufacturers seek these, rather than the PBM, would suggest the arrangements are efficient and not anticompetitive.

The Commission concluded that the high market shares of the merging parties "do not accurately reflect the current competitive environment and are not an accurate indicator of the likely effects of the merger on competition and consumers." This finding is significant because it underlines the basic antitrust point that while large market shares may signal a merger is anticompetitive, they are not conclusive evidence on this point.

Commissioner Julie Brill dissented from the decision.[14] In her view the acquisition violated Section 7 of the Clayton Act and Section 5 of the Federal Trade Commission Act. She wrote the merger would produce a "duopoly with few efficiencies in a market with high entry barriers." Express Scripts is the country's largest PBM with 90 million covered lives and Medco is the third largest with 65 million covered lives. CVS Caremark, with 85 million covered lives, is the second largest company. "After the merger," wrote Commissioner Brill, "the merged entity will be over five times larger than the third largest firm." According to Commissioner Brill, a market could be defined for "large commercial employers," and in this market the merger would increase the Herfindahl-Hirschman Index (HHI) over 1,300 points taking the concentration level from 2,760 to 4,063.

Commissioner Brill argued that whether the relevant market were limited to the top 100 or the top 300 employers, or even the entire employer market, the new firm would have a 45% market share and the big three would have almost three-quarters of the market. In these markets, wrote Commissioner Brill, the HHI would also increase significantly by almost 1,000 points.

The Commissioner commented that she felt "some discomfort about unilateral effects from this merger." In the arena of coordinated effects, however, she felt more strongly the merger "this merger creates an appreciable danger of anticompetitive effects." To bolster her conclusions the Commissioner relied on statements made by Express Scripts' and Medco's CEOs. The majority took note of the same evidence in its opinion, commenting these statements were "ambiguous."

The Commission investigation of the merger took eight months, resulted in the production of millions of pages of documents, and involved over 200 interviews of market participants by Commission staff.

2. FTC Sniffs, OmniCare Sneezes[15]

OmniCare Inc. announced on February 21, 2012, that it had abandoned its effort to acquire rival PharMerica Corp. The decision came in the wake of an Federal Trade Commission challenge to the proposed deal between the two long term care pharmacy companies. The FTC had charged

---

[14] Dissenting Statement of Commissioner Julie Brill FTC File No. 111-0210 (April 2, 2012) available at www.ftc.gov/speeches/brill/120402medcobrillstatement.pdf.

[15] *In the Matter of* Omnicare, Inc., FTC Docket No. 9352, File No. 111 0239 (Order Dismissing Complaint, Feb. 23, 2012) available at www.ftc.gov/os/adjpro/d9352/120223omnicareorder.pdf.

their combination would lead to increased prices for prescription drugs sold to Medicare Part D participants living in skilled nursing facilities (so-calls "SNFs").

Residents in a SNF typically receive their prescription drugs from a long term care pharmacy located within the facility. Omnicare and PharMerica, who own and operate long term care pharmacies throughout the United States, contract with nursing facilities to provide pharmacy services. Many nursing facility residents offset the cost of their medication by participating in the federal government's prescription drug insurance program under Medicare Part D. The Centers for Medicare & Medicaid Services require that health plans offering Part D insurance have contracts with long term care pharmacies to ensure health plan customers have convenient access to prescription drugs.

Omnicare made an unsolicited bid in September 2011 to acquire the outstanding shares of PharMerica, its primary competitor. PharMerica's chief executive officer publically opposed the deal, valued at approximately $760 million.

The FTC sued to block the proposed acquisition on January 27, 2012. A merger between the two, according to the agency, would "combine the largest and only two national long term care pharmacies in the country." The FTC claimed that a combined Omnicare/PharMerica would serve nearly 60% of all licensed SNF beds in the United States and would become a must-have for Part D health plans seeking to meet CMS' "convenient access" requirement. This would enable the company to increase prescription drug prices to what the FTC called, in its press release, the "fragile population" of SNF residents.

In its statement announcing the abandonment of the transaction, Omnicare wrote, "While we continue to strongly disagree with the FTC's decision to seek to block the proposed transaction, we do not believe it is prudent to invest significant time and money in a lawsuit at this time."

The company revealed it had offered to enter into a consent agreement with the FTC that would require divestitures, but apparently the agency did not consider the proposal sufficient to resolve its competitive concerns.

3. Lab Experiment Explodes: FTC Challenge to LabCorp Acquisition of California Rival Rebuffed[16]

In early 2011, a federal judge in California denied the FTC's request for a preliminary injunction that would have stopped the acquisition by LabCorp in California of Westcliff Medical Laboratories, Inc. pending resolution of FTC's administrative complaint against the parties. Unable to stop the acquisition before the matter could be heard in an administrative proceeding, the FTC dropped its suit.

LabCorp – the second largest independent clinical laboratory company in the United States – announced in May 2010 it had agreed to purchase the assets of Westcliff, the third largest

[16] Federal Trade Commission v. Laboratory Corporation of America and Laboratory Corporation of America Holdings, Case No. 8:10-cv-01873-AG-MLG (C.D. Cal. 2011) materials available at http://www.ftc.gov/os/caselist/1010152/index.shtm.

clinical laboratory in California, with operations focused primarily in Orange County. LabCorp agreed to pay $57.5 million to buy Westcliffe, which meant that the acquisition was not reportable to the federal enforcement agencies under the Hart-Scott-Rodino Act.

Nonetheless, the FTC moved to investigate. In a hold-separate agreement, the parties agreed not to consummate the acquisition until 30 days after they had certified compliance with the CID. With the hold-separate agreement set to expire in early December 2010, the FTC acted at the end of November. The agency simultaneously filed an administrative complaint, alleging the acquisition would violate Section 7 of the Clayton Act and Section 5 of the FTC Act, and a complaint in federal court, seeking injunctive relief that would have extended the hold-separate agreement through the completion of the FTC's investigative hearing.

The court denied FTC's requested injunction despite the favorable standard for obtaining injunctive relief under § 13(b) of the FTC Act. Under that statute, the FTC does not have to make a showing of irreparable harm, as private litigants must to obtain injunctive relief. Instead, the FTC need show only a likelihood of success on the merits and the equities balance in favor of injunctive relief.

The court concluded that the FTC did not make either showing. The court made multiple factual findings supporting its conclusion that the FTC had not demonstrated it was likely to succeed on the merits.

- The court rejected the FTC's product market definition. The FTC would have treated capitated and fee-for-service clinical laboratory services as separate products. The court found as a matter of fact, and concluded as a matter of law, the methods by which consumers and payers pay for services do not define the product at issue, in this case clinical laboratory services.

- The court noted that FTC Commissioner J. Thomas Rosch had dissented from issuing the complaint in this matter. Commissioner Rosch called the product market definition in the complaint "misleading" because it turned on the means of payment, not the product being offered. The court found expansion of the product market to include all clinical laboratory services, regardless of the type of payment, "dramatically expands the number of competitors in the market and reduces LabCorp's and Westcliff's market shares significantly."

- The court appeared to reject the FTC's geographic market definition (which would have limited the market to Southern California), suggesting in its findings that the market might be statewide and that such expansion also would reduce the companies' combined market shares.

- The court made several findings suggesting low barriers to entry would preclude any anticompetitive effects as a result of the acquisition. Several competitors had begun providing clinical laboratory services in Southern California in recent years. The court even turned the FTC's product market against the agency and found that Westcliff itself had begun competing for capitated contracts in recent years and had become an effective competitor in a relatively short time. The court concluded that even if there were some

likelihood of anticompetitive concentration as a result of the acquisition, the low barriers to entry would effectively dilute that concentration.

- The court found several merger-specific efficiencies. The defendants presented evidence that clinical laboratories are high fixed-cost businesses and therefore increased volumes would allow LabCorp to offer lower capitated rates to purchasers. The court also noted evidence suggesting the acquisition would produce $22 million in efficiencies through cost and supply savings. Defendants' expert estimated that those efficiencies would result in $2.3 million in annual savings to consumers. The court made separate findings in support of its conclusion that balancing the equities "strongly favors defendants."

- The court again noted the efficiencies to be gained from the acquisition, and concluded reduced cost to consumers is the type of "public interest" most relevant to balancing the equities.

- The court paid particular attention to the length of time the injunction would likely remain in place pending the conclusion of the hearing on the merits. The court made specific findings about the length of the FTC administrative hearings, and found that despite efforts at reform, "that process remains a long, drawn-out ordeal." In the court's opinion, such delay would be particularly inequitable for the defendants given they could not receive compensation for the delay in the event they ultimately prevailed on the merits.

- Westcliff (renamed LabWest) had been losing money since the announcement of the acquisition. The court seemed particularly troubled by the "real possibility that a preliminary injunction here would financially devastate or destroy LabWest."

- Finally, the court found divestiture remained a possibility in the event the FTC prevailed on the merits.

As a result of all these factors, the equities favoring denial of the injunction "heavily outweighed" any minimal likelihood of success by the FTC.

The FTC immediately appealed the decision to the Ninth Circuit and simultaneously requested a stay pending appeal. On February 25, 2011, the district court denied the FTC's request for a stay. The Ninth Circuit also denied the FTC's request for a stay.

In March, the FTC withdrew its appeal. The FTC also agreed to postpone, but not dismiss the underlying administrative action. In the meantime, LabCorp and Westcliff remained free to integrate their operations.

Commissioner Julie Brill dissented from the Commission's decision. Brill identified three issues she believed the appeal would resolve notwithstanding the mootness of the injunction. First, Brill believed the district court ignored internal evidence of the parties' intention to raise prices after the merger. Given the prominent role such evidence plays in the agencies' new Horizontal Merger Guidelines, Brill wanted to give the court of appeals the opportunity to determine the effect of such evidence on requests for injunctive relief. Second, the dissent claimed the district

court had valued the parties' private interests over the "public equities" that injunctive relief by FTC is intended to protect. Third, Brill noted "pre-integration relief is often far more likely to remedy competitive problems than post-integration divestiture," and wanted the Ninth Circuit to make this clear.

Perhaps most significantly, Brill would have persevered with the appeal because "vigorous antitrust enforcement" will help contain rising health care costs. In Brill's view, "an appeal in this case is worth the expenditure of resources because of the industry in which it arises."

In April 2011, the FTC withdrew its administrative complaint, finding that further adjudication would not serve the public interest.

4. No Standing Ovation: Court Affirms Dismissal of FTC's Claims in Pharma Merger[17]

In August 2011, the Eighth Circuit Court of Appeals affirmed the judgment a district court entered against the FTC and the Minnesota Attorney General after the agencies challenged the purchase by pharmaceutical company Lundbeck Inc. of a drug that gave it control of the only two drugs approved for treatment of potentially deadly congenital heart defect affecting low-birth weight premature infants. The court held the FTC had not supported its proposed product market, a fatal flaw in its proof during the bench trial.

There are only two treatments for the heart defect, known as patent ductus arteriosus (PDA): pharmacological treatment or surgical ligation if pharmacological intervention fails. Lundbeck (through its predecessor, Ovation) acquired one of the approved drugs (Indocin IV) in 2005. It acquired the other (NeoProfen) in 2006. Within two years, Lundbeck raised the price of Indocin twenty-fold (from nearly $78 to more than $1,614 per treatment), and introduced NeoProfen to market at a similarly high price.

The FTC challenged Lundbeck's acquisition of NeoProfen, arguing this foreclosed competition. The agency sought to prove Lundbeck had obtained a monopoly by acquiring the only two drugs approved for pharmacological intervention of PDA, and had exercised its monopoly power by raising prices precipitously. The court of appeals, however, affirmed the district court's finding that FTC failed to meet its burden to prove the relevant product market.

The trial court had relied primarily on the testimony of neonatologists, who are responsible for choosing which drug to use to treat PDA. The trial court found the neonatologists were not sensitive to the price of the drugs, because they were not the purchasers of the drug. As a result, the court found that the FTC failed to show demand substitution – i.e., that consumers would shift from one drug to the other in response to changes in their relative cost. "[A]n increase in the price of Indocin IV would not drive a hospital to purchase NeoProfen, and vice versa."

Although the FTC argued the district court erred in ignoring the role hospitals played in the purchasing decisions, the court of appeals nonetheless affirmed the district court's findings

[17] FTC v. Lundbeck, Inc., 650 F.3d 1236 (8th Cir. August 19, 2011).

because "[t]he FTC offers no evidence that hospitals would disregard the preferences of the neonatologists and make purchasing decisions based on price." The appellate court also noted that the district court gave little weight to the functional equivalency of the two drugs and to internal Lundbeck documents suggesting Indocin and NeoProfen are in the same market.

One judge wrote, in a concurring opinion, "the standard of review carries the day in this case as it does in so many others." This judge, however, found it "perplexing" the district court would place so much weight on the testimony of prescribing doctors who did not have to pay for the drugs they ordered. "In an antitrust case, it seems odd to define a product market based upon the actions of actors who eschew rational economic considerations." But the court of appeals reviewed the district court's consideration of the evidence under the "clearly erroneous standard," and whether the court of appeals would have come to the same conclusion was "irrelevant."

5. Footprint Shrinks: FTC Requires Divestiture of Psychiatric Facilities in Delaware, Puerto Rico and Las Vegas[18]

In April 2011, the FTC entered a consent decree conditioning the acquisition of Psychiatric Solutions, Inc. by Universal Health Services, Inc. on the divestiture of 15 psychiatric facilities in Delaware, Puerto Rico, and Las Vegas.

Psychiatric Solutions and UHS agreed to merge in May 2010. UHS owns or operates 25 general acute care hospitals and 102 behavioral health facilities in across the nation. PSI operates 94 inpatient behavioral health facilities.

The FTC argued in the complaint accompanying the consent agreement that the acquisition would merge the two largest providers of acute inpatient psychiatric services in the Delaware, Puerto Rico, and metropolitan Las Vegas, NV markets. Acute inpatient psychiatric services is defined as "inpatient psychiatric services for the diagnosis, treatment, and care of patients deemed, due to an acute psychiatric condition, to be a threat to themselves or others or are unable to perform basic life functions."

D. FTC Enforcement Actions

1. Through Clenched Teeth: FTC Rules against North Carolina Dental Board[19]

Affirming a decision issued by an administrative law judge, the Federal Trade Commission held that the North Carolina Board of Dental Examiners violated Section 5 of the FTC Act when it acted to prevent non-dentists from providing teeth-whitening services in North Carolina.

---

[18] *In the Matter of* Alan B. Miller; Universal Health Services, Inc., and Psychiatric Solutions, Inc., FTC Docket No. C-4309, File No. 101 0142, available at http://www.ftc.gov/os/caselist/1010142/index.shtm.

[19] *In the Matter of* The North Carolina Board of Dental Examiners, FTC Docket No. 9343, File No. 081-0133, available at http://www.ftc.gov/os/adjpro/d9343/index.shtm.

The FTC complaint charged the Board colluded "to exclude non-dentists from competing with dentists in the provisions of teeth-whitening services." The eight-member Board, six of whom are dentists, had declared that when non-dentists provided teeth-whitening services they were engaged in the unauthorized practice of dentistry.

The Board filed a motion before the FTC to dismiss the complaint on grounds it was immune from antitrust attack under the state action doctrine. The FTC denied the motion. The Commission held that active state supervision requires a proper demonstration that the Board was both "fiscally disinterested and politically accountable" because a majority of its members were market participants. When the Board failed to demonstrate this supervision the FTC held it was not entitled to antitrust immunity.

The Board then sought to enlist a federal district court in its efforts to block the FTC's administrative proceeding. The court refused to do so and the matter proceeded to trial before an administrative law judge.

The ALJ found the board's members were had an economic interest in the matter and that their actions reduced competition by reducing sales of teeth-whitening products, causing non-dentist providers to leave the market, and limiting choices available to consumers. The judge rejected all claims that the restrictions were justified by procompetitive efficiencies. The Board had argued its ban protected the public from insufficiently qualified tooth whiteners.

On appeal, the Commission agreed with the ALJ and found the Board's actions violated the FTC Act. The Commission rejected the board's claim that its individual members were not separate actors, holding they were actual or potential competitors and thus liable for anticompetitive collusion. Using a "quick look" approach, the Commission dismissed the Board's claimed efficiencies. The Commission said the claim that the restraint would improve public health and safety was not cognizable under the Sherman Act but that even if it was, no scientific evidence supported the claim.

The Board is now seeking review in the Fourth Circuit.

2. Yellow Dogs: FTC Enters Consent Decree with Amarillo Physicians[20]

In May 2011, the FTC announced it had entered yet another consent decree with yet another physician group that allegedly was bargaining collectively with payors. As with prior consent decrees, the proposed order would prohibit the provider network from negotiating on behalf of its members, with exceptions for contracting on a capitated basis and for entering into "qualified risk-sharing" or "qualified clinically integrated" joint arrangements, as defined in the order.

Southwest Health Alliances Inc., d/b/a BSA Provider Network, is a physician-hospital organization located in Amarillo, TX. BSA included twenty-five hospitals, a handful of

[20] *In the Matter of* Southwest Health Alliances, Inc., doing business as BSA Provider Network, a Texas corporation, FTC File No. 091 0013, available at www.ftc.gov/os/caselist/0910013/index.shtm.

employed physicians, and multiple independent physician practices with approximately 900 members, including approximately 300 primary care physicians.

BSA operated lawful "messenger model" negotiations on behalf of its members, but its members continued to sell their services independently on a fee-for-service basis, and so were not financially integrated.

The complaint alleged that BSA unlawfully deviated from the messenger model when it negotiated independently with its members to set a fee schedule that it then used as a signaling device as to whether members should accept or reject payors' offers. BSA also allegedly renegotiated prices collectively on behalf of its members that were originally set independently (and lawfully) through the messenger model. Finally, the FTC alleged BSA unilaterally raised prices in a joint fee schedule – set through a lawful "reverse messenger" model – without independently asking its members the price at which they would accept offers. Because the IPA members were not integrated clinically or financially, the FTC claimed their actions were nothing more than horizontal price fixing.

3. Gopher It: FTC Enters Consent Decree with Minnesota Physicians[21]

In June 2010, the FTC announced a consent decree with the Minnesota Rural Health Cooperative, a group representing most of the hospitals and 50% of the primary care physicians in southwestern Minnesota. The MRHC required that its board of directors negotiate on behalf of all its members, it used coercive tactics in negotiations with payers, and it obtained higher reimbursement rates than comparable providers and more favorable payment methods. The group entered into the usual stipulations in the consent order.

E. DOJ Enforcement Actions

1. Sacrificing the Firstborn: Department of Justice and State of Montana Object[22]

A group of hospitals in Montana that started a health plan to compete with the dominant payor in that state agreed to divest the health plan's commercial insurance business to resolve a lawsuit filed by the U.S. Department of Justice and the Montana Attorney General's Office. The antitrust enforcers claimed the hospitals violated antitrust laws when they entered into an agreement with Blue Cross Blue Shield of Montana (BCBS) that hamstrung the ability of the hospitals' own health plan to compete.

The Department and Montana Attorney General filed a complaint on November 8, 2011, in federal court in Montana against BCBS, the state's largest health insurer, New West Health

---

[21] *In the matter of* Minnesota Rural Health Cooperative, FTC File No. 051 0199 (June 18, 2010) available at www.ftc.gov/os/caselist/0510199/index.shtm.

[22] United States and State of Montana v. Blue Cross and Blue Shield of Montana, Inc., Billings Clinic, Bozeman Deaconess Health Services, Inc., Community Medical Center, Inc., New West Health Services, Inc., Northern Montana Health Care, Inc., and St. Peter's Hospital, No.1:11-cv-00123-RFC (D. Montana) available at www.justice.gov/atr/cases/bcbsmnw.html.

Services, Inc., a non-profit, provider-sponsored health plan that has become the Montana's third largest insurer, and five of the six hospitals that formed New West.

The Department and Attorney General filed a proposed stipulated judgment on the same day. If the judgment is approved by the court, New West must sell its commercial insurance to PacificSource Health Plans of Oregon.

The complaint alleges that after the hospitals founded New West in 1996, the company became a vigorous competitor in the offering of health insurance in Montana. BCBS reduced its prices in order to maintain its competitive position. Despite this competition, the complaint alleges, BCBS retained a market share of between 43% and 75% in the commercial insurance markets in the cities where New West's hospital owners operate. The complaint states New West's share did not exceed 12% in those markets.

Against this background, the Department and Attorney General charged BCBS agreed to pay the hospitals $26 million if they purchased health insurance for their employer group health plan from BCBS, rather than from New West. BCBS also promised the hospitals two seats on the BCBS board of directors if the hospitals did not "own or belong to an entity that competes" with BCBS in the sale of commercial health insurance.

One of New West's hospital owners operates in Great Falls, Montana's third largest city, and already used BCBS for its employees, independent of the agreement prompting DOJ's investigation. That hospital was not named a defendant in the case.

The complaint alleges separate product markets for group and individual health insurance coverage, but analyzes concentration and effects in an undifferentiated market for "commercial insurance." According to the complaint, New West was the "only significant competitor" in the geographic areas covered by the agreement.

The Department of Justice and Attorney General asserted the agreement between BCBS and the hospitals was likely to eliminate New West as a viable competitor in the sale of commercial health insurance. The complaint identifies three factors that would have caused New West to exit the market for commercial health insurance in the five geographic regions where the hospitals are located:

- First, the complaint alleges the agreement would remove the owners' direct support for New West. The hospitals are some of the largest employers in their respective markets. Moving their employees from New West to BCBS would eliminate one-third of New West's enrollees while simultaneously increasing BCBS's already substantial market shares. Similarly, the complaint alleges the payment and the seats on BCBS's board would reduce the hospitals' incentives to win commercial business for New West.

- Second, the complaint alleges the agreement would lead to the perception that New West was failing because its owners had abandoned it, thus speeding its demise by encouraging other employers to stop purchasing insurance from New West. Indeed, according to the complaint, several employers switched from New West to BCBS after the deal was announced.

- Third, the complaint avers the agreement would create a barrier to new insurers entering the market for commercial insurance. All hospitals had to participate for the agreement to be effective; if one hospital did not move its employees to BCBS, none of the hospitals would receive the payment. The exclusive arrangement between these large employers in four of the largest cities in Montana (Billings, Bozeman, Missoula and Helena) and BCBS, according to the complaint, would make it difficult for any new health insurers to enter the market.

The proposed stipulated judgment filed by the Department and Attorney General is notable for the relief it provides. The antitrust enforcers did not propose to block the hospitals from transferring their employees to BCBS, or from sitting on the BCBS board nor, presumably, from making the $26 million payment. Instead, if the judgment becomes final, New West will be required to divest its commercial insurance business to another insurer, PacificSource. The stated purpose of the proposed relief is to give PacificSource an opportunity to become a viable competitor in the sale of health care in Montana.

New West's divested assets include both fully insured commercial products and administrative services contracts, but do not include its Medicare Advantage contracts. New West also will commit its executives to exercise their best efforts to maintain New West as a viable business with a sufficient number of enrollees during the divestment period, and it will establish an incentive pool to promote those efforts. Divestiture must occur within 30 days of filing the complaint.

The judgment will provide PacificSource with an established network of providers. The hospital defendants have agreed to contract with PacificSource for three years "on terms that are substantially similar to their existing contractual terms with New West." Similarly, New West also must lease its provider network to PacificSource for a period of three years. New West and the hospital defendants must provide support to PacificSource during the transition period.

The judgment limits the contracting activities of BCBS. The insurer must give the Department and Attorney General 30 days' notice of any exclusive deals with insurance brokers or health care providers, as well as 30 days' notice of any most favored nation clauses entered with providers. This notice period would allow either government agency to issue a civil investigative demand or challenge the provisions. These requirements last for six years.

2. Out of Favor: Court Sustains DOJ's Complaint against Michigan BCBS[23]

In June 2011, a federal judge in Michigan denied Blue Cross Blue Shield of Michigan's motion to dismiss a lawsuit filed by the U.S. Department of Justice and the Michigan Attorney General challenging Blue Cross's use of most-favored nations clauses in its contracts with hospitals. The opinion flatly rejected every argument Blue Cross advanced.

[23] United States v. Blue Cross Blue Shield of Michigan, No, 2:10-14155-DPH-MKM (filed Oct. 18, 2010) available at http://www.justice.gov/atr/public/press_releases/2010/263227.htm.

DOJ's suit against Blue Cross challenges two types of "MFN clauses": "MFN-plus" clauses that guarantee Blue Cross discounts from hospital charges greater than those afforded any of its competitors, and the more common "equal-to" clauses that guarantee Blue Cross discounts in an amount at least as great as provided to any of its competitors. DOJ alleged these clauses prevent Blue Cross's competitors from entering the various localized markets for health insurance in Michigan and thereby keep prices higher than they otherwise would be without the clauses.

For example, the complaint alleged an MFN-plus clause in Blue Cross's contract with the only tertiary care hospital in Michigan's Upper Peninsula required the hospital to charge competing insurers at least 23% more than it charged Blue Cross, thereby insulating the Upper Peninsula insurance market from competition.

Blue Cross responded to the complaint with a motion to dismiss.

Blue Cross argued that DOJ had not alleged product and geographic markets with sufficient specificity. The court disagreed. The court found that the complaint plausibly alleged product markets in commercial group health insurance and commercial individual health insurance, and concluded that the complaint need not include detailed allegations about the two markets, participants within those markets, or the products those participants offer. Turning to the allegations of geographic markets, the court rejected Blue Cross's argument that the markets were national based on the national availability of capital. Instead, the court concluded, the complaint plausibly alleged local markets because employers and insureds cannot practicably turn to insurers who do not offer local providers in their networks. The court found the complaint's reliance on statistical data (such as metropolitan statistical areas) sufficient to state plausible geographic markets at the pleading stage.

The court found no fault with the complaint's allegations of market power and anticompetitive effects. Surveying allegations that Blue Cross had between 40% and 80% market share in the various markets alleged and that Blue Cross had successfully excluded competitors, as well as Blue Cross's own admission that it is the "dominant provider" in Michigan, the court found the allegations of market power were plausible.

Turning to the possible effects of that power, the court declined to balance the possible procompetitive benefits of MFNs at the pleading stage, and focused instead on the complaint's allegations that the MFN clauses had raised competitors' costs, increased premiums, and increased the costs of insurance to employers and consumers. In its analysis of effects, the court focused primarily on the MFN-plus clauses, noting that those clauses required Blue Cross's competitors to pay substantially more for healthcare in certain markets than did Blue Cross. Finally, the court noted that the plausibility of possible harm from the MFN clauses because of the alleged exclusion of competitors from certain markets. Again, the court pointed to an example of exclusion arising from the alleged operation of an MFN-plus clause with Marquette Hospital in Michigan's Upper Peninsula. The court's analysis suggests it was most troubled by the effect of the MFN-plus clauses, particularly in rural markets.

The court then addressed several defenses asserted by Blue Cross, and rejected them all. The court first disposed of Blue Cross's argument that its clauses were exempt from the antitrust laws

under Michigan's Antitrust Reform Act. That Act exempts healthcare transactions, including insurance transactions, "when the transaction or conduct is to reduce the cost of healthcare and is permitted by the [insurance] commissioner." Because the complaint alleged that the effect of the MFN clauses was to increase cost, and because Blue Cross could not submit contrary evidence on a motion to dismiss, the court concluded Blue Cross had not established its entitlement to exemption.

The court then rejected a similar argument that Blue Cross is entitled to immunity under the state action doctrine. Blue Cross argued a Michigan law regulating nonprofit healthcare corporations provided the express legislative intention to displace competition and the active supervision necessary to confer state action immunity on private entities. The court disagreed. The court found no intent to displace competition in Michigan's Nonprofit Healthcare Corporation Reform Act and instead found the Act's purpose is "to secure for all the people of this state . . . the opportunity for access to healthcare services at a fair and reasonable price." The court found no intent to discourage competition between insurers or to shift the costs of healthcare between insurers. The court also found no evidence that the Michigan Insurance Commissioner actively supervised the conduct at issue by reviewing and approving Blue Cross's contracts or the MFN clauses within them.

The court declined to abstain from considering the complaint because it found there was no likelihood that the insurance commissioner would in fact review Blue Cross's MFN clauses.

Blue Cross sought interlocutory review but this was denied by the Sixth Circuit.[24] Blue Cross now is seeking review *en banc*.

3. The One and Only Section 2 Case: DOJ Challenges Hospital Monopolist in Wichita Falls, Texas[25]

In the only case brought under Section 2 of the Sherman Act since the Obama administration came to office, the Antitrust Division (along with the State of Texas) sued a hospital in Wichita Falls, Texas, for monopolization.

The complaint, filed in February 2011, alleged that the hospital, United Regional Health Care System, monopolized the markets for general acute care inpatient hospital services and outpatient surgical services. The agencies and the hospital entered into a consent decree settling the charges at the same time the complaint was filed.

The crux of the government attack was the contract terms United Regional had extracted from commercial payors.

United Regional is a 369-bed acute-care hospital and Level III trauma center. United Regional was formed in October 1997 by the merger of Wichita General Hospital and Bethania Regional

[24] Nos. 11-1984/2279 (6th Cir. Feb. 23, 2012).
[25] United States v. United Regional Health Care System, Case No.: 7:11-cv-00030-O (September 29, 2012) available at http://www.justice.gov/atr/cases/unitedregional.html.

Health Care Center, the only two general acute-care hospitals in Wichita Falls at the time. The parties had obtained an exemption from the Texas legislature to consummate the transaction.

The only other hospital in Wichita Falls is Kell West Regional Hospital, a 41-bed, general acute care hospital that opened in January 1999. Kell West does not offer cardiac surgery or obstetrics. There are two other hospitals in the Wichita Falls MSA. Electra Memorial Hospital is a 22-bed hospital in Electra, more than 30 miles west of the city of Wichita Falls. Clay County Memorial Hospital is a 25-bed hospital in Henrietta, more than 15 miles east of Wichita Falls. According to the DOJ's complaint, both Electra Memorial and Clay County Memorial offer a narrower range of inpatient and outpatient surgical services than either United Regional or Kell West.

The government alleged United Regional had market shares giving it monopoly power in two product markets: (1) a 90% share of general acute-care inpatient hospital services; and (2) a 65% share of outpatient surgical services. Further, according to the government, commercial payors consider United Regional a "must have" hospital in their networks because it is the largest hospital and the only provider of certain services such as cardiac surgery, obstetrics, and high-level trauma cases.

The fact of high market shares, however, is not what drove the government's investigation. Instead, the government focused on the "exclusionary contracts" United Regional entered into with payors that, according to DOJ, "effectively prevent insurers from contracting with United Regional's competitors." The government charged United Regional financially punished payors if they included other hospitals or surgical centers in their networks. United Regional provided higher discounts off billed charges for exclusivity within the payor's network, and a much lower discount if the payor added other hospitals or outpatient surgical providers to its network. The government alleged that the penalty for adding an additional hospital or outpatient surgical provider to a payor's network ranged from 13% to 27%.

Relying on testimony from payors, the government alleged United Regional charged monopoly prices. One payor reported payments for inpatient hospital services in Wichita Falls were at least 50% higher than comparable Texas cities. Another payor estimated United Regional's negotiated rates were 70% more than hospitals in the Dallas-Fort Worth area. The government also pointed to evidence that United Regional's reimbursement rate for inpatient stays was 70% higher than its closest competitor, Kell West.

The consent decree prohibits United Regional from conditioning prices or discounts to commercial payors on whether those payors contract with other providers. The decree also prohibits United Regional from preventing payors from entering into agreements with its competitors or taking any retaliatory action from doing so.

4. Step On It: DOJ Enters Consent Decree with Idaho Orthopedists[26]

In May 2010, DOJ announced a consent decree with Orthopedists in the Boise, Idaho area. The complaint alleges that competing physicians had conspired to refuse to treat patients covered by

[26] United States v. Idaho Orthopedic Society, No. 10-268-SEJL (D. Idaho Aug. 30, 2010) (final judgment) available at www.justice.gov/atr/cases/idortho.htm.

Idaho's workers' compensation system in an effort to increase reimbursement from that system. This classic group boycott restricted the supply of orthopedic services and increased the price of those services. The physicians also entered the usual stipulations with the FTC.

F. Federal Policy Activities

1. FTC: Hospital Mergers Do Not Increase Quality[27]

In November 2010, FTC economists released an analysis of the effects on clinical quality of the acquisition of Highland Park Hospital by Evanston Northwestern Healthcare in 2000. The study found "little evidence that the merger improved quality" at Highland Park.

The economists used a "difference-in-differences" analysis of risk-adjusted mortality and complication rates for a number of clinical conditions. Such an analysis compares the difference in outcomes between the merged parties and a control group before the merger with the difference in outcomes between the merged parties and a control group after the merger. The economists studied quality outcomes in four categories according to the claims made by the hospitals during the FTC's challenge to the merger: (1) cardiac surgery and interventional cardiology; (2) advantages of teaching hospitals; (3) nursing-sensitive indicators; and (4) obstetrics.

2. Massachusetts AG: Hospital Mergers Lead to Higher Prices[28]

In response to a legislative directive, the Massachusetts Attorney General submitted a report to the Legislature in 2010 that asserted an "unequivocal 'no'" to the "threshold question … whether we can expect the existing health care market in Massachusetts to successfully contain health care costs." The study surveyed the Massachusetts health care marketplace and concluded:

- Prices paid by health insurers to hospitals and physician groups vary significantly within the same geographic area and among providers offering similar levels of service.
- Price variations are not correlated to quality of care, the sickness of the population or complexity of the services provided, the extent to which a provider cares for a large portion of patients on Medicare or Medicaid, or whether a provider is an academic teaching or research facility.

---

[27] A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare, Patrick S. Romano, David J. Balan, Working paper No. 307 (November 2010) available at www.ftc.gov/be/workpapers/wp307.pdf.

[28] Office of Attorney General Martha Coakley, *Examination of Health Care Cost Trends and Cost Drivers*, (March 16, 2010); Thomas M. O'Brien, Office of Attorney General Martha Coakley, Letter to Brent Henry at Partners HealthCare System, Inc. (June 25, 2010) available at www.mass.gov/ago/docs/healthcare/final-report-w-cover-appendices-glossary.pdf. *See also* Robert A. Berenson, Paul B. Ginsburg, and Nicole Kemper, *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, Health Affairs, Vol. 29, No. 4, April 2010.

- Price variations are not adequately explained by differences in hospital costs of delivering similar services at similar facilities.
- Instead, price variations are correlated to market leverage (measured as the relative market position of a provider compared to similar providers in a geographic region).
- And global payment methods don't help rein in costs: variation in total medical expenses on a per member per month basis is not correlated to the methodology used to pay for health care. Sometimes total medical expenses are higher for risk-sharing providers than for providers paid on a fee-for-service basis.
- Higher priced hospitals are gaining market share at the expense of lower priced hospitals, which are losing volume.

3. Hospitals: Mergers Do *Not* Lead to Higher Prices[29]

In March 2011, economists not affiliated with the FTC concluded that differences in hospital prices are attributable primarily to hospital expenses, not market power, as the Massachusetts study discussed above suggested. The study was sponsored by the American Hospital Association.[30]

Examining historical data, the study concludes that costs are the primary driver of hospital prices. And the primary component of hospital costs, the economists assert, are labor costs, including "salaries and benefits for physicians, nurses, technicians, and numerous other personnel." The study notes that capital investments, such as investments in technology, have contributed to the rise in hospital prices as well. Over the past decade, "hospital revenues closely tracked cost increases, each increasing by roughly 5% per year." From the data, the authors conclude, "revenues are closely tracking costs, and . . . costs are key factors driving hospital price increases."

The authors also report empirical analyses of factors explaining price differences among hospitals. Those analyses included studies of published literature discussing hospital price, as well as an econometric evaluation of price differences. From these analyses, the authors identify objectively verifiable factors that account for differences in hospital prices: "factors such as case mix, regional costs, hospital characteristics, resource utilization, characteristics of the population, and other factors explain a very large proportion – up to 72% of the differences in hospital prices for non-Medicare services across the U.S., and a large proportion of the variability in Medicare and all-payor prices."

---

[29] *Assessment of Cost Trends and Price Differences for U. S. Hospitals*, Compass Lexecon (March 2011) available at http://aharesourcecenter.wordpress.com/2011/03/09/hospital-cost-drivers-market-power-and-pricing-relationship-to-hospital-prices/; *see also A Critique of Recent Publications on Provider Market Power* Compass Lexecon (October 4, 2010) available at www.aha.org/content/00-10/100410-critique-report.pdf.

[30] *See* http://aharesourcecenter.wordpress.com/2011/03/09/hospital-cost-drivers-market-power-and-pricing-relationship-to-hospital-prices/.

While the authors concede they could not account for all factors contributing to price differences, they nonetheless conclude market power is not likely among those factors: "as a matter of economics, it is incorrect that any residual price differences reflect some form of inefficiency or market power."

By focusing on cost and eliminating "automatic" correlations between market power and price differentials, the authors suggest their research makes the case for increased efficiencies: "the research demonstrates a link between improving care coordination, cost reduction, and lower prices."

4. FTC Bureau of Competition: Legislation that Reduces Competition Is Bad

The FTC was busy on the legislative front, providing comments regarding numerous state proposals that might reduce competition in health care:

- The FTC wrote the Maine Board of Dental Examiners (November 2011) arguing that x-ray restrictions imposed on independent practice dental hygienists proposed as part of a pilot test program designed to provide dental services to underserved areas of Maine would lessen competition and reduce the effectiveness of the program.[31]

- The FTC voiced concerns about New York legislation (August 2011) that would reduce the availability of mail order pharmacies.[32]

- The FTC condemned proposed legislation in Texas (May 2011) that would insulate "healthcare collaboratives" from federal and state antitrust laws, and similar legislation in Connecticut (June 2011) that would exempt health care cooperatives from the antitrust laws.[33]

- The FTC encouraged Florida (March 2011) and Texas (May 2011) to approve legislation that would make it easier for APRNs to practice in the state.[34]

- The FTC warned the Mississippi House of Representatives (March 2011) that proposed legislation moving regulation of pharmacy benefit managers from the

---

[31] FTC Letter to Teneale E. Johnson (Nov. 16, 2011) available at www.healthlawyers.org/Members/PracticeGroups/Antitrust/emailalerts/Documents/111214mainedental.pdf.
[32] FTC Letter to Hon. James L. Seward (August 8, 2011) available at www.ftc.gov/os/2011/08/110808healthcarecomment.pdf.
[33] FTC Letter to Representative Elliott Naishtat (May 18, 2011) available at www.ftc.gov/os/2011/05/1105texashealthcare.pdf; www.ftc.gov/os/2011/06/110608chc.pdf.
[34] FTC Letter to Hon. Daphne Campbell (May 11, 2011) available at www.ftc.gov/os/2011/03/V110004campbell-florida.pdf; FTC Letter to Hon. Rodney Ellis and Hon. Royce West (May 11, 2011) www.ftc.gov/os/2011/05/V110007texasaprn.pdf.

Office of the Insurance Commissioner to the authority of a Pharmacy Board composed of pharmacists might reduce competition and increase drug prices.[35]

- The FTC urged Alabama (November 2010) and Tennessee (September 2011) to reject rules and legislation that would restrict the practice of pain management to physicians, thereby excluding CRNAs from practice.[36]

G. State Activities

1. New York, New York: No Market For You[37]

A very long time ago (2005) two health insurance carriers, Group Health Incorporated ("GHI"), and HIP Foundation/Health Insurance Plan of Greater New York (together, "HIP"), announced a merger and their intent to convert from nonprofit to for-profit status. After the Department of Justice and New York's attorney general decided not to challenge the merger, the City of New York sued to permanently enjoin the merger under federal and state antitrust laws.

GHI's and HIP's plans cover a vast majority of the employees in the City's health benefits program and the City's concern focused on the risk that the merger of the carriers would reduce competition, with the result of higher health insurance premiums being paid by the City.

The City unsuccessfully sought a temporary restraining order and the merger was consummated. Discovery ensured. Years passed. In December, 2009, Defendants moved for summary judgment arguing that market alleged by the city – a "low-cost municipal health benefits market" that included only those insurance plans that are inexpensive and that the City selects for inclusion in the Health Benefits Program – is legally insufficient. Days before its opposition papers were due, the City sought to amend its complaint to include all health benefits plans operating in downstate New York. The City also sought to base its claim on the "Upward Pricing Pressure" test, which analyzes the effect of a merger on the merged firm's pricing incentives. The City contended that the Upward Pricing Pressure test could establish the anticompetitive effect of the merger without the need to define a relevant market. Agreeing that an alleged market based on the city's preferences, and that ignores the market of insurance providers that compete for the city's business, is inconsistent with established precedent requiring a test of interchangeability and cross-elasticity of demand, the trial court granted the summary judgment motion and denied leave to amend.

GHI and HIP also argued that the city could not demonstrate a relevant antitrust injury because any increased premiums would result from the carriers' conversion to for-profit entities, not from their merger.

---

[35] FTC Letter to Honorable Mark Formby (March 22, 2011) available at www.ftc.gov/os/2011/03/110322mississippipbm.pdf.
[36] FTC Letter to Patricia E. Shaner (November 3, 2010) available at www.ftc.gov/os/2010/11/101109alabamabrdme.pdf; FTC Letter to Hon. Gary Odom (September 28, 2011) available at www.ftc.gov/os/2011/10/V11001tennesseebill.pdf.
[37] City of New York v. Group Health Inc., 649 F.3d 151 (2d Cir. August 18, 2011).

The Second Circuit affirmed the district court. While not finding the lateness of the amendment to be evidence of bad faith, it did not think it was an abuse of discretion for the district court to find that this delay, together with the prejudice that would result from the amendment, warranted denial of the City's motion to amend. The Second Circuit also agreed with the district court's rejection of the "Upward Pricing Pressure" test noting that the City failed to explain how the test can substitute for a definition of the relevant market in the pleadings. Whether or not the Upward Pricing Pressure test could be admissible evidence of impaired competition is irrelevant to the adequacy of the pleadings, the court concluded.

2. Pennsylvania AG: Urology Merger Could Lead to Higher Prices[38]

In August 2011, the Pennsylvania Attorney General's Office filed a complaint and simultaneously entered a consent decree against a group of urologists in the Harrisburg area who merged their practices in 2005. The complaint and decree are notable for several reasons: (1) the action is another reminder that enforcement agencies may investigate and take action years after a merger occurs; (2) the decree imposes various restrictions on the urologists' negotiations and referrals; and (3) neither the U.S. Department of Justice nor the Federal Trade Commission participated in the consent decree.

In November 2005, five independent urology practices in the Harrisburg area merged into a single practice, Urology of Central Pennsylvania Inc. That merger brought 13 of the 22 urologists practicing in a 20-mile radius of Harrisburg into a single practice. The complaint alleges UCPA enjoyed an 84% market share. With resulting annual revenues of approximately $7 million, the merger sailed under the Hart-Scott-Rodino radar.

But an investigation by the Pennsylvania AG ensued into the urology group's post-merger conduct. Whether that investigation uncovered evidence of actual, supracompetitive price increases as a result of the merger is unclear. The complaint alleges the group's "urologists were able to collectively bargain with area health plans to obtain increases in reimbursement rates for urology services and ancillary services," but does not include details of any price increases. The complaint does not allege any particular percentage increases or whether such increases impacted all payors. Elsewhere, the complaint merely alleges the group had the "increased ability and incentive" to raise its prices – again, without any specific allegations of actual price increases.

Apart from actual or perhaps possible price increases, the complaint expresses concern about changes in the urologists' service offerings and referral patterns. For example, the complaint alleges that as a result of the merger, the group hired its own radiation oncologist and referred its patients in-house for radiation services instead of to area radiation oncology centers, which experienced "a dramatic decline in the number of referrals of prostate cancer patients." The complaint also alleges that postmerger the urologists opened their own prostate cancer center and expanded their output of technologies like robotic surgery, while performing fewer (less-expensive) brachytherapy procedures.

---

[38] Pennsylvania v. Urology of Central Pennsylvania, Inc., et al., Civil Action No. 1:11-cv-O1625-JEJ (M.D. Pa. August 31, 2011).

The consent decree's "public interest determination" does not discuss whether the state considered breaking up UCPA, although state and federal officials have noted the difficulty in "demerging" physician practices. Instead, the AG extracted several behavioral modifications from the urologists.

3. Pennsylvania AG: Hospital Merger Could Lead to Higher Prices[39]

In July 2011, the Pennsylvania Attorney General announced it had entered into a consent decree imposing conditions on the merger of two central Pennsylvania hospitals. The accompanying complaint alleges that the two competing hospitals together controlled 60% of the market for primary and secondary acute-care hospital services in Northumberland County in central Pennsylvania.

The complaint alleges the merger would have left Medicare Advantage Plans doing business in Northumberland County with only one option for acute care services. This allegedly would have presented a problem because the plans predominantly serve senior citizen consumers who "have less physical ability to travel and often have less income to pay for travel costs than other consumers."

The complaint also alleges the merger would harm competition for physician services by preventing independent physicians from obtaining staff privileges at the surviving entity. This was a concern because the acquiring hospital was a closed staff model, while the target was an open staff model.

Simultaneously with the filing of the complaint, the parties entered a consent decree permitting the merger to proceed on several conditions. The decree addresses the Attorney General's allegations regarding Medicare Advantage Plans by requiring the acquiring hospital to permit plans with existing contracts at the target's facilities to extend the contracts for three years from the date of closing, at prices adjusted annually. Regarding competition for physician services, the decree requires the system to allow independent physicians to maintain staff privileges at the target's facilities after the merger, and bars the system from requiring that these physicians practice exclusively at its facilities.

---

[39] Pennsylvania v. Geisinger Medical Center and Shamokin Area Community Hospital, No. 344-MD (Pa. Commonwealth Court).

II. PRIVATE LITIGATION

A. Exclusionary Conduct Cases

1. Still Breathing: Section 1 Claims Against Heart and Lung Center Survive while Section 2 Claims Expire[40]

A federal district court denied a motion to dismiss Deborah Heart and Lung Center's Section 1 claims that competing hospitals conspired to exclude it from the emergency cardiac procedures market but granted Deborah's motion to dismiss its Section 2 claim in late December 2011.

Deborah is a nationally-renowned specialty hospital in Burlington County, New Jersey. Defendants are Virtua Health, Inc. which operated three hospitals in the area; Presbyterian Medical Center of the University of Pennsylvania Health System and related entities; and the Cardiology Group, P.A.(CGPA) a group of cardiologists performing services at local hospitals.

At the time of the suit, Virtua Memorial Hospital operated the principal emergency room in Deborah's market and transferred all patients needing cardiac procedures to nearby hospitals including Deborah. Deborah asserted that Virtua entered into a conspiracy with other defendants to exclude it from the market for critical, advanced cardiac interventional procedures and that the conspiracy was intended to permit to permit the Virtua defendants to monopolize the market for emergent/primary angioplasties. The alleged scheme consisted of two interlocking written agreements: first, between the Virtua and CGPA, making CPGA the exclusive provider of cardiology services at Virtua Memorial; and second, between CGPA and the Penn defendants, making the Penn defendants the exclusive recommended referral of CGPA. Deborah characterized these agreements as the building blocks of the larger conspiracies to exclude Deborah from receiving transfers from the Virtua, drive it out of the market, and allow Virtua to monopolize the emergency procedures market.

Addressing standing, the court found Deborah had plausibly alleged that defendants had conspired to harm Deborah causing harm in the form of lost patient revenues, and further that Deborah's loss of revenues from its exclusion is among the types of harm the antitrust laws were designed to prevent.

Relying on direct and circumstantial evidence, the court held plaintiff adequately pled concerted action to exclude Deborah from receiving patient transfer from the Virtua. As direct evidence, the court cited two interlocking written agreements: first, between the Virtua and CGPA, making CPGA the exclusive provider of cardiology services at Virtua and, second, between CGPA and the Penn Defendants, making the Penn Defendants the exclusive recommended referral of CGPA. Circumstantial evidence included "the powerful shift in the Virtua Defendants' transfer pattern"; the fact that the shift in patients needing emergency procedures was made despite increased medical risks and costs; "coercive conduct" by defendants to prevent patients from exercising their choice of hospital "in the face of a statutory obligation to allow that very choice"; and the defendants' dissemination and discussion of "leakage reports" tracking patient

[40] Deborah Heart and Lung Center v. Penn Presbyterian Medical Center, Civil No. 11-1290 (RMB) (D.N.J. Dec. 30, 2011).

referrals to other hospitals. Further buttressing the court's conclusion was an email by CGPA's president concerning the possibility of Deborah being driven out of business which hypothesized that that process could be accelerated by no longer transferring certain cardiac patients there. Adding to the mix was defendants' view that Deborah's exit would enhance the possibility that Virtua might be awarded a Certificate of Need to perform additional cardiac interventional procedures.

Turning to whether Deborah had plausibly alleged adverse, anticompetitive effects, the court observed that its allegations of direct anticompetitive effects obviated the need to assess whether plaintiff adequately alleged market power. While finding Deborah's allegations of supracompetitive pricing "too conclusory to be credited," the court was satisfied by allegations of: (1) higher prices through co-pays and related expenses and increased transportation costs, particularly helicopter transport costs; (2) reduced quality of care as through allegations that the increased transport time may cause adverse medical outcomes; and (3) the loss of consumer choice in cases where patients request to be transferred to Deborah but are denied.

Notably, Deborah is one of only three hospitals in the United States that are legally exempt from collecting insurance co-pays and deductibles from patients. However, the court refused to accept defendants' argument that lower costs at Deborah were attributable to this "regulatory anomaly" and not competition. Further, the court rejected defendants' argument that they have no "duty to cooperate" under the antitrust laws, reasoning that the essence of plaintiff's claim rests on the harmful effects on consumers from its exclusion. Finally, the court was satisfied that plaintiff had adequately pled the "rough contours of the marketplace for both elective and emergency procedures" – the former being a marketplace in southern New Jersey and Philadelphia with the latter being a more restricted geographic market, which excludes Philadelphia. The court found the pleading plausible in light of the need for patients needing emergency treatment to receive more rapid care and the alleged greater transport time in transit to Philadelphia.

On the other hand, Deborah's Section 2 claim failed to survive because it had not plausibly alleged that the conspirators had a specific intent to enable Virtua to monopolize the market. While holding that a dangerous probability of success is not a required element of a conspiracy to monopolize claim, the court observed that likelihood of success may be significant to addressing whether the defendants had the specific intent to monopolize the relevant market.

Several facts undermined plaintiff's allegation of specific intent. At the time the conspiracy occurred, Virtua had (at most) very limited ability to perform any of the emergency procedures. Moreover any future ability to perform these procedures was constrained by the need to obtain a Certificate of Need from the state. Furthermore, Virtua faced robust competition from at least two other hospitals besides Deborah. Given these market conditions, the court found it implausible that the defendants would have had the requisite intent to achieve successful monopolization of the emergency services market by Virtua.

2. Claims Barred: Bard Wins[41]

The Eighth Circuit affirmed the dismissal of two Missouri hospitals' claims against C.R. Bard Inc. in June 2011. The court held the hospitals were attacking share-based discounts, which are not unlawful in the Eighth Circuit.

Bard manufactures and sells various types of urological catheters. The hospitals brought claims against Bard on behalf of themselves and all direct purchasers of Bard urological catheters whose purchases were governed by contracts between Bard and various group purchasing organizations and integrated delivery networks. The plaintiffs claimed that Bard has a monopoly in the urological catheter market, and that it has maintained its monopoly through exclusionary contracts with these purchasing organizations that foreclose competition and result in overcharges for hospital purchasers. The contracts at issue included "share-based discounts" that "gave hospitals discounts for committing to purchase specified percentages of their catheter needs from Bard."

The district court certified the matter as a class action in September 2010. The parties subsequently moved for summary judgment, which the district court granted.

3. Menage a Trois: Highmark Swaps UPMC for West Penn[42]

As the baseball season gets underway, Pittsburgh Pirates fans once again have little to look forward to.[43] But steel city denizens seeking alternative entertainment could do worse than pay close attention to the soap opera involving Pittsburgh's two leading health care systems and western Pennsylvania's largest health care insurer.

The story so far: the University of Pittsburgh Medical Center (#1 in Pittsburgh hospital market share) battles Highmark, Inc., a Blue Cross and Blue Shield plan and the area's largest payer. Then, UPMC rethinks its approach and cozies up to Highmark, outraging West Penn Allegheny (#2 in the hospital market) in the process. West Penn sues UPMC and Highmark. The lawsuit is tossed by a district court. The court of appeals reverses and sends the parties back to the start line. But then West Penn dismisses its lawsuit. Why? Highmark has jilted UPMC and announced merger plans with … West Penn. UPMC reacts with predictable outrage.[44] DOJ issues a (rare) public closing statement in April explaining why it decided not to oppose the merger. The insurance commissioner, meanwhile, promises hearings on the deal.[45]

---

[41] SE Mo. Hosp. v. C.R. Bard, Inc., 642 F.3d 608 (8th Cir. 2011).
[42] West Penn Allegheny Health Sys., Inc. v. UPMC, 627 F.3d 85 (3rd Cir. 2010).
[43] *See, e.g.*, "Pittsburgh Pirates MLB 2012 Predictions," Betfirms.com available at http://www.youtube.com/watch?v=f_Kr4euJ9Fo.
[44] *See* UPMC Statement (November 30, 2011) available at www.upmc.com/mediarelations/newsreleases/2011/pages/jar-statement-before-the-pennsylvania-senate-banking-and-insurance-committee.aspx.

[45] "State hearings on Highmark-West Penn merger set for April," Pittsburgh Tribune-Review(March 3, 2012) available at www.pittsburghlive.com/x/pittsburghtrib/business/s_784609.html#ixzz1rbQfwYSV.

Developments over the coming summer promise to be unpredictable. The Pirates? Not so much.[46]

West Penn Allegheny Health System (according to the complaint it filed in the now-dismissed litigation) is the second largest hospital system in the Pittsburgh area, with a market share of approximately 23% of hospital services. UPMC enjoys market share of approximately 55% of hospital services. West Penn and UPMC are the only competitors for tertiary and quaternary care. Highmark, Inc., a Blue Cross and Blue Shield plan serving markets in Pennsylvania and West Virginia, is the dominant health insurer in the region, with between 60% and 80% of the market for commercial insurance.

West Penn alleged that UPMC was "obsessed" with driving West Penn out of business. Thus, according to the complaint, beginning in approximately 2002, UPMC and Highmark abandoned a previous course of mutual hostility and began conspiring to protect each other's market shares and inflate each other's profits. West Penn alleged that UPMC refused to enter into provider agreements with Highmark's rivals, thereby leveraging the health system's "must-have" status to foreclose entry into the regional commercial health insurance market.

In return, Highmark allegedly paid UPMC supracompetitive reimbursement rates, provided financial support to UPMC in the form of grants and low-interest loans that it denied to West Penn (after having provided such support to West Penn in the past), and artificially depressed West Penn's reimbursement rates. West Penn also alleged that UPMC agreed to shrink its own captive insurer, UPMC Health Plan – Highmark's main competitor – in exchange for Highmark eliminating its low-cost insurance product. According to West Penn, this quid pro quo lasted for five years and resulted in increased health insurance premiums charged to consumers and supracompetitive profits for UPMC and Highmark.

West Penn claimed that UPMC's "obsession" extended beyond conspiracy and led to unilateral acts taken solely for the purpose of harming West Penn. For years, UPMC allegedly raided West Penn's (and other hospitals') key physicians, not because UPMC needed or could even use those physicians profitably, but because hiring them away, even at "bloated" salaries, would keep them and their referrals from West Penn.

UPMC purportedly also pressured community hospitals into forming joint ventures with UPMC, key features of which were exclusive agreements with UPMC for those hospitals' referrals.

Finally, West Penn alleged that UPMC went so far as to issue false statements about West Penn's financial health in order to discourage investors from purchasing West Penn bonds.

The district court dismissed all counts set forth in the complaint. As to West Penn's claim that UPMC and Highmark had conspired to restrain trade in violation of Section 1 of the Sherman Act, the court found insufficient allegations of an agreement. As to West Penn's claim that UPMC unilaterally had attempted to monopolize the market for hospital services in violation of

---

[46] "Phillies Beat Pirates 1-0 in 2012 Season Home Opener," wpxi.com (April 5, 2012) www.wpxi.com/news/news/local/pirates-looking-improve-2012-season-gets-under-way/nMKX6/.

Section 2 of the Sherman Act, the court found insufficient allegations of anticompetitive conduct. The Third Circuit reversed on all points.

Addressing West Penn's allegations of conspiracy, the court of appeals found allegations of direct evidence of an agreement between UPMC and Highmark. The court noted that West Penn alleged, with specificity, that when West Penn had asked Highmark to refinance a loan Highmark had given to West Penn, Highmark declined by stating it would violate Highmark's "agreement" with UPMC, which agreement Highmark allegedly admitted was "probably" illegal. The court further noted that Highmark allegedly admitted West Penn's reimbursement rates were too low, but that Highmark could not raise them because that would violate its "agreement" with UPMC. Finally, the complaint alleged that UPMC's CEO had stated to a meeting of UPMC employees that UPMC had agreed to shrink its captive insurer in exchange for Highmark's elimination of its low-cost product. The court held these allegations were sufficient to survive a motion to dismiss.

The question of antitrust injury was closer. Maintaining some dramatic tension, the court of appeals first rejected West Penn's argument that it was injured as a result of Highmark's decision to eliminate its low-cost insurance product, which in turn reduced competition and increased health insurance premiums. This argument failed because West Penn does not participate in the health insurance market as a consumer or competitor but as a supplier, and "a supplier does not suffer an antitrust injury when competition is reduced in the downstream market in which it sells goods or services." Building the drama (if only slightly), the court then rejected West Penn's argument that Highmark's refusal to refinance its loan caused it antitrust injury. The court noted that Highmark was hardly the only source of capital and that West Penn did, in fact, turn to other lenders to refinance its debt.

The Third Circuit found an antitrust injury, however, in the reduced reimbursement rates Highmark paid to West Penn as a result of the alleged conspiracy. The court noted that had Highmark acted independently in negotiating lower reimbursement rates with West Penn, Highmark's actions likely would not have offended the Sherman Act. Yet because the complaint alleged that Highmark agreed with UPMC to use its monopsony power to hinder West Penn's ability to compete with UPMC, in exchange for UPMC taking steps to insulate Highmark from increased competition, the lower reimbursement rates Highmark paid to West Penn was sufficient antitrust injury. In addition to noting the potential for diminished quality and availability of hospital services that could result from the reduced payment rates, the complaint alleged that Highmark did not pass its savings on to its members in the form of lower premiums, but instead kept the savings for itself; and, in any event, such an agreement is simply anticompetitive and therefore the harm flowing from it was antitrust injury.

Turning to West Penn's Section 2 claim, the court noted that UPMC's conduct, "taken as a whole," was sufficiently anticompetitive to survive a motion to dismiss. The court noted the following allegations: UPMC had engaged in a conspiracy with UPMC to drive West Penn out of business; "UPMC hired employees away from West Penn by paying them bloated salaries," even when it did not need those employees and in some cases lost money on them; UPMC had strong-armed community hospitals into entering joint ventures that required exclusive referrals to UPMC; and UPMC had made false statements to West Penn's potential investors, causing "West Penn to pay artificially inflated financing costs on its debt." Taken as a whole, the court

concluded, these allegations plausibly suggested UPMC had competed "on some basis other than the merits."

The Third Circuit's decision noted that the alleged conspiracy between UPMC and Highmark came to an end in 2007, when the Antitrust Division of the Department of Justice began investigating the relationship between UPMC and Highmark. Notably, in testimony before Congress two days after the Third Circuit's decision, Sharis Pozen, then Chief of Staff at the Antitrust Division warned that one of its top enforcement priorities is "to carefully scrutinize and continue to challenge exclusionary practices by dominant firms … that substantially increase the cost of entry or expansion" in health insurance markets.[47] She noted the Division will be targeting "most-favored nations clauses, exclusive contracts, or similar arrangements between insurers and significant providers that reduce the ability or incentive of providers to negotiate discounts with aggressive insurance entrants."

The United States Supreme Court denied UPMC's petition for certiorari in October 2011. That, however, was not the end of the saga. That same month, as noted above, Highmark and West Penn announced merger plans (with Highmark stating it would invest $475 million in West Penn). Not surprisingly, West Penn dismissed its complaint against Highmark.

In April the Antitrust Division took the relatively unusual step of issuing a closing statement, explaining why it had determined not to oppose the transaction.[48] The Division asserted the affiliation "holds the promise of bringing increased competition to western Pennsylvania's health care markets by providing [West Penn] with a significant infusion of capital" and by increasing the incentives for market participants to compete.

The Division noted that the consolidation is a vertical one, as neither Highmark nor West Penn compete in each other's product markets. "Vertical agreements," the Division stated, "can reduce competition by limiting entry or expansion by third parties." But such effects were not foreseen by the Division here. The agency noted that Highmark was not likely to sponsor expansion by a hospital network other than West Penn "because there is no other significant network with which Highmark could partner.

In addition, West Penn "on its own likely would not have promoted entry or expansion by other health insurers" because it had tried previously to sponsor entry by national insurers "and largely failed." Moreover, the affiliation, in the Division's view, is not likely to reduce West Penn's "incentive to offer competitive rates to insurers other than Highmark because [West Penn] has strong incentives to increase its patient volume."

---

[47] Statement of Sharis A. Pozen, Chief of Staff, Antitrust Division, Before the Subcommittee on Antitrust, Competition Policy and Consumer Rights Committee of the Judiciary, United States Senate, "Antitrust Laws and their Effects on Healthcare Providers, Insurers and Patients" (December 1, 2010), available at www.justice.gov/atr/public/testimony/264672.pdf.

[48] "Statement of the Department of Justice's Antitrust Division on Its Decision to Close Its Investigation of Highmark's Affiliation Agreement with West Penn Allegheny Health System," (April 10, 2012) available at www.justice.gov/opa/pr/2012/April/12-at-439.html.

While the federal antitrust review has ended, as of the date this paper was prepared the insurance commissioner's review had not yet been completed. The date when the happy couple may tie the knot remains uncertain.

4. Standup Guys: Federal Jury Awards $35 Million to Upright MRI Providers

A federal jury in the Eastern District of New York returned a verdict in November 2010 in favor of plaintiff radiologists who were excluded from CareCore's preferred provider network, in violation of the Sherman Act. After a two week trial, the jury awarded plaintiffs $11.3 million dollars in damages, which was trebled to nearly $35 million.[49] In September 2011, the trial judge denied CareCore's post-trial motions to vacate the jury's award.

Defendant CareCore offers radiology benefits management services to health insurers, offering risk contracts for managing the care of members' outpatient radiology needs. Plaintiffs were radiologists who provided "upright MRIs," which are MRIs taken in a standing or sitting position instead of lying down. Plaintiffs claimed they were excluded from CareCore's network, which acted as a "gatekeeper" in denying plaintiffs access to some of the largest health insurance networks in New York. Plaintiffs claimed CareCore excluded them from its networks in order to protect CareCore's owners (also radiologists) from competition from the allegedly superior upright MRI procedures.

B. Antitrust Potpourri: Indirect Purchasers, Noerr, Gun Jumping

1. No Antitrust Injury: Tying White Blood Cells to Red Blood Cells Doesn't Hurt Hospital[50]

The dismissal of a Pennsylvania hospital's complaint against pharmaceutical company Amgen was affirmed by the Third Circuit in June 2011 because the hospital was an "indirect purchaser" and thus had not sustained "antitrust injury."

The hospital claimed Amgen had conditioned discounts for its white blood cell growth factor drugs on the purchase of its red blood cell growth factor drugs. Amgen has a monopoly in the market for white blood cell drugs, but faces real competition in the market for red blood cell drugs. The hospital asserted the discounts on the white blood cell drugs made it economically irrational to turn down the red blood cell drugs in favor of cheaper alternatives.

However, because the hospital purchases all the drugs through a middleman, the district court dismissed the hospital's claims as it was an indirect purchaser. The court of appeals affirmed.

---

[49] Stand-up MRI of the Bronx P.C. v. CareCore National, LLC, No. 08-cv-2954 (E.D.N.Y. Nov. 30, 2010).

[50] Warren Gen'l Hosp. v. Amgen, Inc., 643 F.3d 77 (3rd Cir. 2011).

2. Say What You Will: *Noerr* Protects It[51]

In May 2011, the Seventh Circuit upheld the dismissal of one hospital's antitrust claims against a competitor under the Noerr-Pennington doctrine.

The Mercatus Group LLC had partnered with Evanston Northwestern Healthcare to construct a new physician center in the village of Lake Bluff, Illinois. Nearby Lake Forest Hospital recognized the project as a competitive threat and campaigned to persuade the Lake Bluff Village Board to deny approvals necessary for construction to proceed. Among other actions, the hospital lobbied board members individually and at board meetings and launched a public relations campaign encouraging others to do the same.

After the village board denied Mercatus' application, Mercatus sued Lake Forest Hospital. Mercatus alleged that the hospital violated Section 2 of the Sherman Act by misrepresenting the detrimental impact of the physician center on the price and availability of care during its campaign.

The district court granted summary judgment in favor of Lake Forest Hospital. It held the Noerr-Pennington doctrine, which protects petitioning activity from antitrust liability, immunized any misrepresentations the hospital may have made to the village board or to the general public. The court of appeals affirmed.

3. Shooting Blanks: Gun Jumping Claim Loses at the Seventh Circuit[52]

The Seventh Circuit in January 2011 rejected claims by institutional pharmacy Omnicare challenging pre-merger planning and information exchanges between two health insurers, UnitedHealth Group and PacifiCare Health Systems.

The federal merger rules promulgated under the Hart-Scott-Rodino pre-merger notification statute prohibit parties to a planned merger from transferring beneficial control a company to its merger partner before the HSR waiting period expires. The practice frequently is referred to as "gun jumping."

In 2005, United and PacifiCare each were negotiating reimbursement contracts with Omnicare, the nation's largest institutional pharmacy, which provides pharmaceutical services to long-term care facilities like nursing homes. At the same time, United and PacifiCare were planning to merge and, as a result, were exchanging information as part of due diligence and preparing for post-merger operations.

Before the merger closed, United and Omnicare negotiated an agreement on terms favorable to Omnicare, while PacifiCare was able to obtain favorable concessions from Omnicare. Shortly after the merger closed, United abandoned its Omnicare contract and joined PacifiCare's

---

[51] Mercatus Group LLC v. Lake Forest Hosp., 641 F.3d 834 (7th Cir. 2011).
[52] Omnicare, Inc. v. UnitedHealth Group, Inc., 629 F.3d 697 (7th Cir. 2011).

contract. Omnicare sued, claiming that the insurers had coordinated their approaches with Omnicare to ensure that one of them was able to make a deal for a lower reimbursement rate.

Omnicare's claims turned on evidence of pre-merger conspiracy between the insurers. Without direct evidence of an agreement between the two, Omnicare pointed to circumstantial evidence. The district court granted the insurers' motion for summary judgment, finding a lack of evidence of improper coordination.

The court of appeals affirmed, holding the evidence of conspiracy was "ambiguous." Because the evidence was equally consistent with either conspiracy or independent action, Omnicare had to produce evidence excluding the possibility of independent action on the part of the insurers. Omnicare failed to carry its burden. The court concluded, in fact, the inference of conspiracy was less reasonable than the inference of independent action. Without evidence of an agreement, Omnicare's claims could not survive summary judgment.

C. Private Litigation Following Public Enforcement

1. Out of Favor: Michigan Court Dismisses Claims against Blue Cross Blue Shield[53]

Issuing not one but two decisions, a federal district judge in Detroit dismissed claims made by the City of Pontiac, Michigan, against Blue Cross Blue Shield of Michigan arising out of its use of most-favored-nations clauses in its contracts with hospitals. The rulings dismiss only one of several class actions pending against BCBS over the MFN clauses, and have no effect on the Department of Justice's case (reported above) against BCBS.

In October 2010, the department of Justice and the Michigan Attorney General filed suit against BCBS, alleging that its use of MFN clauses had excluded competing health insurers from the market and had driven up the cost of insurance to employers and individuals. Numerous private lawsuits followed.

The City of Pontiac filed a complaint on behalf of persons who did not purchase their health insurance directly from BCBS. Instead, the City was self-insured and used BCBS only as a third-party administrator. Its theory was that the MFN clauses caused hospitals to raise their prices for all services sold to self-insured entities like the city: the MFN clauses set a cost floor that the resulted in higher premiums for the city and its employees. Pontiac sued BCBS as well as 22 hospitals it accused of conspiring to raise prices.

The district judge before whom all of the BCBS cases are pending issued two orders dismissing Pontiac's claims on March 30. First, the court dismissed the city's claims against BCBS. Second, the court dismissed the city's claims against the hospitals.

The city alleged only per se violations of Section 1 of the Sherman Act. Per se violations describe that set of agreements among horizontal competitors that are so pernicious that courts

[53] City of Pontiac v. Blue Cross Blue Shield of Michigan, No. 11-10276 (E.D. Mich., March 30, 2012).

need not examine their competitive effects in order to condemn them. But the court found BCBS and the hospitals have a vertical relationship in the market, not a horizontal relationship as competitors, and therefore per se condemnation was not an option.

While the hospitals are horizontal competitors, Pontiac nowhere alleged an agreement between them, an essential element in a Section 1 claim. Although the city argued in its briefing the court might infer an agreement, it failed to make any such allegations in the document that mattered – the complaint. The court searched the city's complaint for allegations that might support a rule of reason claim, but found none.

The court also found implausible the city's allegations that the hospitals and BCBS were unjustly enriched by payments by the city.

2. The Beat Goes on: Class Certification Revived in Evanston[54]

The saga of the Evanston, Illinois, hospital market continues. The background: three hospitals in suburban Chicago merged on January 1, 2000. In 2004, the FTC took the unusual step of challenging that merger retroactively. In 2005, an FTC administrative law judge held that the merger violated section 7 of the Clayton Act and ordered the merger to be dissolved. The record contained substantial evidence that the merged entity, Northshore, had raised prices substantially after consummating the merger; indeed defendants' own expert ultimately acknowledged price increased at least nine or ten percent above competitive prices. In 2007, the full FTC upheld the finding on liability, but reversed the remedy and ordered only a controversial "conduct" remedy (separate contracting) instead of a "structural" remedy (divestiture).

Private litigation soon followed. In 2007, plaintiffs sued Evanston Northwest in a putative class action, claiming that the merger had caused them to pay too much for their health care at the three hospitals. Plaintiff sought to certify a class of consumers who bought health care services directly from any Northshore entity between 2000 and 2008.

In April 2010, a federal district judge in Chicago denied plaintiffs' motion for class certification, holding that the plaintiffs could not prove "antitrust impact," that is, causal injury, on a uniform basis across the proposed class.[55] Plaintiffs certainly tried: the decision turned on a battle of two expert economists who spent a lot of time (and no doubt money) developing and critiquing economic models for proving impact on a class-wide basis.[56] The court concluded that the plaintiffs' expert's methodology for calculating the amount price increases resulting from the exercise of market power would not permit class-wide proof of antitrust injury in the form of higher prices. In order to work as a class-wide proof, the court reasoned, this methodology required proof that defendant raised its prices at uniform rates affecting all class members to the

[54] Messner v. Northshore University HealthSystem, 7th Cir., No. 10-2514, 1/13/12).
[55] In re Evanston NW Healthcare Corp. Antitrust Litig., 268 F.R.D. 56 (N.D. Ill. Apr. 12, 2010).
[56] The Seventh Circuit explained the vigorous contest over class certification: "In light of the FTC's findings that the merger had violated the law and enabled Northshore to raise its prices at least nine or ten percent above competitive prices, it is understandable that Northshore put up a determined opposition to class certification."

same degree. Because the court found price increases were not uniform, the court concluded that the plaintiffs could not show predominance.

Noting the importance of the issue for "for private antitrust enforcement, particularly with respect to hospitals and health care providers with complex pricing systems," the Seventh Circuit granted the petition for interlocutory appeal. It found the district court's conclusion that a lack of uniform price increases required denial of class certification was erroneous as a matter of both fact and law, and hence an abuse of discretion. First, it found that the trial court failed to determine whether the defense expert's report used to attack plaintiff's method of common proof was admissible pursuant to Fed.R.Evid. 702 and *Daubert*.[57] Noting that the defendants' expert's report and testimony were important to an issue decisive for certification, the expert's testimony was "critical" under Seventh Circuit precedent[58] and hence the court needed to rule conclusively on plaintiff's challenge to her opinions before it turned to the merits of plaintiffs' motion for class certification.

The court then went on to analyze whether common issues predominate among the putative class. It found that the trial court failed to apply the correct standard under Rule 23, which the court explained as examining only whether common questions represent a significant aspect of the case and can be resolved for all class members in a single adjudication. Plaintiffs need not prove antitrust impact at this stage, it concluded, only that antitrust impact is capable of proof at trial through evidence common to the class. The court noted that plaintiff's economic expert claimed that he could use common evidence – the post-merger price increases Northshore negotiated with insurers – to show that all or most of the insurers and individuals who received coverage through those insurers suffered some antitrust injury as a result of the merger. "That was all that was necessary to show predominance for purposes of Rule 23(b)(3)," the court concluded. The fact that some members of the proposed class were not injured (*e.g.*, Blue Cross Blue Shield of Illinois, the largest putative class member, allegedly suffered no injury) or are immune from price increases was of no moment. "All of this is at best an argument that some class members' claims will fail on the merits if and when damages are decided," the court explained.

D. Nurse cases

1. Working Overtime: No Agreement, No Case[59]

Plaintiffs, acting on behalf of themselves and a class of nurses and technical care specialists, alleged that the Hospital Association of Southern California and several member hospitals conspired to depress nurse wages throughout Southern California in violation of California's antitrust statute, the Cartwright Act. Their claim asserted that defendants entered into a secret agreement to lower the hourly wage rate of nurses by 15 percent in order to offset the effects of a California law (AB 60) that reinstated mandatory overtime pay. Putting in its own overtime, the California Court of Appeal parsed the record on summary judgment and affirmed the trial court's

[57] Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993).
[58] American Honda Motor Co. v. Allen, 600 F.3d 813, 815-16 (7th Cir. 2010).
[59] Zumbowicz and Gordon v. Hospital Association of Southern California, No. B215633 (November 16, 2010, Court of Appeals of California, Second District).

dismissal of the case based on plaintiffs' failure to identify sufficient evidence of an agreement to depress wages.

After observing that "many nurses preferred the option of a 12-hour shift because it allowed them to take more days off or pick up additional shifts at different hospitals," the appellate court explained that several hospitals had decided to implement a 15 percent "equivalency pay reduction" in the hourly pay rate for nurses who worked a 12-hour shift in order to "provide nurses the same amount of compensation for a 12-hour shift that they had received prior to the passage of the new law."

Under Cartwright Act precedent, plaintiffs may demonstrate "illegal concerted action based on consciously parallel behavior" by showing (1) that the defendants' behavior was parallel; (2) that the defendants were conscious of each other's conduct and that this awareness was an element in their decision-making process; and (3) certain "plus factors." The court found plaintiffs' evidence on all three factors wanting.

The court reviewed three categories of evidence proffered by plaintiffs in support of their claim: (1) testimony and documentary evidence from non-defendant hospitals indicating that they had participated in association-sponsored meetings and phone calls regarding AB 60 where some hospital administrators had revealed that they intended to adopt equivalency pay reductions, (2) a memo the hospital association sent to its members stating that the "safest course" was to adopt an equivalency pay reduction, and (3) testimony from a non-defendant hospital administrator stating that hospitals that did not adopt equivalency pay reductions would have a competitive advantage in recruiting and retaining nurses over hospitals that did impose such a reduction.

First, the court found defendants' behavior was not sufficiently "parallel" given that of the 18 hospitals operated by the seven defendants, only one hospital mandated an equivalency pay reduction "that adjusted the straight time base hourly rate of pay for … 12 hour shift registered nurses," while nine other hospitals permitted nurses to vote on whether they preferred to convert to 8 hour shifts and retain their level of hourly base pay, or, alternatively, retain 12 hour shifts with an equivalency pay reduction, and the remaining eight hospitals did not adopt an equivalency pay reduction of any kind. Evidence that hospitals purportedly urged each other to adopt equivalency pay reductions did not support the claim that the actions undertaken were "parallel," especially where so many hospitals did not so act.

Second, plaintiffs offered testimony from non-defendant witnesses stating that they participated in association-hosted conferences and phone calls wherein competitors discussed potential responses to the new law and an association memo that purportedly encouraged member hospitals to adopt equivalency pay reductions. The court held that even if this evidence demonstrated that defendants were "conscious" of each other's conduct, plaintiffs had failed to satisfy the second prong of the inquiry, i.e. that the "awareness was an element in the Defendants' decisional process."

Finally the court was not satisfied that plaintiff had established the "plus factors" necessary to survive summary judgment. As to the most important factor, whether the conduct was contrary to defendants' economic self interest if acting alone, evidence that an administrator of a non-defendant hospitals thought so was not enough. While acknowledging the existence of a nursing

shortage in California, the court stressed plaintiffs' failure to introduce any expert testimony or statistical evidence suggesting that nurses would actually behave in the manner they suggested. It regarded as insufficient the testimony of "a single lay witness" supporting this claim as it merely repeated an "economic truism" that ignored crucial economic factors such as the fact that hospitals were not paying their nurses the same base hourly wage.

The court also found a strong economic motive for each hospital to independently adopt the equivalency pay reduction in the increased cost associated with overtime pay. Further undermining plaintiffs' case was the absence of evidence indicating that the ten defendant hospitals that did impose equivalency pay reductions suffered a competitive disadvantage in retaining nurses in comparison to the eight defendant hospitals that did not impose such reductions. Also lacking was "any evidence indicating that the hospital industry, or the market for hospital nurses, is oligopolistic in nature and therefore conducive to price fixing."

As to the plus factor the court called "traditional evidence of a conspiracy," there was plenty: (1) various HASC-hosted meetings and phone calls during which hospital administrators discussed potential responses to AB 60; (2) a memo circulated by HASC that refers to equivalency pay reductions as "the safest course," and (3) other statements and documents demonstrating that hospitals were collectively discussing AB 60 and aware of competitors" planned response to AB 60. Again, the court found the evidence wanting. While acknowledging that the meetings were intended to "discuss strategies on how to deal with [AB 60]," the court was more impressed with testimony that some participants came away believing that only a minority would adopt the equivalency pay reduction option and it was plausible that "the hospitals met to educate themselves on the various ways an entity might respond to AB 60's requirements, and then used that information to independently decide which option was best for their institution." The court went on to find the "safest course" memo and seemingly damning statements from hospital representatives about "getting together" to resolve the issue as subject to multiple interpretations.

2. Arizona Temporary Nurse Cases Settled

In September 2010, the Arizona Hospital Association settled a class action with temporary nurses for $22 million. The settlement arose out of the association's nurse registry program. That program begin wisely enough as a clearinghouse for vetting the credentials of nurses traveling to Arizona for temporary work during the winter months. But over the years, the registry branched out into pricing data and eventually became a vehicle through which the hospitals allegedly suppressed the wages of traveling nurses.

In 2007, the Department of Justice announced a settlement with the association enjoining it from continuing to engage in any price-related behavior.[60] Private litigation followed and a federal judge ultimately certified the matter as a class action (although the certification order was limited to per diem nurses, not traveling nurses). Nonetheless, the pressures of class certification led the association and defendant hospitals to settle for a significant amount of money.

---

[60] United States v. Arizona Hospital and HealthCare Association, No. CV07-1030-PHX (September 12, 2007) available at http://www.justice.gov/atr/cases/azhha.htm.

III. HEALTH CARE REFORM AND ANTITRUST: ACOS

The federal antitrust agencies issued the final statement of their antitrust enforcement policy regarding Accountable Care Organizations participating in Medicare's Shared Savings Program on October 20, 2011.[61]

The statement departs in two significant ways from the proposed statement released in March 2011 by the Federal Trade Commission and the Department of Justice's Antitrust Division.

First, and most significantly, the agencies will not require any ACO to submit to mandatory review by the antitrust agencies as a condition to entry into the Shared Savings Program. The statement issued in March proposed to require review for ACOs combining providers with shares of 50% or more in overlapping services within their primary service areas (PSAs).

Second, the guidance in the final statement applies to "all collaborations among otherwise independent providers and provider groups that are eligible and intend, or have been approved, to participate in the Medicare Shared Savings Program." The earlier statement proposed to limit applicability to collaborations formed after March 23, 2010 (the date the Patient Protection and Affordable Care Act was enacted).

The final policy statement, issued on the same day CMS issued its final rule on ACOs, confirms the federal antitrust enforcement agencies will apply the so-called "rule of reason" to combinations of providers meeting CMS eligibility criteria for ACOs participating in the Shared Savings Program rather than the considerably more harsh "per se" rule of illegality reserved for provider collaborations that do not involve significant financial or clinical integration.

ACOs with groups of providers who offer common services that cumulatively account for no more than 30% of those services within their PSAs fall within a "safety zone." Such ACOs "are highly unlikely to raise significant competitive concerns." Therefore, the agencies state, they will not challenge these ACOs under the antitrust laws, "absent extraordinary circumstances."

ACOs that do not qualify for the safety zone "may be procompetitive and legal." But, "not all ACOs are likely to benefit consumers." According to the final policy statement, "under certain conditions ACOs could reduce competition and harm consumers through higher prices or lower quality of care."

The effect of the final policy statement is to place the responsibility squarely on the shoulders of each ACO and its antitrust advisors to determine the legality under the antitrust laws of ACOs that fall outside the safety zone. Newly formed ACOs that want guidance from the antitrust agencies may request a statement as to the agencies' assessment of the ACO's likely competitive effects through an expedited, 90-day review process detailed in the policy statement. No ACO is required to obtain such input, however, before applying for entry to the Shared Savings Program and commencing operations. ACOs that choose to skip a review by the antitrust agencies are

[61] Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (October 28, 2011) available at www.ftc.gov/os/fedreg/2011/10/111020aco.pdf.

provided with advice on how to operate so as to minimize the possibility of a later antitrust enforcement action.

Applicability of the Policy Statement

The policy statement applies to "collaborations among otherwise independent providers and provider groups that are eligible and intend, or have been approved, to participate in the Shared Savings Program." The agencies recognize many ACOs will provide services to commercially insured patients as well. The policy statement provides a framework under which the agencies will analyze CMS-qualified ACOs when they provide services in the commercial market.

The policy statement does not apply to single, integrated entities, nor does it apply to mergers.

"Rule of Reason" Treatment for Price Negotiations by Qualifying ACOs with Commercial Payors

Under standard antitrust principles, otherwise competing providers who jointly negotiate contracts with commercial payors are fixing prices in violation of Section 1 of the Sherman Act, unless the providers are either clinically or financially "integrated." In antitrust jargon, such joint negotiations are a "per se" violation of Section 1. In the event the providers are "integrated," however, their collaboration is judged under the more lenient "rule of reason." As the agencies explain in the final policy statement, a rule of reason analysis examines both the efficiencies that flow from the collaboration and its anticompetitive effects. The arrangement is unlawful only if, on balance, the likely anticompetitive effects outweigh the efficiencies.

The antitrust agencies have provided a great deal of advice elsewhere on what constitutes sufficient financial or clinical integration to escape per se treatment and bring an arrangement under the rule of reason. In particular, the "Statements of Antitrust Enforcement Policy in Health Care," issued by the two federal antitrust agencies in 1996, provide detailed guidance on how providers might integrate.[62] Both the Federal Trade Commission and the Department of Justice have issued advice letters that discuss adequate financial or clinical integration in specific factual circumstances. Speeches from enforcement officials and various agency reports have further illuminated the criteria the agencies consider to determine when integration is present.

While the criteria by which financial integration is judged are broadly understood and have caused little controversy, the same cannot be said about clinical integration. Until now, the antitrust agencies have resisted setting out specific criteria required to establish clinical integration. Instead, in the years since the issuance of the 1996 antitrust enforcement advice, the

[62] Examples of sharing financial risk include accepting capitation or setting a fee schedule with a substantial risk withhold. Clinical integration is evidenced by the implementation by a network of an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and the creation of a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. Networks that are clinically integrated may set prices jointly, so long as such price setting is reasonably necessary to achieve promised efficiencies.

FTC has issued a number of staff advice letters explaining what does, and does not, qualify as clinical integration sufficient to permit joint price setting.

In an important departure from this history, the policy statement provides that ACOs participating in the Medicare Shared Savings Program will be presumed to be clinically integrated (and so able to negotiate prices with commercial payors without running afoul of the antitrust laws) as long as they comply with the CMS eligibility criteria for participation in the Share Savings Program and participate in that program. Such ACOs also must employ in their commercial business "the same governance and leadership structures and the same clinical and administrative processes" used to qualify for and participate in the Shared Savings Program.

The antitrust agencies have deferred to CMS in this area because they consider CMS's eligibility criteria to be "broadly consistent with the indicia of clinical integration" traditionally employed by the antitrust enforcers.

Therefore, so long as an ACO participates in the Shared Services Program and keeps the same governance and clinical structures in place as existed at the time of CMS's approval of the ACO's application for participation in that program, the ACO's negotiations with commercial payors will not be considered by the antitrust agencies as per se violations of the antitrust laws.

Calculation of Shares for Determining the Applicability of the Safety Zone

The policy statement establishes an antitrust "safety zone" for ACOs in the Shared Service Program when shares of overlapping providers do not exceed 30%. ACOs falling within this safety zone are assured that "absent extraordinary circumstances" the agencies "will not challenge" either their formation or their operation.

If an ACO wishes to establish that it qualifies for the safety zone it must engage in a detailed share calculation. To conduct the required share analysis, the ACO first must determine which services are provided by two or more competing providers (or groups of providers) in the ACO. The ACO then must calculate, for each such "common service," the share all the ACO's providers hold of that service within each provider's PSA."

For example, if an ACO were to include two otherwise independent groups of cardiologists, the PSA for each group would be separately determined. Then the combined shares of both groups would be calculated within each of the two PSAs.

The guidelines borrow the CMS definition of a PSA as the lowest number of zip codes from which the provider draws a least 75% of its patients for a particular service.

In order to perform these calculations:

- Physician services are defined by a physician's specialty, as defined by the Medicare Specialty Code ("MSC");
- Hospital inpatient services are identified by Major Diagnostic Categories ("MDCs");

- Outpatient services are defined by categories to be identified by CMS.

Shares will be calculated for hospital inpatient services by using all-payor discharge data for the relevant MDCs when they exist at a state level. Physician shares will be calculated using Medicare fee-for-service allowed charges. Outpatient services will be measured by Medicare fee-for-service payment data for hospitals and fee-for-services allowed charges for ambulatory surgery centers. If available, an ACO can use state-level, all-payor discharge data instead. For services rarely used by Medicare beneficiaries, such as pediatrics, obstetrics and neonatal care, ACO applicants are directed to use "other available data" to determine shares.

An appendix to the Policy Statement provides detailed examples of share calculations.

The 30% Safety Zone

A safety zone applies to an ACO that combines providers with shares of no more than 30% in any common service (i.e., any overlapping service line) in each PSA where an ACO provider of such service is found.

If an ACO includes hospitals or ASCs, those facilities must be "non-exclusive" to the ACO to fall within the safety zone. This means a hospital or ASC must retain the ability to contract or affiliate with other payors or ACOs or the protection of the safety zone is lost.

- Rural Hospitals. An ACO may include "Rural Hospitals" on a non-exclusive basis and still qualify for the safety zone even if the shares for common hospital services exceed 30%. A Rural Hospital is defined as a Sole Community Hospital or Critical Access Hospital under CMS regulations, or any other acute care hospital in a rural area that has no more than 50 beds and is located at least 35 miles from another hospital.

The safety zone for physicians applies regardless of whether they contract with the ACO on an exclusive basis or not – unless the physicians fall within either the "rural exception" or "dominant participant limitation," in which case they must contract on a non-exclusive basis to take advantage of the safety zone.

- Rural exception for physicians. An ACO in a rural area that has more than a 30% share within a PSA may still qualify for the safety zone if that share is the result of including no more than one physician or pre-existing physician group practice, per specialty, from a rural area. The physician or group, however, must be included on a non-exclusive basis to qualify for the safety zone. The agencies borrow the definition of rural areas developed by the Health Research Center at the University of Washington.

- Dominant Provider Limitation. If a provider with a share greater than 50% is included in an ACO, the ACO will still qualify for the safety zone if the provider is non-exclusive to the ACO and no other providers of the same service are included. The ACO also may not require a commercial payor to contract exclusively with it.

Except as set forth in the rural exception and the dominant provider limitation, an ACO could require its physicians to provide their services on an exclusive basis, and still qualify for the safety zone, so long as the 30% thresholds are not exceeded.

To qualify for the safety zone, unless the rural exception applies, an ACO could not exceed 30% in any of the service lines in which it combined competing providers. While failing to qualify for the safety zone would not mean the ACO had run afoul of antitrust law, falling outside the safety zone could impose additional administrative burdens, as discussed below.

Guidelines for ACOs outside the Safety Zone

ACOs that fall outside the 30% safety zone "may be procompetitive and lawful." Such ACOs, however, remain exposed to possible antitrust challenge by the enforcement agencies. The risk of such a challenge will rise with the market power held by an ACO. The policy statement does not give specific guidance as to when an ACO with a share or shares above 30% may violate the antitrust laws. Nonetheless, the agencies do provide guidance as to how such ACOs may reduce competitive concerns.

The policy statement identifies four types of conduct ACOs "with high PSA shares or other possible indicia of market power" should consider avoiding to minimize the likelihood of an antitrust challenge. Such ACOs should not:

1) Prevent or discourage commercial payors from steering patients to certain providers through "anti-steering," "anti-tiering, "guaranteed inclusion," "most favored nation," or other similar contractual provisions.
2) Tie sales of the ACO's services to a commercial payor's purchase of other services from providers outside the ACO.
3) Contract on an exclusive basis with ACO participants. There is no exception for primary care physicians.[63]
4) Restrict a commercial payor's ability to share cost, quality, efficiency, and performance information with its enrollees.

Regardless of the ACO's market shares, the Agencies warn that its operations should not facilitate price-fixing or other collusion among competing participants in the sale of their services outside of the ACO. For example, the ACO should implement firewalls or other safeguards to prevent improper exchanges of competitively sensitive information among non-integrated participants, such as the prices participating providers accept when contracting with payers outside the ACO.

---

[63] The policy statement notes that while CMS "requires the physician practice through which physicians bill for primary care services and to which Medicare beneficiaries are assigned to contract exclusively with one ACO for the purposes of beneficiary assignment, CMS does not require either those individual physicians or physician practices to contract exclusively through the same ACO for the purposes of providing services to private health plans' enrollees."

Voluntary Antitrust Review by the Agencies

Any "newly formed" ACO may seek, on an "expedited" basis, antitrust review from the enforcement agencies. A newly formed ACO is one that, as of March 23, 2010, had not signed or negotiated contracts with a commercial payor, and had not participated in the Shared Savings Program.

An ACO that wants a review must inform the FTC and DOJ it wants a review, using a form available on the agencies' website. The agencies then decide which agency will conduct that review and inform the ACO. The ACO then must submit certain identified information to that agency. The required information includes: (1) the application and supporting documents submitted to CMS for participation in the Shared Savings Program; (2) documents discussing the ACO's business strategies or plans to compete in the Medicare and commercial markets, including the ACO's impact on quality or price; (3) documents discussing competition among ACO participants and in markets to be served by the ACO; and (4) information sufficient to show the common services offered by two or more ACO members, and the share calculations by PSA for those services, "or other data that show the current competitive significance of the ACO or ACO participants."

Within 90 days of receiving "all" the required information, the reviewing agency will inform the ACO that the group's formation and operation "does not likely raise competitive concerns," "potentially raises competitive concerns," or "likely raises competitive concerns." The agency may condition a finding that the ACO does not likely raise competitive concerns on agreement by the ACO to take certain prescribed steps to remedy concerns raised by the agency.

All request letters and responses will be public documents. The two antitrust agencies also will establish a joint working group "to collaborate and discuss issues arising out of the ACO reviews."

Observations

- No mandatory reporting. Unlike the proposed policy statement issued in March, the final statement does not require any ACO to submit anything to the antitrust enforcement agencies. This means antitrust enforcement in this area is consistent with antitrust enforcement philosophy generally: parties may form and operate a collaborative venture without first seeking permission from the government. But if they violate the antitrust laws they may be the subject of an enforcement action by those agencies.

- PSAs are not antitrust relevant markets. The policy statement expressly notes a PSA is not necessarily equivalent to a relevant geographic market used in traditional antitrust analysis and it nowhere states the calculations providers make will result in "market shares." (The statement is careful to use the word "shares," without the modifier "market," throughout.) Nonetheless, for the purposes of the Shared Savings Program, the policy statement in effect considers PSAs as proxies for antitrust relevant geographic markets. As a matter of antitrust law, however, a PSA at best is only a rough approximation of a relevant geographic market. At worst it bears no resemblance at all to

a relevant geographic market, and market analysis based on PSAs can yield incorrect antitrust conclusions.[64]

- Data Limitations. The share calculations necessarily are limited to available data. The antitrust agencies recognize that many states collect and publish all-payer discharge data that permit, when hospital services are at issue, share calculations based on these data. But similar data generally are not available for physician services. Accordingly the statement discusses the use of Medicare data for physicians and outpatient services. But this necessarily produces shares based on Medicare revenues. Not all physicians in the same specialty see Medicare patients, however, and of those who do, not all do so in equal proportions. Consequently, share calculations based on Medicare data may be either higher or lower than calculations based on all-payer data – which, the agencies acknowledge, is preferable to Medicare data. Incomplete data (such as Medicare reimbursement data only) may lead to incorrect conclusions.

- Safety Zones Do Not Provide Antitrust Immunity. While an ACO that applies for antitrust review and receives a letter from an antitrust agency indicating that the ACO is not likely to raise competitive concerns may proceed safe in the knowledge that the federal antitrust agencies will not prosecute it (so long as it does not substantially change the manner in which it does business), it will have no such protection from private litigants. Similarly, if an ACO falls within the 30% "safety zone," this protects it only from an enforcement action by the agencies. Private parties would be free to sue the ACO.

- Uncertainty for ACOs that Are Not Qualified by CMS. If an ACO is structured in a way that falls within the safety zone described in the policy statement, but the ACO chooses not to qualify under the Medicare Shared Savings Program and instead focuses on commercial business, it is not clear whether the antitrust enforcement agencies would scrutinize it under the guidelines set forth in the policy statement or under more traditional antitrust principles.

- Different Criteria for Clinical Integration? The effect of the deferral by the antitrust agencies to CMS to determine when otherwise competing providers are clinically integrated is uncertain. Despite the hopeful claims in the policy statement that CMS's eligibility criteria "are broadly consistent with the indicia of clinical integration" and that organizations meeting the CMS criteria are "reasonably likely to be bona fide

---

[64] Courts, antitrust commentators and enforcers repeatedly have warned against confusing the area from which a seller obtains its customers with a relevant geographic market. "[A] court would often be mistaken to conclude that a seller's 'trade area,' or the area from which it currently draws its customers, constitutes a relevant geographic market. In fact, the 'trade area' and the 'relevant market' are precisely reverse concepts." Bathke v. Casey's General Stores, Inc., 64 F.3d 340, 346 (8th Cir. 1995) (quoting H. Hovenkamp, FEDERAL ANTITRUST POLICY § 3.6d, at 113-14); Federal Trade Commission v. Freeman Hosp., 69 F.3d 260, 268 (8th Cir. 1995); see also Antitrust Issues Raised by Rural, Health Care Networks, R. Leibenluft, Assistant Director, Health Care, Federal Trade Commission (February 20, 1998) (emphasis in original) available at www.ftc.gov/bc/ruralsp.shtm.

organizations" intended to improve quality and reduce costs, it remains to be seen whether, in practice, CMS's criteria are more lenient than those the agencies would have used to test clinical integration. The possibility that CMS's criteria will be different from – and more relaxed than – those applied until now by the antitrust agencies is a real one.

- Information to Be Provided and the 90-Day Review Period. The Policy Statement promises an expedited 90-day review for an ACO applying for a letter indicating the enforcement intentions of the antitrust agencies. ACOs expecting to hear definitively from an antitrust agency 90 days after they submit their applications must take great care to provide what can be a burdensome and complex amount of data in advance. Whether the agencies have sufficient staff to follow through on the promise of expedited review remains to be seen, especially as the volume – and complexity – of ACO voluntary requests is unknown and difficult to predict. Nonetheless, the burden on the agencies clearly will not be as great as it would have been had they required review of ACOs with shares over particular thresholds.

Mr. GOODLATTE. I hate to cut you off, as well. We are going to turn to Dr. Gottlieb.

To let the Members know, the Ranking Member and I have been talking, and we understand that Professor Greaney needs to be out of here not too long after 1 o'clock. This vote series is going to run

for probably at least an hour. So it is our intention after Dr. Gottlieb testifies to adjourn the hearing.

And we will submit lots of questions from any Member who wishes to have questions submitted—and I certainly have a lot of questions; I am sure the Ranking Member does, as well—to all of you to respond in writing. We apologize for the brevity of this, but I think it is not going to resurface later this afternoon on a day when Members are leaving.

So, Dr. Gottlieb, welcome.

TESTIMONY OF SCOTT GOTTLIEB, M.D., CLINICAL ASSISTANT PROFESSOR, NEW YORK UNIVERSITY, RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE

Dr. GOTTLIEB. Thanks, Mr. Chairman.

Mr. Chairman, Mr. Ranking Member, and Members of the Subcommittee, I appreciate the opportunity to testify here today.

By next year, about two-thirds of American physicians will be working as salaried employees. This trend was been under way for years, as has been noted, but it is accelerating. And provisions in the Patient Protection and Affordable Care Act are responsible for some of these combinations. The largest portion of these newly salaried physicians are being directly employed by hospitals or hospital-owned medical practices. According to the Medical Group Management Association, almost two-thirds of the doctors who signed employment contracts in 2009 entered into arrangements with hospitals. This includes half of all doctors leaving residency training.

It is not just hospitals; health plans are also looking to purchase providers to gain more control over utilization rates, and in turn costs, in an environment where they see their premiums capped and their utilization fixed by new mandates. These trends aren't a consequence of natural market forces. It is the result of a deliberate policy set in motion by changes in the way health care is being reimbursed, in particular where doctors see flat or declining reimbursement levels and increasing costs.

PPACA relies on layers of provisions designed to shift financial risk onto providers in a bid to move away from the fee-for-service reimbursement model that is blamed for excessive and, some argue, inappropriate use of healthcare services. By shifting financial risk on to providers, the law hastens this sort of consolidation.

That consolidation is being hailed by many as a needed industrialization of the practice of medicine, a way to make the delivery of care more efficient and scalable. There is a premise that, once doctors become employed by larger groups and health systems, it will be easier to put in place measures to manage their use of medical services. There is also a perhaps excessive faith that consolidated networks will have the incentive, capital, and wherewithal to pursue measures that lead to better coordination of care.

These arrangements have many champions, but they also carry significant uncertainty. First, there is evidence that, as doctors transition into becoming salaried employees of hospitals and health systems, their individual productivity generally declines. Concerns are also raised about the potential for consolidation to raise costs. There is evidence that constructs like ACOs can add to costs, as

some providers, particularly hospitals, gain market power to negotiate higher-than-competitive rates in the private market. Finally, the consolidation is leaving a great deal of uncertainty among providers about what is permissible and appropriate. This is distorting the business decisions that are being made.

Historically, innovations in the delivery of health care, from the advent of the first HMO to the creation of long-term-care hospitals and home infusion to skilled nursing facilities, arose as the result of startup outfits, often backed by venture capital and headed by entrepreneurs who were in search of above-market rates of return on invested capital.

But PPACA contains deliberate provisions aimed at regulating returns on invested capital, discouraging different forms of entrepreneurship. These provisions are, in many cases, the expression of a political philosophy. That philosophy views profits earned on the provision of care as money that should have been channeled instead to direct patient care. But the result is that these entrepreneurs are not pursuing new healthcare services ventures. Capital flowing to these endeavors has fallen sharply.

The only way we are going to bend the healthcare cost curve is by introducing genuine innovations in how we provide medical care—new approaches that lower costs while providing more health care for each dollar that we spend. These innovations won't appear as a result of the critical mass created through carefully orchestrated mergers. These ideas won't be hatched inside CMS. Nor are these concepts likely to arise from new twists on old concepts like capitation. Instead, genuine innovation in the delivery of health care will arise the way it always has: from entrepreneurs who raise capital in search of profitable new ways to reengineer old systems, appealing to consumers by bringing them a better service at a lower price.

Thank you, Mr. Chairman.

Mr. GOODLATTE. Thank you.

[The prepared statement of Dr. Gottlieb follows:]

Prepared Statement of Scott Gottlieb, M.D., Resident Fellow, American Enterprise Institute*

INTRODUCTION

Chairman Goodlatte, Ranking Member Watt, and Members of the Subcommittee, I appreciate the opportunity to testify here today.

By next year, about two-thirds of American physicians will be working as salaried employees of large groups and hospitals. This movement has been underway for years. Over the last decade, the number of independent physicians was falling by about 2% a year. But these trends are now accelerating. Many observers point to provisions in the recently enacted Patient Protection and Affordability Act (PPACA) as a primary driver. Starting in 2013, the number of independent physicians will start declining by 5% a year according to a recent report by Accenture Health.[i]

The largest proportion of these newly salaried physicians are being directly employed by hospitals or hospital owned medical practices.[ii] Hospital physician employ-

*The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.

[i] Clinical Transformation: Dramatic Changes as Physician Employment Grows, Accenture Health, 2011

[ii] Anne Mutti and Jeff Stensland. Provider consolidation and prices. Presentation before the Medicare Payment Advisory Committee. October 9, 2009

ment rose 32% from 2000 to roughly 212,000 physicians in 2010. That means that hospitals directly employ about a quarter of all U.S. physicians.[iii,iv]

These realities are reflected in multiple surveys. Another report found 70% of national hospital and health systems plan to hire more physicians in the next three years. Meanwhile, two-thirds of hospitals reported that they are seeing more requests from independent physician groups seeking direct employment or collaboration with hospitals.[v] This is confirmed by a recent review of the open job searches held by one of the country's largest physician-recruiting firms. It shows that nearly 50% are for jobs in hospitals, up from about 25% five years ago.[vi]

According to the Medical Group Management Association, almost two-thirds of the doctors who signed employment contracts in 2009 entered into arrangements with hospitals. This includes half of all doctors' leaving residency training.[vii] Surveys of physicians demonstrate that an increasing number of newly minted doctors prefer the salaried arrangements to the traditional private practice models. Recent survey data also shows that physicians believe the current employed trend will continue and be a preferred option for them.[viii]

It's not only hospitals that are acquiring doctors. Health plans are also dipping their toes in the water, looking to purchase healthcare delivery organizations to gain more control over practices, utilization rates, and in turn costs. Toward the end of 2011, United Health Group purchased Monarch, the largest physician group in Orange County California with 2300 members. As another example, Pennsylvania-based insurer Highmark is teaming up with West Penn Allegheny Health System to compete with UPMC, the large, well-known medical center in Pittsburgh.[ix]

Investment bankers who work on mergers and acquisitions in the healthcare services industry privately concede that there is a lot of activity among health plans looking to acquire physician networks. So far, the large health plans have not been able to buy as many assets as the hospitals. For their part, the doctors seem to prefer to sell their practices to hospitals rather than the health plans.

These trends aren't a consequence of natural market forces. It's the outgrowth of a deliberate industrial policy set in motion by changes in the way healthcare is being organized and reimbursed. These new arrangements have been hastened by PPACA. The law relies on layers of provisions designed to shift financial risk onto providers in a bid to move away from the fee-for-service reimbursement model that's blamed for excessive, and some argue inappropriate use of healthcare services.[x] PPACA contains deliberate constructs to industrialize healthcare by moving physicians into capitated arrangements and larger groups where reimbursement, utilization, and quality measures can be more tightly controlled. These arrangements have many champions, but also carry significant uncertainty.

As I will discuss at the close of my testimony, the only sure way that we're going to bend the cost curve is by coming up with fundamentally new ways to deliver healthcare services that improve efficiencies and enable us to get more medical care for each dollar we spend. These ideas are going to come forward the same way better ideas have always arisen—from start-ups backed by entrepreneurs, supported by investment capital, coming together in search of profits. Yet PPACA contains provisions that I fear tilt against these kinds of innovations. The legislation relies instead on arrangements that could serve to entrench existing players.

Principal among these new arrangements is the creation of Accountable Care Organizations (ACOs). This concept envisions that providers will consolidate into networks that will, in turn, take charge for the medical care of defined populations of patients. An ACO will be able to share in some of the savings that they achieve by reducing utilization and improving outcomes for the patients assigned to it. Along with other forms of capitated payment arrangements (such as bundled payments and medical homes) the combined effect of the legislation's payment reforms is to shift financial risk to providers. In the face of these changes, doctors are choosing to sell their medical practices rather than take on added uncertainty.

[iii] 2012 Edition of the American Hospital Association Statistics

[iv] Haydn Bush. Hospital Statistics Chart Rise in Physician Employment. Hospital and Health Networks Daily, January 06, 2012

[v] Karen M. Cheung. 70% hospitals, health systems plan more physician employment. Fierce Healthcare, October 12, 2011

[vi] Scott Gottlieb. No, You Can't Keep Your Health Plan. The Wall Street Journal, May 18, 2010

[vii] Medical Group Management Association. Physician Placement Starting Salary Survey: 2010 Report Based on 2009 Data. June 4, 2010

[viii] Survey by McKesson Practice Consulting and Modern Medicine, 2011

[ix] Rita Numerof. Massive Healthcare Consolidation in the PPACA Era, April 13, 2012

[x] Atul Gawande. The Cost Conundrum, What a Texas town can teach us about health care. The New Yorker, June 1, 2009

Many industry experts are asking whether the current trend to employ physicians is sustainable or just a revisiting of what occurred in the 1990s, when hospitals were employing physicians in response to managed care, growing competition, and pressure to aggregate market share. The 1990s mergers were mostly defensive gestures aimed at thwarting competition from expanding, for-profit hospital chains.

This time things may be different, and in many ways the same.

This time, there may be no turning back from these arrangements. Doctors who enter into these new salaried appointments may find themselves hard pressed to unwind these relationships, even should the terms change and these affiliations no longer appear financially attractive or personally rewarding.

The current consolidation is being hailed in some quarters as a needed industrialization of the practice of medicine—a way to make the delivery of medical care more efficient and scalable. There is a premise that once doctors become employed by larger groups and health systems, it will be easier to put in place measures to manage doctors' use of medical services in ways that can improve efficiencies and lower costs. There's also a perhaps excessive faith that larger, consolidated networks of providers will have the incentive, capital, and wherewithal to pursue management and technology improvements that lead to better coordination of care. There is plenty of reason to be skeptical of these assumptions.

IMPACT OF CONSOLIDATION ON CLINICAL PRODUCTIVITY

First, there's evidence that as doctors transition into becoming salaried employees of hospitals and health systems, their individual productivity (in terms of metrics such as volume and intensity of care delivered) generally declines outright, or is unfavorably impacted by these arrangements in other, more subtle ways.[xi,xii,xiii,xiv,xv]

It's important to note that studies that have examined this question contain many limitations. This is because of the inherent difficulty in studying the impacts of different payment systems.[xvi] It's hard to look at controlled experiments that address questions of how doctors respond to different payment systems.

It's also true that data shows some offsetting economic impacts to these drops in productivity. For example, physicians' use of services such as diagnostic tests and procedures also shows corresponding decline when doctors move into salaried arrangements. The totality of the data suggests, however, that the reduction in costs generated by the salaried schemes (typically as a result of the delivery of fewer tests and treatments) may be partially, if not completely offset by the lower intensity of work (productivity) that physicians achieve under these arrangements.[xvii]

While it's generally hard to isolate the impact of payment structure on productivity, a number of studies have attempted to assess these impacts. In one study researchers used a resident continuity clinic to compare prospectively the impact of salary versus fee-for-service reimbursement on physician practice behavior. This model allowed randomization of physicians into salary and fee-for-service groups and separation of the effects of reimbursement from patient behavior.[xviii]

The authors found that physicians reimbursed by fee-for-services (FFS) scheduled more visits per patient than salaried physicians (3.69 visits versus 2.83 visits, $P < .01$) and saw their patients more often (2.70 visits versus 2.21 visits, $P < .05$) during the 9-month study. Fee-for-service physicians also provided better continuity of care than salaried physicians by attending a larger percentage of all visits made by their

---

[xi] Lawton Robert Burns and Ralph W. Muller. Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration. Milbank Quarterly 2008;86:375–434

[xii] Christopher D. Ittnera, David F. Larckerb, Mina Pizzinic. Performance-based compensation in member-owned firms: An examination of medical group practices, May 2007

[xiii] Wolinsky F, Marder W. Spending time with patients, the impact of organisational structure on medical practice. Medical Care 1982; 20(10):1051–9

[xiv] I S Kristiansen, K Holtedahl. Effect of the remuneration system on the general practitioner's choice between surgery consultations and home visits. Journal of Epidemiology and Community Health 1993;47:481–484 doi:10.1136/jech.47.6.481 http://jech.bmj.com/content/47/6/481.abstract?ijkey=286b3bd9c25afb8bb73203854199b0c2b49d86e0&keytype2=tf_ipsecsha

[xv] Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Impact of payment method on behavior of primary care physicians: a systematic review. Journal of Health Service Research Policy 2001 Jan;6(1):44–55

[xvi] Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Capitation, salary, fee-for-service and mixed systems of payment: effects on the behavior of primary care physicians. Cochrane Database Systematic Reviews 2000;(3):CD002215.

[xvii] T. Gosden, L. Pedersen and D. Torgerson. How should we pay doctors? A systematic review of salary payments and their effect on doctor behavior. QJM 1999;92:47–55

[xviii] Gerald B. Hickson, William A. Altemeier, James M. Perrin. Physician Reimbursement by Salary or Fee-for-Service: Effect on Physician Practice Behavior in a Randomized Prospective Study. Pediatrics 1987;80:344–350

patients (86.6% of visits versus 78.3% of visits, P < .05), and by encouraging fewer emergency visits per enrolled patient (0.12 visits versus 0.22 visits, P < .01).[xix]

Another review article surveyed the available literature examining how salaried arrangements impact physician productivity. It drew similar conclusions. The article found that salary payment reduces activity compared with fee for service. Capitation appeared to have a similar but more subdued effect. The authors concluded that "if cost containment is a key policy aim of government then salaried payment systems are more likely to achieve this compared with FFS and possibly more effective than capitation systems. However, cost containment by itself may be inefficient if it results in the provision of sub-optimal care." [xx]

This data raises a fundamental choice: If the goal is reduce spending by driving down utilization then the salaried arrangements might provide a more direct means of imposing top-down controls. If the goal is to reduce costs by increasing productivity then the salaried arrangements might thwart these types of outcomes.

CONSOLIDATION CAN DRIVE UP HEALTHCARE COSTS

Concerns have also been raised about the potential for consolidation to drive up costs. If constructs such as ACOs end up fostering more market concentration among providers, they have they could merely shift costs to payors. "Must-have" [xxi] hospitals and physician groups can exert considerable market power to demand higher rates from insurers. There is plenty of empiric evidence demonstrating that these arrangements can add to costs. Studies of pricing have shown that some providers, particularly hospitals, can gain significant market power to negotiate higher-than-competitive prices as they gain this sort of local market share.[xxii]

While a full discussion of these economic issues is beyond the scope of my testimony today, we need to carefully consider the potential impact from the arrangements that are being encouraged under PPACA. It has been observed that exclusive relationships, particularly those involving highly sought after or high-quality specialist physicians and hospitals, could give a consolidated network such as an ACO undue leverage.[xxiii] Exclusivity may also promote increased internal referrals within the network, which could magnify the effects of increased market power.[xxiv] In the past, antitrust policy has generally proved ineffective in curbing provider strategies that capitalize on gains in market power to win higher payments.[xxv] For these reasons, we should be especially mindful of the potential risks of encouraging a rapid evolution toward these consolidated relationships.

While observers are pointing to other entities that might form ACOs (large multi-specialty medical groups, venture capital backed services companies) the bottom line remains that hospitals are likely to dominate the formation of these new arrangements. There are two principal reasons. First, the largest avoidable costs are related to hospitalizations. Second, in many communities, the hospital is the only organized delivery system able to access capital and execute on the model.[xxvi]

The hospitals also have an ulterior motive. It's still unclear if ACOs will be profitable, successful enterprises. But for a hospital to succeed with the model, it need not succeed in lowering costs. If the process of forming an ACO lets a hospital consolidate local providers, the hospital will wins even if the ACO fails to succeed.

Physicians, for their part, are being driven to these arrangements by changes in the landscape that sees their practice costs rising, their reimbursement falling, while the financial risk they need to bear under PPACA increases through more capitated arrangements. Seeing costs rise amidst shrinking revenue, doctors are

---

[xix] Gerald B. Hickson, William A. Altemeier, James M. Perrin. Physician Reimbursement by Salary or Fee-for-Service: Effect on Physician Practice Behavior in a Randomized Prospective Study. Pediatrics 1987;80:344–350

[xx] T. Gosden, L. Pedersen and D. Torgerson. How should we pay doctors? A systematic review of salary payments and their effect on doctor behavior. QJM 1999;92:47–55

[xxi] These must have groups are generally providers that health plans need to include in networks to be attractive to employers and consumers in a local market.

[xxii] Ginsburg PB. Wide variation in hospital and physician payment rates evidence of provider market power. Res Briefs 2010 Nov;(16):1–11

[xxiii] Berenson RA, Ginsburg PB, Christianson JB, Yee T. The growing power of some providers to win steep payment increases from insurers suggests policy remedies may be needed. Health Affairs 2012 May;31(5):973–81

[xxiv] Richard M. Scheffler, Stephen M. Shortell, Gail R. Wilensky. Accountable Care Organizations and Antitrust Restructuring the Health Care Market. Journal of the American Medical Association 2012;307(14):1493–1494. doi:10.1001/jama.2012.451. http://eresources.library.mssm.edu:11635/article.aspx?doi=10.1001/jama.2012.451

[xxv] Berenson RA, Ginsburg PB, Kemper N. Unchecked provider clout in California foreshadows challenges to health reform. Health Affairs 2010 Apr;29(4):699–705

[xxvi] Jeff Goldsmith. Accountable Care Organizations: The Case for Flexible Partnerships Between health Plans and Providers. Health Affairs, January 2011 vol. 30 no. 1 32–40

finding the prospect of trading in their businesses for a salaried position at a hospital attractive.

The concern that ACOs and other consolidated networks could serve to increase healthcare costs have already been raised among a diverse group of observers, including employers,[xxvii] the Federal Trade Commission (FTC)[xxviii], as well as policymakers. For example, it has been suggested that the schemes may exacerbate cost shifting to commercially insured patients by ACOs looking to qualify for the Medicare cost-reduction bonuses.[xxix] This cost shifting may be enabled by the ACOs new market power. One study showed that this is what happened in California as independent practice associations flourished there.[xxx]

For their part, some hospitals and other dominant providers in local markets have long sought to concentrate their power. They have been checked in these efforts by legal uncertainty and anti-trust concerns. We need to be careful that the urge toward creation of ACOs and other entities capable of bearing risk not be used to provide a guise to enable consolidation that is fundamentally unattractive. The widespread political appeal of ACOs should not be allowed to influence how the FTC and Justice Department interpret their responsibilities in these areas.[xxxi]

Otherwise, we could end up with the worst of both outcomes: consolidated providers that reduce efficiencies and raise costs, without any offsetting benefits from the (still largely untested) ACO model.[xxxii] In part, the nod toward hospitals to be the consolidators and the entities that stand up ACOs should heighten these concerns. Hospitals are an industry with some unique attributes, but it's been said that nothing about the specifics of the health care industry suggests that the unregulated use of market power in this industry is socially beneficial.[xxxiii]

PPACA LEAVES CONSIDERABLE UNCERTAINTY AMONG PROVIDERS

Finally, the consolidation is leaving a great deal of uncertainty among providers about what is permissible and appropriate and, as a business matter, what physicians should be doing. This is distorting the kinds of business decisions that get made. Many of the mergers are being driven merely out of a desire to gain market share rather than pursue efficiencies because providers don't trust that the business arrangements will be legally or financially sustainable in the long run.

In part, this uncertainty is heightened by the fact that when it comes to concepts like ACOs, that much of these basic ideas have been tried before, without success.

Among the sweeping changes of the Balanced Budget Act (BBA) of 1997 was a provision enabling providers to contract directly with Medicare through the formation of a provider-sponsored organization (PSO). This provision was part of a package that created a new Medicare Part C, giving beneficiaries the choice to elect to receive benefits through the traditional fee-for-service Medicare or through enrollment in a "Medicare Choice" plan that took financial risk, and was eligible to offer health insurance or health benefits coverage.

A PSO was widely defined as a managed care contracting and delivery organization that accepted full risk for beneficiary lives. The PSO received a fixed monthly payment to provide care for Medicare beneficiaries. PSOs could be developed as for-profit or not-for-profit entities of which at least 51% must be owned and governed

---

[xxvii] Employers express anti-trust and cost-shifting concerns on ACOs. America's Health Insurance Plans Coverage. June 3, 2011. http://www.ahipcoverage.com/2011/06/03/employers-express-anti-trust-and-cost-shifting-concerns-on-acos. Accessed October 2012

[xxviii] Federal Trade Commission, Department of Justice. Statement of antitrust enforcement policy regarding accountable care organizations participating in the Medicare shared savings program. Federal Register 2011;76(209):67026–67032

[xxix] Remarks of J. Thomas Rosch. Accountable Care Organizations: What Exactly Are We Getting? Commissioner, Federal Trade Commission, before the ABA Section of Antitrust Law Fall Forum, Washington, DC. November 17, 2011. http://www.ftc.gov/speeches/rosch/111117fall forumspeech.pdf

[xxx] Robert A Breneson, Paul B. Ginsbur, Nicole Kemper. Unchecked provider clout in California foreshadows challenges to health reform. Health Affairs 2010;29:699

[xxxi] Federal Trade Commission, Department of Justice, Antitrust Division. Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program. Federal Register Vol. 76, No. 75. Tuesday, April 19, 2011

[xxxii] Remarks of J. Thomas Rosch. Accountable Care Organizations: What Exactly Are We Getting? Commissioner, Federal Trade Commission, before the ABA Section of Antitrust Law Fall Forum, Washington, DC. November 17, 2011. http://www.ftc.gov/speeches/rosch/111117fall forumspeech.pdf

[xxxiii] Gaynor M. Why don't courts treat hospitals like tanks for liquefied gases? Some reflections on health care antitrust enforcement. Journal of Health, Politics, Policy and the Law 2006 Jun;31(3):497–510

by health care providers (physicians, hospitals or allied health professionals).[xxxiv] As a practical matter, these PSOs were structured similarly to how the ACOs are being conceptualized. The two concepts also aimed at achieving some of the same goals in terms of giving providers an incentive to better coordinate care, and to introduce other efficiencies and controls to reduce the use of services deemed wasteful.[xxxv]

Yet the Provider Sponsored Organizations failed badly. The reasons that these entities couldn't succeed seem to mirror some potential shortcomings in the ACO model. This history only heightens the uncertainty in the provider community around not only whether the consolidated entities now being created will be legally permissible, but also whether they are sustainable and whether the government will continue to partner with these new organizations once the current fashion fades.

Most of the PSOs had inadequate resources to finance their risk and weak management. They lacked the capacity to introduce cost-saving innovations in how they coordinated and delivered care, and manage the use of services. A few of these ventures survived, evolved, and went on to have success, most failed badly.[xxxvi] Some of the successful ventures include the Geisinger Health System in Pennsylvania and Intermountain Health Care in Utah. But most of these PSO ventures failed.

The very changes to the Medicare reimbursement schedule that's driving doctors toward consolidation, only serve to underscore how uncertain the entire landscape is and, at times, how variable, if not predictable, Medicare can be when it comes to entering into business relationships with providers and provider-let entities.

As the Part B reimbursement schedule is dramatically reduced for many procedures such as cardiology and radiology, doctors and hospitals see an advantage to moving these services under the Part A billing scheme, which has remained comparatively intact. The magnitude of the cuts to certain Part B procedures is adding to provider concerns that they cannot rely on their Medicare-based revenue models.

The resulting effort to link up with hospitals, and move from the Part B to Part A billing scheme, is a temporary arbitrage, to be sure. It's another reason why the consolidation that looks attractive now to the hospitals may be unwieldy and unsustainable once the Medicare payment schedule catches up with these new realities. It's another reason why the consolidation that is taking place in the provider community may fall far short of its hoped for effects of improving efficiencies, driving greater coordination of care, and ultimately lowering costs. And it's another reason why there is so much uncertainty about the long-term structures.

For their part, the hospitals are experiencing economic loses as they acquire medical practices—another reason providers are engaging in these relationships on shaky ground. The losses stem in part because reimbursement levels don't leave much room for operating profits. It is also a function of the fact that the hospitals have been focused on acquiring specialty practices like cardiology and surgical specialties, which require the payment of larger, longer-term employment contracts. The losses that hospitals experience in acquiring practices are likely to exceed the potential gain sharing that they stand to earn under PPACA for operating under new shared savings arrangements created by PPACA.[xxxvii] This, of course, begs the question as to whether hospitals will merely shift the costs onto payors once they gain sufficient local market concentration. There is ample evidence, from past experience, to demonstrate this can be precisely what happens.[xxxviii,xxxix,xl]

Finally, providers also need to face the prospect that whatever relationships they enter into now may be hard to unwind should the legal or reimbursement environment change with respect to concepts like ACOs and the consolidation taking place today around hospitals. In the late 1990s, when physicians sold their practices to practice management companies (such as Medpartners and PhyCor) many of these companies eventually failed. Once these outfits folded, doctors were able to unwind

---

[xxxiv] Stephen C. Gleason, Jacque J. Sokolov, and Christine Henshaw. Provider Sponsored Organizations: A Golden Opportunity in Medicare Managed Care Physicians and other providers will soon have a chance to bypass the middleman and compete in managed Medicare. Family Practice Management 1998 Mar;5(3):34–45

[xxxv] Judith R. Peres. PSOs offering new partnership potential; provider service organizations: a possible gateway to 21st-century long-term care—Forecast '98. February 1998

[xxxvi] Jeff Goldsmith. Accountable Care Organizations: The Case for Flexible Partnerships Between health Plans and Providers. Health Affairs, January 2011 vol. 30 no. 1 32–40

[xxxvii] Jeff Goldsmith. Accountable Care Organizations: The Case for Flexible Partnerships Between health Plans and Providers. Health Affairs, January 2011 vol. 30 no. 1 32–40

[xxxviii] Vogt WB, Town R. How has hospital consolidation affected the price and quality of hospital services. Princeton (NJ): Robert Wood Johnson Foundation; 2006. Research Synthesis Report No. 9

[xxxix] Berenson RA, Ginsburg PB, Kemper N. Unchecked provider clout in California foreshadows challenges to health reform. Health Affairs. 2010;29(4):699–705

[xl] Anne Mutti and Jeff Stensland. Provider consolidation and prices. Presentation before the Medicare Payment Advisory Committee. October 9, 2009

the relationships that they had with these firms and go back to the individual practices. Today's current round of consolidation may not end as well.

Hospitals will realize that these relationships are not financially sustainable owing to declining hospital reimbursement, an inevitable equalization between the Part A and Part B payment schemes, and the high cost of owning and managing physicians. Physicians will have a hard time going back to their old arrangements. In many cases, they simply won't have the capital to regain their prior medical practices.

A 2011 survey by the American Medical Group Association, looking at the operating margins of large, often multi-specialty medical groups, would suggest that running a large group of physicians (whether they are employed by an independent multi-specialty group or a hospital) isn't profitable in today's payment environment. This financial analysis only serves to underscore these points, and the reason to be uncertain about the new arrangements that are taking shape in today's market.

The cost of practicing medicine continues to rise while reimbursement rates remain largely flat, or decline slightly over time. As a result, the survey of operating margins of large medical groups shows that most groups are operating at a loss. The northeast has some of the worst performing groups. According to the survey, groups in this region are operating at an average loss of around $10,000 per physician.[xli]

There is a possibility that, through pursuit of policy constructs that aim to consolidate providers into larger networks, we end up with the worst of both worlds: A Medicare policy failure that drives private-sector costs higher.[xlii]

DOES CONSOLIDATION LEAVE A ROLE FOR ENTREPRENEURSHIP?

In the end, PPACA's most significant challenge to organizational change in how providers are structured and services delivered is the legislation's relationship to innovation and entrepreneurship in this space. In my opinion, the modest rewards offered to accountable care organizations, through gain sharing, may not be enough to incentivize these groups to make meaningful investments in costly new systems and infrastructure that lead to genuine improvements in the coordination of care.

As a result, the entities taking advantage of the opportunity set may be those who have other motives. They will be the existing market participants who stand to gain through the ability to consolidate providers and gain local market power.

Historically, innovations in the delivery of healthcare—from the advent of the first HMO to creation of long term care hospitals and home infusion (to name just several)—arose as the result of start-up outfits, often backed by venture capital, and headed by entrepreneurs who were in search of above market returns on invested capital. Under the existing rules, this often meant that new arrangements sought to earn profits by moving patients from higher cost settings of care to lower cost settings and capturing some of the money they saved the system in that process.[xliii]

But PPACA contains deliberate provisions aimed at regulating returns on invested capital; discouraging different forms of entrepreneurship. These provisions are, in many cases, the expression of a political philosophy that guides a number of provisions in PPACA. That philosophy views profits earned on the provision of care as money that should have been channeled instead into direct patient care.

The result is that entrepreneurs are not pursuing new health services ventures. Capital flowing to these endeavors has fallen sharply. The lack of incentive for entrepreneurs further entrenches existing players, meaning that tools that could help better coordinate care (for example, healthcare information technology) is only adopted through outright subsidies to existing providers, rather than through the creation of new approaches to replace an existing way of delivering care.

I work with investors who support entrepreneurs creating some of these new ideas. I have also served as a consultant to, and board member, of firms working on entrepreneurial healthcare services start-ups. I worry that PPACA advances a number of provisions that tilt too much against these entrepreneurs. The combined effect of these policies will serve to potentially freeze out disruptive new models.

There are other legacy practices that create impediments to innovation, entrepreneurship, and genuine change in the delivery of healthcare services. For example, existing laws restrict innovative ways to provide primary care (PPACA merely restricts how we pay for it). We could develop entities that make better use of skilled

---

[xli] American Medical Group Association. 2011 Medical Group Compensation and Financial Survey Finds Continued Financial Losses in Most Regions, Average Increase in Physician Compensation at 2.4%. August 16, 2011

[xlii] Jeff Goldsmith. Accountable Care Organizations: The Case for Flexible Partnerships Between health Plans and Providers. Health Affairs, January 2011 vol. 30 no. 1 32–40

[xliii] Chris van Gorder and Eric Topol. Embracing the Future. Modern healthcare, May 14, 2012. 24

nurses and other non-physicians providers to reach into homes, workplaces and communities to provide early care more efficiently and cheaply.

This would cause "prevention" to rise rather than having PPACA make "prevention" free without addressing the fact that people often don't see doctors because it's inconvenient. Such efforts would require changes in laws that empower certain providers over others and create barriers to more flexible approaches to delivering care. In the past, physicians have been resistant to extending more responsibility to non-physician providers. I expect this resistance to diminish as the incentives change under new payment schemes. Under capitated schemes, there's more incentive to move patients from costly hospitals and offices and (where appropriate) into lower costs settings and providers. Under these arrangements, doctors may be keener to share increasing responsibilities with other providers.

CONCLUSION

In a well functioning market that creates proper incentives for innovation in delivery of healthcare, consumers would have a closer relationship to the insurance product that they carry and their purchase of routine healthcare. In a well functioning market, the insurance product would be portable across employers and states, and would enable multi-year contracts, guaranteed-renewable products, and other elements similar to the way consumers buy life insurance today.

Such a market would provide cash vouchers to individuals priced out of the system because of their economic or medical circumstances. Under the current scheme, where health insurance products are tightly regulated, where government agencies and not consumers choose what is covered, and where profits are punished, it leaves little room for entrepreneurship in how healthcare services are delivered.

Yet the only way we're going to bend the healthcare cost curve is by introducing genuine innovations in how we provide medical care—new approaches that lower costs while providing more healthcare for each dollar that we spend. These innovations won't arise as a result of the critical mass created through carefully orchestrated mergers. These ideas won't be incubated inside CMS.

Nor are these concepts likely to arise from new twists on old concepts like capitation and PSOs. Instead, genuine innovation in the delivery of healthcare is going to come about the way it always has—from entrepreneurs who raise capital in search of profitable new ways to re-engineer old systems, appealing to consumers by bringing them a better service at a more affordable price. PPACA tries to engineer its own new constructs, while pursuing provisions that could crowd out entrepreneurs from developing their own ideas. We could end up with neither.

Mr. GOODLATTE. I would like to thank our witnesses again. Apologize again for the brevity of this hearing, but we will enlarge it in writing and we will submit lots of questions to you.

Without objection, all Members will have 5 legislative days to submit to the Chair additional written questions for the witnesses, which we will forward and ask the witnesses to respond as promptly as they can so that their answers may be made a part of the record.

Without objection, all Members will have 5 legislative days to submit any additional materials for inclusion in the record.

And, with that, I again thank the witnesses, and this hearing is adjourned.

[Whereupon, at 11:55 a.m., the Subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Prepared Statement of the Honorable Bob Goodlatte, a Representative in Congress from the State of Virginia, and Chairman, Subcommittee on Intellectual Property, Competition, and the Internet

Good morning, and welcome to this hearing of the Subcommittee on Intellectual Property, Competition and the Internet.

Today's hearing does not examine the competitive effects of a specific merger or business practice. Instead, it examines the general competitive state of the health care industry, and specifically the competitive effects of a law, the Patient Protection and Affordable Care Act, commonly known as the ACA or Obamacare.

The centralized, regulatory approach that the ACA takes to the health care market creates deep tension with the free market, competition based approach embodied in the antitrust laws. Indeed, I believe that the ACA has and will continue to substantially lessen competition to the detriment of health care consumers.

Instead of encouraging businesses to offer innovative and competing products and allowing consumers to steer the market, the ACA imposes a top-down, one size fits all model throughout the health care industry.

The ACA prevents health care competitors and consumers from entering certain transactions that they should be allowed to enter in a competitive market. It also forces them to enter transactions they may not have entered in a free market.

Instead of the choices that a competitive market offers consumers, the ACA offers mandates.

Troubling symptoms are already emerging of the ACA's anticompetitive effects.

Mergers among health care providers have increased by 50 percent since passage of the ACA. Small medical practices and clinics have been forced to consolidate because they have been unable to remain independent while weathering the regulatory costs and burdens of the ACA.

Specific provisions in the ACA encourage consolidation and collaboration among larger competing health care providers.

We know that many health care mergers and integrations are likely pro-competitive—each transaction must be judged on its own merits.

Integrated health care delivery models can be efficient and can realize cost savings. Independent health care delivery models can also offer great treatment advantages. What we should avoid is government policies that distort competition in the market and artificially eliminate competition.

A freer market will invariably choose between models more efficiently than the federal government can. Market driven consolidation benefits patients more than regulation driven consolidation.

The consternation that the law has caused to both health care providers and the federal antitrust enforcement agencies about how to treat the ACA's new Accountable Care Organizations highlights the tensions between the ACA's purposes and the antitrust laws.

Another symptom of the ACA's anticompetitive effects can be seen in the consolidating and increasingly undifferentiated insurance markets. This is a result of the ACA's mandates about what health plans must cover and how they may spend their

revenues. We are already seeing the emergence of a new order in which a shrinking number of health insurers offer a highly standardized product at increasing prices.

That the ACA would force all Americans to buy this product highlights how far from a competitive free market the Act would take us.

Antitrust economics are clear. If we raise barriers to entry, preclude product differentiation, dictate how competitors spend their revenue, mandate an increase in demand, and consolidate the market, we are likely to see anticompetitive results.

The health care market has not been a perfectly competitive market even before the ACA. But instead of increasing competition, the ACA injects more artificial, government-imposed incentives into this market which lead us further away from competition and toward higher costs, lower quality care, and less innovation.

Prepared Statement of the Honorable John Conyers, Jr., a Representative in Congress from the State of Michigan, and Ranking Member, Committee on the Judiciary, and Member, Subcommittee on Intellectual Property, Competition, and the Internet

Thank you, Chairman Goodlatte, for holding this hearing on health care consolidation. It might surprise the Chairman to hear that I agree with him: Obamacare raises serious questions about competition in the healthcare industry. But not because the law promotes consolidation.

The real question is whether Obamacare can be implemented in a way that will halt consolidation and anti-competitive practices that have plagued the healthcare industry for more than 30 years.

Because the Administration and the States are still in the development phases and the major pieces of the law don't come into effect until 2014, we have the opportunity now to influence how Obamacare can be used to increase competition, quality, and access to care.

To begin with, the forces promoting hospital consolidation, allowing for insurance price distortion, and raising the overall cost of healthcare costs were in place long before President Obama signed the Affordable Care Act into law.

Some on the other side have suggested that Obamacare has caused healthcare consolidation. Besides the fact that the major provisions of the law affecting competition, the insurance exchanges and accountable care organizations, will not come into effect until 2014, this conjecture categorically ignores more than thirty years of recent history.

Hospital mergers have been on the rise for more than 20 years, and, unfortunately, the version of Healthcare Reform that became law lacked the protections that House Democrats pushed to prevent the anti-competitive consolidation we are discussing today.

Increased market concentration, deregulation, blanket antitrust exemptions, and scant antitrust enforcement against healthcare insurance companies have prevented meaningful competition from taking place across the industry for decades.

Our privatized healthcare system, by its nature, creates an innate tension between increasing profits for shareholders on the one hand and increasing healthcare access and quality on the other.

This is precisely why our country needs a single-payer system, the implementation of Obamacare presents our country with a unique opportunity to turn the tide.

We will hear from the detractors of healthcare reform that Medical Loss Ratios (MLRs) and the standards governing Accountable Care Organizations (ACOs) are promoting consolidation. But the fact is that the Department of Health and Human Services and Center for Medicare and Medicaid Studies are only in the nascent stages of implementing the Affordable Care Act. No general conclusions can be drawn because most of the regulations are still at the drawing board.

Second, the Justice Department, the Federal Trade Commission, and state Attorneys General from across the country have made attempts to challenge hospital and insurance consolidation with very limited success for decades.

Overly broad antitrust exemptions, namely the McCarran-Ferguson Act of 1945, and an anti-competition judicial bench have allowed healthcare corporations to run roughshod over consumers and care-givers.

Most of the country's health insurance markets are disproportionately dominated by only a handful of powerful players. The Justice Department, for example, has finally taken action against Blue Cross Blue Shield of Michigan because of its dominance and conduct in the state.

Recent cases at the Justice Department and FTC are promising—including suits to block hospital mergers in Illinois, Virginia, and Georgia by the FTC and cases against insurers and actions by the DOJ against insurers in Michigan, Montana, and other states. Our federal antitrust enforcement has been on the whole, however, insufficient. Most markets are dominated by one or two plans, and the exchanges therefore offer an opportunity to encourage insurance companies to enter markets.

The barriers to entry to starting new insurance companies or entering new markets are extremely high, and these market concentrations have pushed hospitals to claim the need to merge in order to effectively negotiate with the major insurance plans.

Our regulating and enforcement agencies must prevent incumbent, dominant insurers from hampering competition through exclusionary or collusive conduct as the exchanges and Accountable Care Organizations ramp up.

Third, major opportunities lie with how plans within the state exchanges will compete with existing insurers, and whether the exchanges will allow for new and innovative players to enter the market. I am weary of the early murmurs that regulators might give rubber stamps to existing, dominant players to exert undue influence in the new markets.

Simply allowing the entrenched players to continue business as usual under the guise of participating in the exchanges will not be acceptable.

The exchanges must promote transparent plans, subject to public scrutiny, that focus on the health outcomes of patients instead of stock dividends and executive windfalls. Moreover, we need vigorous use of the prosecutorial powers by our federal antitrust enforcement authorities, the Justice Department and FTC.

It is for all of these reasons that I re-introduced a McCarran-Ferguson reform measure this morning that will roll-back the antitrust exemptions for health insurers and medical malpractice insurers.

As all of us on the dias are concerned about competition in health care, and because a similar version of this legislation passed during the last Congress with more than 400 votes, I would welcome the Majority's assistance in bringing this measure to the Floor again.

The time is ripe to finally change this marketplace with pro-competition and pro-consumer actions by the federal health and antitrust agencies.

Prepared Statement of the Honorable Howard Coble, a Representative in Congress from the State of North Carolina, and Member, Subcommittee on Intellectual Property, Competition, and the Internet

We have the greatest healthcare delivery system in the world but I also think that it is facing some very difficult challenges.

In particular, how will the Patient Protection and Affordable Care Act (PPCA) effect availability and quality, both of which are very complicated concepts.

In our district, consolidation has not driven costs—in fact it has helped hold costs down and keep remote points or service up and running for many of our rural constituents.

Mergers and acquisitions have been their life-ring and I am deeply concerned that if the PPCA results in limited options for providers to merge or pool resources, health care costs will increase and points of service will start to disappear.

Material submitted by the Honorable Melvin L. Watt, a Representative in Congress from the State of North Carolina, and Ranking Member, Subcommittee on Intellectual Property, Competition, and the Internet

2011 NCHA State of the State Report

January 2012

Report prepared by:

Sarah J. Broome, PhD.

Director of Economic Research

North Carolina Hospital Association

Table of Contents

Executive Summary 1
Introduction 2
The Current Economic Environment: GDP and Unemployment 3
Factors Affecting North Carolina's Total Hospital Cost Trends 7
The Financial Impact of the Economy on the Average NC Hospital 10
Drivers of Hospital Expense and Revenue Trends 16
Volume Trends by Financial Classification 23
Medicare and Medicaid Reimbursement Trends 33
Charity Care and Bad Debt Cost Trends 35
Looking Forward 37
Appendix A: Annual Inflation Rates Indexed to 2006 41
Appendix B: Demographics of Hospitals by Location and Size 42
Appendix C: Supplemental Figures by Hospital Location and Size 43
Appendix D: Measure Definitions 60

List of Figures

Figure 1: Quarterly Growth Rates in US Real Gross Domestic Product, January 2005–September 2011. 3
Figure 2: Trends in US Real GDP (in $ billions), January 2006–September 2011. 4
Figure 3: NC per Capita Real GDP, 2005-2010. 4
Figure 4: United States and North Carolina Unemployment Rates, October 2008–December 2011. 5
Figure 5: Total Employed on North Carolina Payrolls, 1990-2011. 6
Figure 6: North Carolina Hospital Employment Trends, 1990-2011. 6
Figure 7: Total NC Cost Trends, 2006-2010. 7
Figure 8: Factors Responsible for Cost Increases from 2006 to 2010. 8
Figure 9: Trends in Average Margins, January 2007-June 2011. 10
Figure 10: Operating Margin Distribution of Hospitals, January 2007-June 2011. 10
Figure 11: Margin Trends for Urban and Rural Hospitals, January 2007-June 2011. 11
Figure 12: Margin Trends for Large, Small and Critical Access Hospitals, January 2007-June 2011. 12
Figure 13: Average Financial Trends, 2006-2010. 13
Figure 14: New Capital to Depreciation Ratio and Non-Operating Revenue Trends, 2006-2010. 14
Figure 15: Total Hospital Capital Expenses, 2006-2010. 15
Figure 16: Average Operating Revenues & Expenses, relative to FY06 Expenses, 2006-2010. 16
Figure 17: Net Patient Revenue Trends by Payor, 2006-2010. 17
Figure 18: Average Expense Trends, by Expense Type, 2006-2010. 18
Figure 19: Average Expenses and Patient Revenues, per Inpatient Day, 2006-2010. 20
Figure 20: Average Expenses and Patient Revenues, per Adjusted Day, 2006-2010. 20
Figure 21: Average Case Mix Index, by Payor, 2006-2010. 21
Figure 22: Average Expenses and Patient Revenues, per CMI adjusted-day, 2006-2010. 22
Figure 23: Trends in NC Medicaid Eligibles, 2006-2011. 23
Figure 24: Trends in Average Days by Bed Type, 2006-2010. 24
Figure 25: Trends in Discharges by Payor Type, 2006-2010. 26
Figure 26: Trends in Days by Payor Type, 2006-2010. 27
Figure 27: Trends in Inpatient Surgery Volume, by Payor Type, 2006-2010. 28
Figure 28: Trends in Outpatient Surgery Volume, by Payor Type, 2006-2010. 29
Figure 29: Trends in Emergency Dept. Visits, by Payor Type, 2006-2010. 30
Figure 30: Trends in Outpatient Visits, by Payor Type, 2006-2010. 31
Figure 31: Average Hospital's Percent of Medicare Costs Paid, 2006-2010. 33
Figure 32: Average Hospital's Percent of Medicaid Costs Paid, 2006-2010. 33
Figure 33: Trends in Total Uncompensated Care, April 2008-June 2011. 35
Figure 34: Trends in Total Hospital Uncompensated Care, by Payor Type, 2008-2010. 36
Figure 35: Medicare Losses, Medicaid Losses, Charity Care and Bad Debt Costs, 2006-2010. 37
Figure 36: Trends in Commercial versus Medicare, Medicaid and Uninsured Volume, 2006-2010. 38
Figure 37: Impact of Medicare, Medicaid and Uninsured on Operating Margins, 2006-2010. 38
Figure 38: Pressure of Medicare, Medicaid and Uninsured on Commercial Rates, 2006-2010. 39
Figure 39: Inflation, Indexed to 2006. 41

Executive Summary

The economic health of the US is improving: US Gross Domestic Product is growing, although more slowly than preferred. The national unemployment rate is moving downward, again more slowly than preferred. Inflation remains in check. For North Carolina, per capita real GDP grew 2.2% in 2010. The unemployment rate started downward in 2010; but in mid-2011 it rebounded up for four months, before once again starting downward. North Carolina hospitals, however, continue to increase staff. This increase in staff corresponds with increased demand. Increases in demands lead to increases in costs. Total NC costs of hospital care have increased each year since 2006. The growth rate of costs is slower after controlling for population growth and nearly eliminated when adding controls for population aging and the worsening NC health environment. Costs are nearly unchanged since 2006.

Hospital finances for 2010 are as disappointing as they were at the official end of the Great Recession in June 2009. While annual costs and revenues in hospitals appear to be increasing steadily since 2006, adjusting these measures for inflation, volume and case mix shows that both revenues and expenses are ***below*** 2006 levels. Urban and large hospitals are driving an overall total increase in patient volumes, while in the average NC hospital volume has declined. Rural and small hospitals are seeing continued volume declines, except in emergency departments. Commercial volume continues to decline across all sizes of hospitals, locations of hospitals and types of services.

Increasing Medicare, Medicaid and uninsured volumes are associated with hospital financial losses. Progressively more unsustainable pressure is being placed on commercial rates as these losses grow and as the volume of commercial patients shrinks. For an average NC hospital to be financially healthy in 2010, commercial payors would need to reimburse hospitals 67% above hospital costs. Because commercial payors are unwilling to pay this rate, hospital finances have suffered.

Hospitals continue to delay important upgrades to physical plant and equipment, and are implementing other cost-containment measures to remain afloat. These delays are not sustainable. Hospitals are now poised to close some unprofitable but needed service lines while waiting for national efforts to cover the uninsured and state-level efforts to mitigate Medicaid losses with a provider assessment plan.

Covering the uninsured and finding additional funds to offset Medicaid losses would help hospital finances and in turn alleviate the pressure on commercial rates. In addition, economic recovery and corresponding job growth promise to increase commercial insurance coverage. In the meantime, hospitals will continue to focus on reducing costs of care and may need to terminate needed but under-reimbursed community services. Policymakers and public health administrators should seek care delivery reform that re-routes Medicaid and uninsured urgent care needs into care settings other than the ED, so that patients can get better care while hospitals can save costs and reduce their pressure on the commercial payors.

Introduction

This report highlights the recent financial and volume trends in the *Advocacy Needs Data Initiative* (ANDI) database, NCHA's source for timely financial, community benefits and workforce hospital data. Limited quarterly financial data is presented, but to remove possible seasonal affects, this report focuses on annual data through 2010. While ANDI has much more data than is presented here, these are the recent important trends related to finance and volume. A separate report focusing on hospital workforce trends is planned for release later this year. The analysis below is divided into the following topics:

- The current economic environment: GDP and unemployment
- Factors affecting North Carolina's total hospital cost trends
- The financial impact of the economy on an average NC hospital
- Drivers of hospital expense and revenue trends
- Volume trends by financial classification
- Medicare and Medicaid reimbursement trends
- Charity care and bad debt costs trends
- Looking forward

In addition, the following appendices supplement the material in this report:

- Appendix A: Annual inflation rates, indexed to 2006
- Appendix B: Demographics of hospitals by location and size
- Appendix C: Supplemental figures by hospital location and size
- Appendix D: Measure definitions

This report, the figures and hospital companion reports are available online for each hospital via the ANDI portal. For questions regarding NCHA's ANDI or this report please contact the NCHA ANDI team (andi@ncha.org, 919-677-2400).

The Current Economic Environment: GDP and Unemployment

Officially the Great Recession has been over since mid-2009, though few would say we have recovered from its impact. While the national economy is growing, gross domestic product adjusted for inflation has revealed small and slow recovery during the last year. The following figure documents the quarterly growth rates in seasonally adjusted US real GDP. The area shaded in gray indicates the period when the National Bureau of Economic Research considered the US in the Great Recession.

Quarterly Growth in US Gross Domestic Production

Adjusted for Inflation

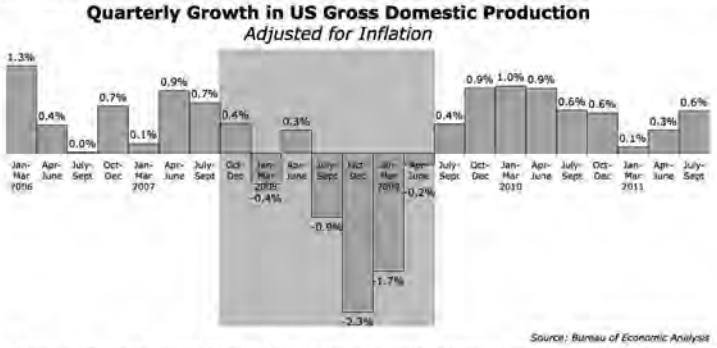


Figure 1: Quarterly Growth Rates in US Real Gross Domestic Product, January 2005–September 2011.

Quarterly growth rates make it difficult to determine if and when the US economy returned to pre-recession output levels.[1] The following figure documents the trends in real GDP levels (seasonally adjusted and reported in "2005 dollars").

[1] We cannot sum the rates to determine when output levels are where they were pre-recession. For example, a 50% decrease in one quarter (from $10,000 to $5,000) followed by a 50% increase ($5,000 to $7,500) does not translate to a return to GDP of $10,000.

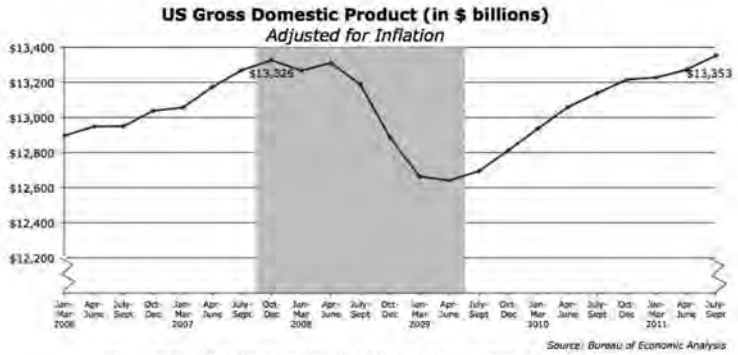


Figure 2: Trends in US Real GDP (in $ billions), January 2006–September 2011.

The nation reached pre-recession production levels in the second quarter of 2011. State-level GDP is available for North Carolina through 2010 from the Bureau of Economic Analysis. Because population affects GDP and NC population continues to grow rapidly, total NC GDP cannot signal when the state has recovered from the recession. Instead trends in per capita GDP, adjusted for inflation, give the clearest evaluation of the level of recovery by NC. The following figure shows annual per capita NC GDP since 2005, adjusted for inflation to 2005 dollars. It also reports this GDP measure as a percent of the 2006 amount to gauge the extent of the state's economic recovery.

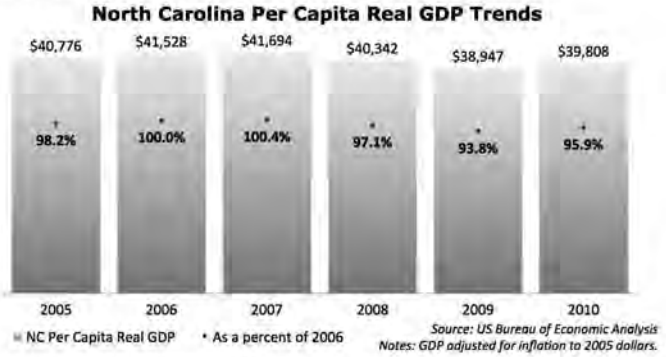


Figure 3: NC per Capita Real GDP, 2005-2010.

The 2010 per-capita North Carolina real GDP figures show that North Carolina's economy grew 2.2% in 2010. The level is only 95.9% percent of 2006 per capita GDP. The state has not yet reached pre-recession 2006 output levels. With an optimistic growth rate of 3%, the state will remain behind 2006 levels until 2012.

Output, or GDP, is only one measure of economic recovery. Unemployment is an important economic measure often paired with GDP. Unemployment rates soared during the Great Recession and remain high. The following figure charts the monthly unemployment rates for the US and NC since October 2007. The national rate continues to generally decrease since its October 2009 high of 10%. The North Carolina rate, however, lags behind the national rate in peak and recovery. NC reached its high of 11.4% unemployment in January of 2010 and, after 15 months of decline, reversed course, increasing to 10.5% by September 2011. October saw a second reversal and it is now returning to a trend of declining rates. While national rates are near 8% now, North Carolina's rate remains stubbornly above national levels near 10%. Both US and NC rates are much higher than the pre-recession rates of 4.6%.

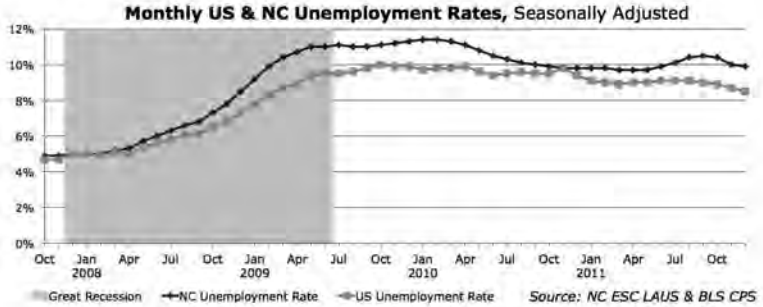


Figure 4: United States and North Carolina Unemployment Rates, October 2008–December 2011.[2]

Unemployment rates can be misleading when they fail to capture those who have left the labor force entirely (early retirements and "discouraged workers" who stopped looking for a job). Examination of the employed supplements the story of unemployment. The figure below shows the millions of employees on North Carolinian payrolls each quarter since 1990. Currently, North Carolina employers have 3.8 million people on their payrolls, versus the highest number in December 2007 when 4.1 million people were employed. The number of employed North Carolinians remains low and has not yet started a recovery trend.

[2] NC ESC is the North Carolina Employment Security Commission (www.ncesc.com), which recently changed its name to North Carolina Department of Commerce Division of Employment Security. Its LAUS is the Local Area Unemployment Statistics program. BLS is the US Bureau of Labor Statistics (www.bls.gov). It publishes unemployment estimates based on its Current Population Survey (CPS).

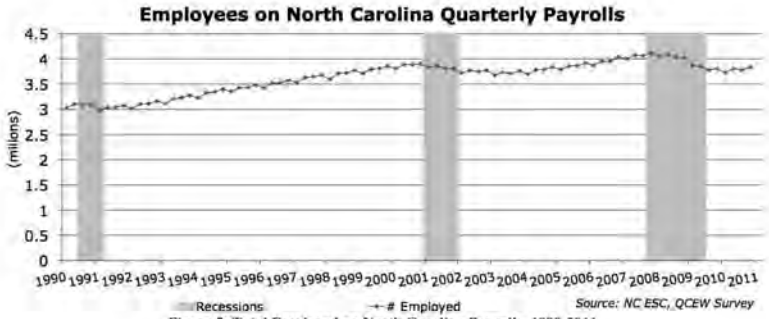


Figure 5: Total Employed on North Carolina Payrolls, 1990-2011.

Hospitals in North Carolina, on the other hand, managed to hold on to nearly all their employees during the Great Recession, and some hired more workers. As of the beginning of 2011, North Carolina hospitals employed over 192,000 individuals: the highest level on record. On a per capita basis, the number of North Carolina residents per hospital employee is the same as pre-recession: 50. Even in tough economic times, people continue to get sick and seek care.

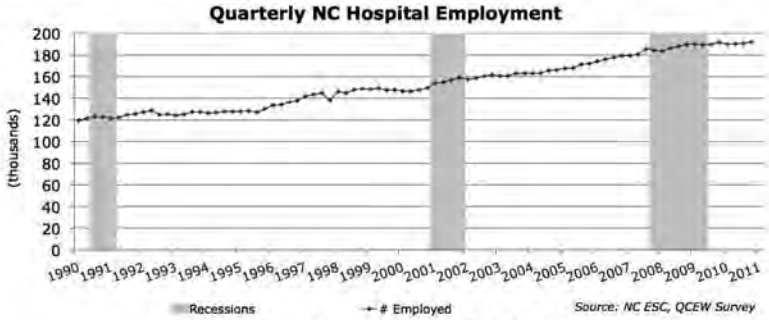


Figure 6: North Carolina Hospital Employment Trends, 1990-2011.

Factors Affecting North Carolina's Total Hospital Cost Trends

The state's total hospital costs increased from $15.3 billion in 2006 to $19.4 billion in 2010. The following figure documents the upward trend in North Carolina's estimated statewide hospital costs since 2006. There are many factors that contributed to the increase including those outside hospital control: inflation, NC population growth, aging of the population and less healthy living conditions. Between 2006 and 2010, the US has seen general inflation of 8.2%, or about 2% per year.[3] Adjusting for inflation, the $19.4 billion in 2010 hospital costs is reduced to $17.9 billion in 2006 dollars; a 17% increase over the five years. North Carolina's resident population has increased from 8.9 million in 2006 to 9.6 million in 2010. More residents increases the demand for hospital services. To control for the impact of an increasing population, the following figure also shows NC hospital costs per capita. Per capita costs rose to $1,872 in 2010[4] from $1,728 in 2006 (8.3%).

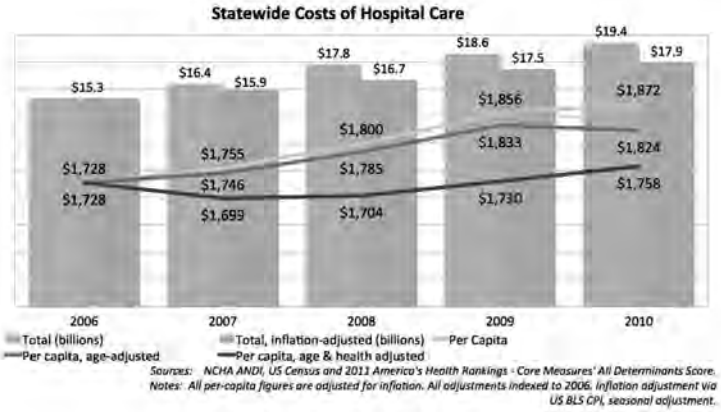


Figure 7: Total NC Cost Trends, 2006-2010.

In addition to the increase in the number of residents, the population in North Carolina is aging. Healthcare needs increase with age. Between 2006 and 2010, the median resident age changed to 37.4 years from 36.4 years. Adjusting for aging reduces the per capita cost figure in 2010 to $1,824. Lastly, the health-related living conditions of NC declined: air pollution increased, more children lived in poverty and the numbers of uninsured rose (typically the uninsured delay maintenance of chronic care conditions until the conditions lead to acute episodes)[5,6,7]. Obesity rates also increased, leading to an

[3] Appendix A lists the inflation factor for each time period since 2006.
[4] This amount has been adjusted for inflation and is in 2006 dollars.
[5] Ferris, Timothy G, et al. *Insurance and Quality of Care for Adults with Acute Asthma*. **Journal of General Internal Medicine**, 2002 December; 17(12): 905–913.
[6] *The High Costs of Cutting Mental Health*. **National Alliance on Mental Illness,** 2010, www.namiwisconsin.org/documents/HealthcareandMI.pdf.

increase in the proportion of residents that need hospital services. *America's Health Rankings* provides a yearly state-level index on a composite of 14 health determinant measures. The composite determinant core measure index for North Carolina worsened by 4% during the 2006-2010 period. Adjusting cost per capita for this decline further reduces the cost from $1,824 to $1,758.[7] If the number of residents, age of residents and health-related living conditions in NC were the same in 2010 as in 2006 and there had been no inflation, the total cost of hospital care provided at NC hospitals is predicted to have increased by only an average of $65 million a year, or 0.4% annually. The estimate is sensitive to the state's index of health-related living conditions and an alternate measure could produce estimates of declining costs.

The following figure shows the breakdown of each of these factors on the total increase in costs across the five-year period. Total costs increased 26.5% from 2006 to 2010, but 9.6 of the 26.5 is due to inflation. The increase in the number of residents was responsible for 8.5 percentage points of the cost increase. Aging and worsening health conditions were responsible for 6.7 percentage points, leaving only 1.7% of 2006 costs unexplained. Costs are nearly unchanged since 2006.

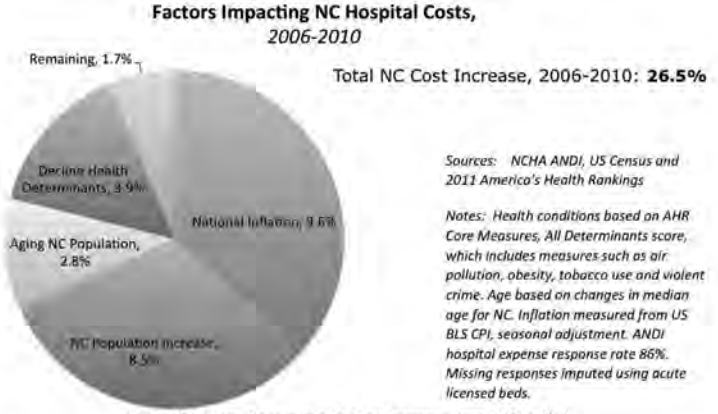


Figure 8: Factors Responsible for Cost Increases from 2006 to 2010.

The 1.7% residual growth in hospital costs reflects the physician visits that hospitals now provide. Since the beginning of the Great Recession, there has been a rapid decline of independent physician practices in communities.[8,9] Physicians have grown weary of increased regulations, lower reimbursements and less reliable revenue streams at a time when national healthcare policy is pushing collaboration and integration. As a result, many hospital financial statements and volume reports now include physician visits. The level of integration has not been estimated because some hospitals have moved their

[7] Kempe, Allison, et al. *Quality of Care and Use of the Medical Home in a State-Funded Capitated Primary Care Plan For Low-Income Children*. **Pediatrics**. Vol. 105 No. 5 May 1, 2000, 1020 -1028.
[8] *Physician Employment At Hospitals Jumps 34% In A Decade*, The Advisory Board Company, January 26, 2012 (http://www.advisory.com/Daily-Briefing/2012/01/26/Physician-employment).
[9] Broome, Sarah. *2010 NCHA State of the State Report*, North Carolina Hospital Association, November 8, 2010.

physician practices outside the hospitals' finances to separate but related corporate entities, while other hospitals have absorbed physician practices directly into their operations. In the ANDI data, the category of outpatient visits that includes physician services is the measure that captures all other outpatient visits that are neither observation, surgical, emergency department or home health. This category has increased 20% during the last five years, and, of the two-thirds of hospitals reporting workforce data, physician employment head count has increased 50% during the same time period. Both of these account for some, if not all, of the 1.7% of unexplained cost increases. Hospital costs in the state may not have increased at all over the past five years.

Total hospital costs in North Carolina provide an aggregate picture of the state as a whole, but do not show the story of smaller hospitals. Forty percent of hospitals account for only 10% of total hospital costs. Dramatic changes in small hospitals will not be large enough to observe in the overall aggregate trends. North Carolina hospital averages, however, can provide equal weight to the story of small and large NC hospitals. The average NC hospital trends are reported in the remaining sections.

The Financial Impact of the Economy on the Average NC Hospital

The following figure shows average hospital margins by quarter. It documents that margins, which plummeted during the recession, have rebounded but not to pre-recession levels. The seasonal impact on hospital volume (more flu cases in January, for example) shows that margins generally climb in the first half of each year, and then decline. Despite this quarterly "noise," the average hospital patient margin remains below zero, signaling that hospitals cannot cover costs with patient revenues alone. Operating revenue includes revenues from non-patient care services such as the cafeteria and gift shop. It adds about two percentage points to patient margin and hovers below pre-recession levels. Total margin includes returns from financial investments. The instability of the stock market leads to total margin fluctuations that inhibit a hospital's ability to plan for large expenditures such as major capital projects.

Figure 9: Trends in Average Margins, January 2007-June 2011.

Trends in averages sometimes reflect trends across all hospitals, but sometimes reflect instead a dramatic change in a sub-population of hospitals. The distribution of operating margins in the following figure shows that a third have negative margins, which is similar to pre-recession amounts.

Figure 10: Operating Margin Distribution of Hospitals, January 2007-June 2011.

Nearly a third now barely break even and more than a third have operating margins above 5%. This is an improvement over the April-June 2007 and 2008 quarters, worse than the April-June 2009 quarter and about the same as one year ago. The effect of the economic times has not been even across all hospitals.

In general, hospitals in urban areas faired better than those in rural areas. For example, the average operating margin in the April-June 2011 quarter for rural hospitals was 1.8%, compared with 3.6% for urban hospitals. Since most urban hospitals are able to cover costs of care with patient revenues, patient margins are at or just above zero. Patient revenues of rural hospitals are not enough to cover patient care costs and these hospitals sustain negative patient margins. Rural hospitals made up this difference by increasing other operating revenues and returns on their investments.

Figure 11: Margin Trends for Urban and Rural Hospitals, January 2007-June 2011.

The differences between large and small hospital margins are more pronounced than between urban and rural hospitals. The following figures show average margins for large (120+ staffed beds), small (less than 120 staffed beds and no critical access status) and critical access hospitals (CAHs). The CAH financial structure is different than other hospitals', as they are reimbursed by Medicare and Medicaid differently. The average operating margin for the most recent quarter for these three hospital groups are 4.7% for the largest hospitals, 3.6% for the smaller hospitals and -3.6% for CAHs.

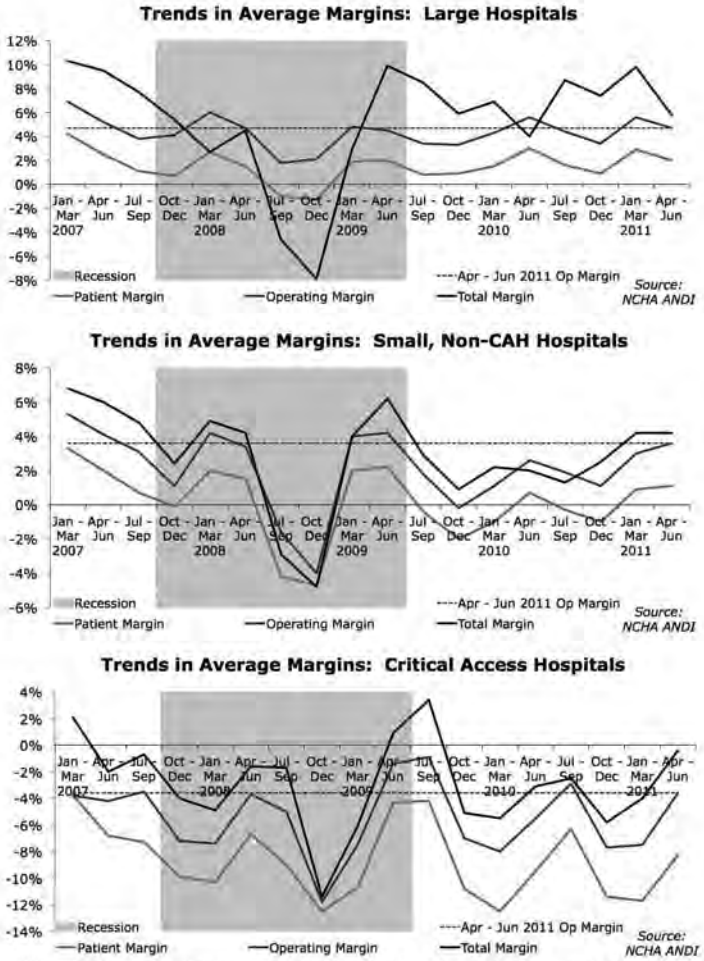


Figure 12: Margin Trends for Large, Small and Critical Access Hospitals, January 2007-June 2011.

Larger hospitals fare better financially than smaller hospitals, which fare better than CAHs. Large hospitals are better able to cover patient care costs with patient revenues. Small hospitals hover close to

breakeven. The average CAH has not been able to cover its costs with patient revenues for many years, despite its different reimbursement method.

Not all urban hospitals are large and not all large hospitals are urban. One fifth of large hospitals are rural hospitals and one quarter of CAHs are urban hospitals. The small, non-CAH hospitals are nearly evenly split across urban/rural locations. Appendix B shows the percent and average characteristics of NC hospitals by location and size. For some measures the differences are more pronounced between urban/rural location and for others, such as margins and general finance, size is the determinant. Payor mix measures tend to be more sensitive to location than size. (Low response rates on certain measures for small or critical access hospitals limit the analysis that can be completed by hospital size.)

As stated previously, the most recent status of the state is only available in quarterly data, but quarterly data can be confusing as seasonal effects show up in averages. Therefore, to demonstrate a more accurate reflection in trends, annual data, is used for the following analyses.

Margins are not the only measure of financial struggle. The following figure shows a variety of annual financial indicators, including margins, during the past five fiscal years for the average NC hospital. The first chart shows trends in annual margins. The average patient margin in 2010 was -1.8%, operating margin 0.9% and total margin 2.7%. The trends are downward, however quarterly numbers reported earlier forecast that margins will show improvement when FY 2011 data becomes available.

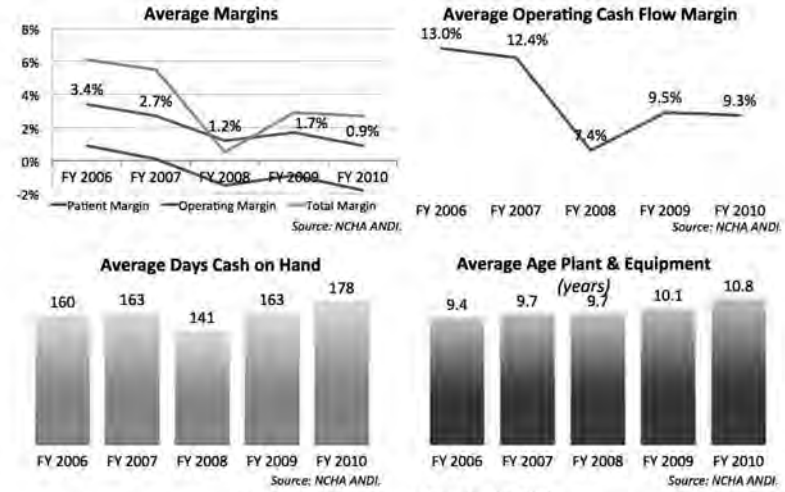


Figure 13: Average Financial Trends, 2006-2010.

Operating cash flow margin is trended the next chart. It differs from the other margins in that it focuses on the cash flow of the operation and removes any impacts of depreciation and interest expense. It is a measure of a hospital's ability to cover its daily expenses with operating revenues. The average

operating cash flow margin has improved since 2008, but remains below the 2006 average of 13%. Cash flow is on its way to recovery. Days cash-on-hand has recovered and now surpasses the 2006 average of 160 days. This is an indication that more hospitals are in a position to re-start capital projects that were put on hold during the recession. The result of putting capital projects on hold is that buildings and equipment age. This is reflected in the trends of increasing average age of plant and equipment. 2010 had an average plant and equipment of 10.8 years, which was more than a year older than the pre-recession average of 9.4 years. Trends in new capital projects are reflected in the figure below.

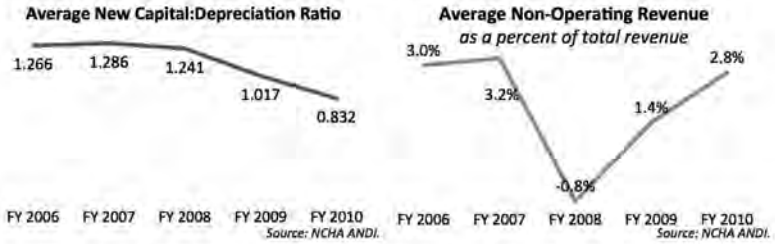


Figure 14: New Capital to Depreciation Ratio and Non-Operating Revenue Trends, 2006-2010.

The ratio of new capital expenses to depreciation expenses shown on the left side of the previous figure shows what amount of a hospital's capital expenses are being used to build new capacity versus replace old buildings and equipment. The higher the ratio is above one, the more capital is being dedicated to new capital projects. Prior to the recession, the average ratio was above one at 1.266. In 2010 the average continued downward to 0.832. This shows that hospitals have a backlog of older buildings and equipment to update before many can return to investing in upgrades for new technologies and expansions in needed new services.

Non-operating revenue is one source of seed money for capital projects, as a steady stream of investment returns can reduce interest payments on loans or bonds for new capital projects. While non-operating revenues returned to near pre-recession rates in 2010, investments have yet to return to the steady status needed to support capital projects. Without the funds to ensure projects can be completed, new capital projects may still be on hold.

As with margins, the differences for many of these financial measures are more pronounced when analyzed by bed size as opposed to by location. Appendix C contains the financial figures that correspond to the following discussion about urban, rural, large, small and critical access hospitals. CAHs and rural hospitals have the lowest average patient margins, operating margins, operating cash flow margin and days cash-on-hand; and the highest average age of plant/equipment. Large hospitals have the best average results (except for age of plant/equipment, where urban hospitals are younger). CAHs and small hospitals have the lowest total margins and new-capital-to-depreciation ratios. Small hospitals also have the lowest average non-operating revenues. In general the higher performing are large hospitals, while the lower are critical access hospitals. Rural hospitals experience poorer financial health than small hospitals. Size and location matter together. Each presents different financial pressures.

While the levels of hospital capital expenses are not yet enough to offset the delayed expenses from the recession, they are increasing. Capital projects take significant time to begin and end and more than a year elapsed at the beginning of the recession before hospitals could stop existing capital projects. They are only now regaining momentum as indicated in the following figure.

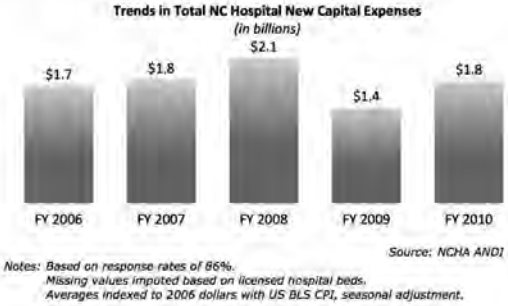


Figure 15: Total Hospital Capital Expenses, 2006-2010.

For 2010, NC hospitals spent an estimated $1.8 billion on new buildings and equipment. Most of these expenses went to replacing old buildings and equipment scheduled for replacement, but delayed due to the recession.

The economic climate for hospitals was mixed in 2010. There are promising signs that 2011 data will show economic improvement.

Drivers of Hospital Expense and Revenue Trends

NC hospital average expenses and revenues[16] grew modestly throughout 2010, even after adjusting for inflation. The following figure shows average hospital expenses and revenues, as a percent of 2006 expenses. This allows for comparisons between revenues and expenses and across years. For example, revenues in 2007 were slightly lower than expenses in 2007 and much lower than 2008 revenue levels.

The growth in *average* expenses across the five years (12.9%) is lower than growth in *total* NC hospital costs (17% from the figure on page 7) because expenses grew more slowly in smaller hospitals, affecting the average but not the total. In 2006, revenues adjusted for inflation, were 1% higher than expenses. The recession saw expenses initially outpace revenues and then reverse. As described previously, the growth is attributable to the changes in the state's population and composition, as well as the movement away from privately-owned physician practices to hospital-owned.

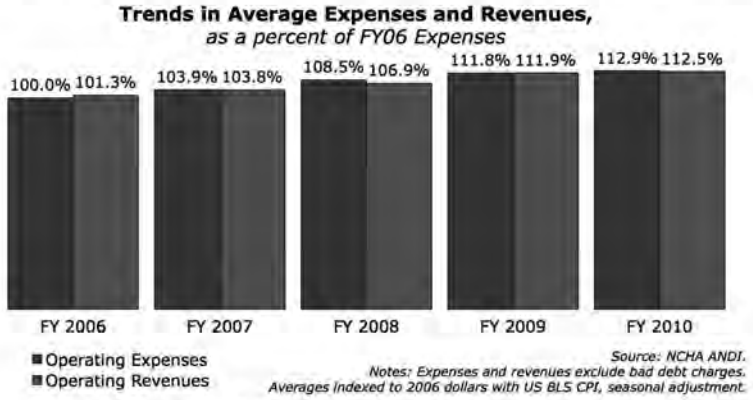


Figure 16: Average Operating Revenues & Expenses, relative to FY06 Expenses, 2006-2010.

A bigger difference in trends exists between urban and rural hospitals than between small and large hospitals. Since 2006, urban hospitals increased expenses an average of 18%, but rural hospitals only 8%. On the revenues side, a similar story: Urban hospitals increased revenues an average of 20% while rural hospitals saw increases of only 4% on average. These increases are across five years. The average annual rates are much lower: 4.5% for urban hospital expenses and 1% for rural hospital expenses.

Net patient revenues make up the largest piece of revenues. They have increased an average of 11% in 2010 over 2006 levels, after adjusting for inflation. The following figure shows the average growth of net revenue by payor classifications, inflation adjusted (IA).

- The percentages of 2010 net patient revenue from each payor class prove to be nearly identical to the percentages in 2006.

[16] Revenues, net patient revenues and expenses exclude bad debt charges.

- Per thousand, revenues increased $111, from 2006 to 2010, with commercial net patient revenues accounting for $38 of the increase, Medicare $57, uninsured $4, Medicaid $10 and other payors the remaining amount.
- Medicaid net revenues increased by an average 8% across the five years, but since all revenues increased by about the same amount, Medicaid's share of 2010 revenues remains nearly unchanged from 2006.
- Commercial's share of net revenues increased in 2007, but by 2010, it was back to the same share of 2010 revenues as it was in 2006 (40%).

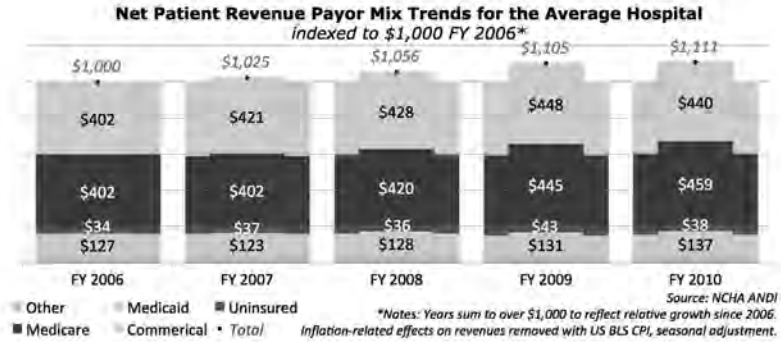


Figure 17: Net Patient Revenue Trends by Payor, 2006-2010.

Figure 17:

- The foreground columns with dollar figures show the scale of the growth since 2006, and demonstrate increased revenues at an average of 11% 2006 to 2010, IA ($1,000 to $1,111).
- The background columns show the relative growth of each payor source, summing to 100% each year.
- The amounts in gray indicate the total growth of $1,000 since 2006.
- The payor category-specific numbers allow for comparisons within a column and across columns, as they are indexed to 2006. For example:
  - In 2006 the share of revenues from Medicare and commercial payors was evenly divided at $402 per thousand, but by 2007 commercial revenues had grown to $421 while Medicare revenues remained at $402.
  - Net revenue grew by $25 per thousand, from 2006 to 2007 and of that $25, most ($19) was due to an increase in commercial revenues with commercial revenues growing to 41% ($421 / $1,025) of 2007 revenues, from 40.2% the previous year.

Net revenues are growing faster in urban hospitals than in rural hospitals and urban hospitals are seeing increasing commercial net revenues, whereas rural hospitals a decline. Reliance on Medicare net revenues continues to grow for both urban and rural hospitals. While urban and rural hospitals both saw increases in net revenues between 2006 and 2010, they were due to different payors. In urban hospitals, 2010 net revenues grew $163 (16.3%) for each $1,000 of 2006 net revenues. Of that $163, half was due

to increasing commercial revenues, with second place gains from Medicare and even gains from Medicaid. Average net revenues from the uninsured declined between 2006 and 2010 for urban hospitals. By 2010, the distribution of payors in urban hospitals had changed: Urban hospital commercial revenue increased and uninsured dropped. Medicare crept higher and Medicaid dipped slightly.

The trend in rural hospitals is different. Over the last five years, their net revenues increased by an average of $51 for every $1,000 in 2006 net revenues (5.1%). Medicare was responsible for most of the increase, followed by the uninsured and Medicaid. Commercial net revenues declined. As a result, the share of 2010 rural net revenues from commercial payors has declined, and Medicare, Medicaid and the uninsured have increased.

As with revenues, average hospital expenses adjusted for inflation have increased since 2006. This is due to the state's demographics and healthcare field's structural changes.

- For every $1,000 in 2006 expenses, hospitals incurred an average additional $129 of expense in 2010. Of that $129, labor costs were responsible for $79 and other expenses (such as supplies) for $42.
- Reductions in contract labor expenses represent a $2 cut from the $129 per thousand increase. As a result, the distribution of 2010 total expenses has changed somewhat. Labor costs now represent more of 2010 total expenses (to 52.5% from 51.3%), contract labor less (to 2.3% from 2.7%), and other expenses less (to 37.6% from 38.2%).
- The average hospital's total expenses have grown during the last five years and no single type of expense is responsible for the growth.

The following figure shows the break out of expenses into labor (payroll and benefit expenses), contract labor expenses, interest expenses, depreciation and other expenses.

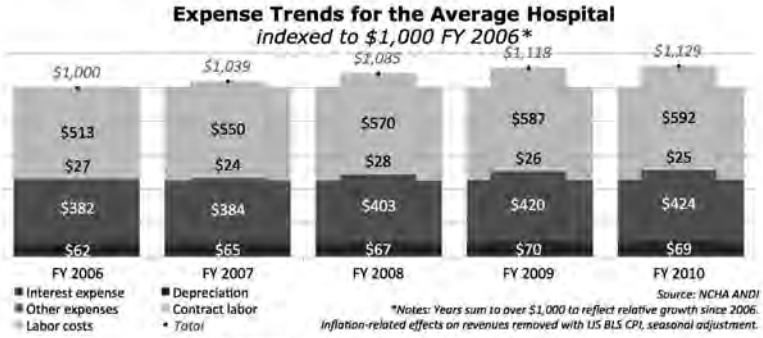


Figure 18: Average Expense Trends, by Expense Type, 2006-2010.

Figure 18:

- As with revenues, the expense figure shows the growth of each category, relative to each $1,000 in 2006 expenses for the average hospital, after adjusting for inflation. For example
  - For each $1,000 in 2006 total expenses, total expenses in 2007 increased by an average $39.
  - Labor costs were responsible for $37 ($550 - $513) of the $39 and contract expenses declined by $3 for every $1,000 of 2006 expenses.
- The background columns that sum to 100% show the relative share of these categories to each year's total expenses.

The story is different between urban and rural hospitals. Both groups had increases in total expenses across the last five years, with the increase in urban expenses (17.5%) being greater than rural (7.8%). The growth in urban hospital total expense is largely due to increased other expenses (such as supplies and equipment), not labor, although labor expenses did grow from 2006 levels. Urban hospitals cut contract labor expenses in half. For rural hospitals, labor costs account for the biggest proportion of growth and now represent an average of 54.8% of 2010 rural expenses. Other expenses did grow, but not enough to keep up with labor. Unlike in urban hospitals, rural hospitals also saw increases in contract labor expenses. The relative increase in rural labor costs reflects tight constraints on other expenses and absorption of community physician practices, and does not signal a large increase in rural hiring.

The growth in expenses and revenues may seem surprising during a time of economic distress. None of these averages, however, are controlling for the growing size of the hospitals' communities. To control for increased demand, total expenses and revenues can be calculated on a per-patient-day basis. The following figure shows the trend of expenses and revenues per patient day. The percentages printed in white are not annual, but cumulative from 2006. Expenses and revenues per day show average growth in excess of the growth rates reported under total average hospital revenue and expense trends: They show that expenses grew by an average of 21.6% (versus 12.9% in Figure 16) and revenues 18.6% (versus 11.1% in Figure 16) since 2006, adjusted for inflation. Averages that are higher with hospital size controls than without would imply that expenses and revenues have increased faster in smaller hospitals, which is not the case. The issue here is the adjustment factor used: patient day. Patient day captures differences in inpatient population only. Reporting by patient day is a common practice, but is an insufficient adjustment when outpatient changes are occurring at different rates than inpatient changes.

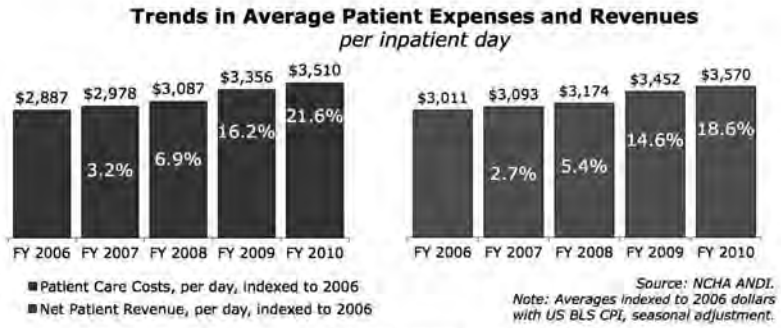


Figure 19: Average Expenses and Patient Revenues, per Inpatient Day, 2006-2010.

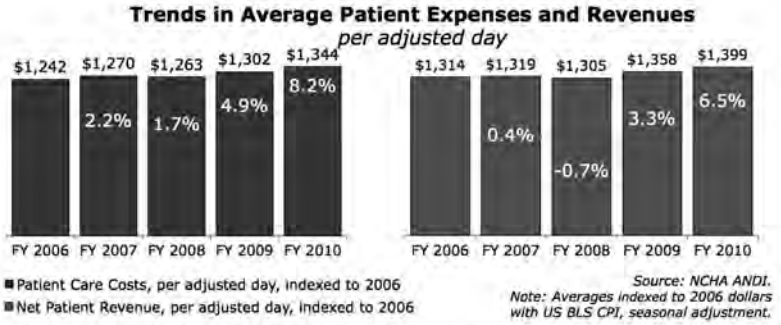


Figure 20: Average Expenses and Patient Revenues, per Adjusted Day, 2006-2010.

A better control is one that captures changes in both inpatient and outpatient volumes: outpatient-adjusted patient day. This is particularly important when existing independent physician practices are being absorbed into hospitals and therefore hospital outpatient volumes are increasing at rates unrelated to inpatient volumes. Expenses and revenues per adjusted day show average growth rates far below the average hospital revenue and cost growth rates listed in Figures 16 or 20. Between 2006 and 2010, patient revenues per adjusted day grew an average of 6.5% while costs 8.2%. Spread over the five-year period, this is an average annual growth rate of only 1.6% for revenues and 2% for costs. Costs and revenues per adjusted day grew more in urban hospitals since 2006: 11% and 9%, respectively. In rural hospitals, the growth rates were much slower: 4% for costs and 2% for revenues.

These growth rates are also attributable to an increase in patient severity and case complexity. One measure in which these factors are considered is case mix index (CMI). The following figure reports the trends in average case mix index, both across the entire patient population and by payor type. The results presented using case mix index should be used with caution, as ANDI response rates for CMI questions are much lower than other measures. In some payor types, response rates for CMI dipped to 30%. For the all-payor measure, 50% percent of hospitals responded. In particular, small and critical access hospitals were less likely to report than larger hospitals. It is possible that the following conclusions are influenced by low data response rates.

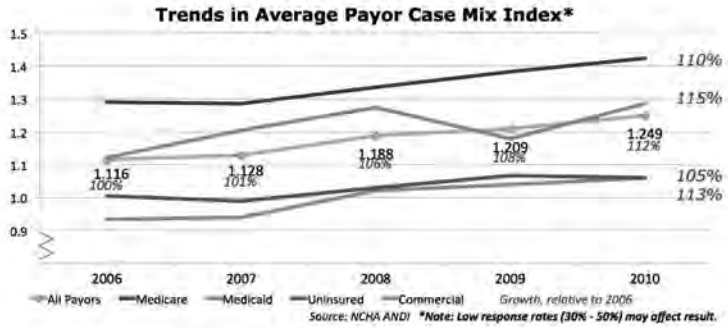


Figure 21: Average Case Mix Index, by Payor, 2006-2010.

On average, hospitals saw patient cases that were 12% more complex in 2010 than what they saw in 2006. The growth in average case mix index value was similar in urban hospitals (10%) and rural (15%) hospitals. The following figure adjusts both patient costs and revenues by case mix index.

After adjusting for inflation, population growth, outpatient volume increases and increased case mix complexity, both patient revenues and expenses in 2010 are *lower* than 2006 levels. Hospitals, on average, reduced their costs by 3.4% since 2006 and saw revenues decline by 5.5%.

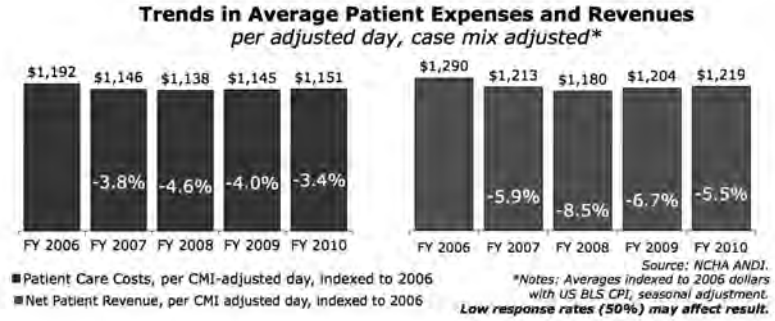


Figure 22: Average Expenses and Patient Revenues, per CMI adjusted-day, 2006-2010.

Urban hospitals reduced costs less than rural hospitals (2.5% versus 4.7%). Rural hospitals experienced a larger decline in revenues than urban hospitals (6.4% versus 5.0%).

In summary, during the recession and its current aftermath, the state's total hospital revenues and expenses increased. In general, the increases were proportional across sources of revenues and types of expenses. While a growing industry appears counter-intuitive during a struggling economy, there are other influencing factors:

- The nation experienced an 8% inflation rate between 2006 and 2010.[11]
- In 2010 there are 7.3% more North Carolinians than there were in 2006.
- The composition of many hospitals has changed as they are now responsible for previously independent physician practices.
- Patient cases are now more complex requiring more services per case.

After controlling for these factors, the average cost of care in North Carolina hospitals has *decreased* 3.4% from 2006 levels. Unfortunately, hospital revenues have decreased even more: 5.5%. Hospitals continue to react to reductions in revenues, knowing that in the current political environment federal and state budgets for healthcare are unlikely to increase in the near future.

[11] See Appendix A for trends in inflation.

Volume Trends by Financial Classification

Revenues changed because volume in hospitals has changed. The state has 7.3% more people than it did in 2006, which has increased demand for healthcare. Some new residents have Medicare coverage, and therefore as expected, Medicare volumes increased. It was unclear if the influx of new residents with commercial insurance would be enough to offset the losses of commercial coverage due to layoffs or employers cutting coverage benefits since The Great Recession. It is now clear they did not and commercial volumes declined in 2010.

The effect of unemployment trickles down to other payor classes. Some of the unemployed are now uninsured, and as expected 2010's uninsured volumes are higher than 2006. Others that have become unemployed are now eligible for Medicaid. The increase in NC Medicaid eligibles is well-documented and appears in the following figure. Compared with 2006, 2010's Medicaid hospital utilization has increased.

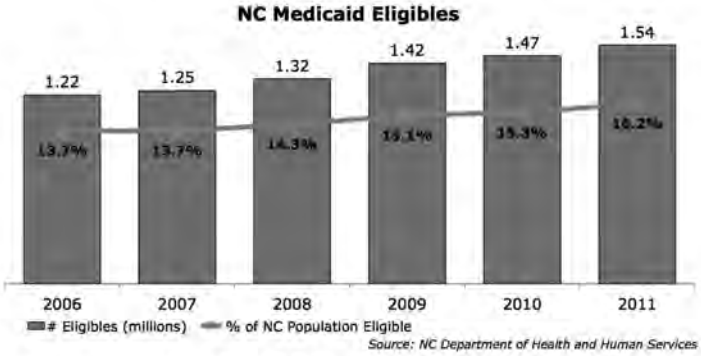


Figure 23: Trends in NC Medicaid Eligibles, 2006-2011.

Since 2006, estimated statewide volumes increased in North Carolina, for all hospital services, except for outpatient surgeries, which declined slightly. The following table lists estimated service volume totals for North Carolina. Most increases are small. Total outpatient visits show the highest growth rate across the last five years: It is estimated to have increased to 19.6 million from 16.8 million (16%).

Trends in Estimated Total NC Volume
(in millions)

	2006	2007	2008	2009	2010
Total Discharges	1.01	1.03	1.06	1.05	1.05
Total Inpatient Days	5.51	5.66	5.78	5.76	5.78
Inpatient Surgical Operations	0.30	0.31	0.31	0.31	0.31
Outpatient Surgical Operations	0.65	0.63	0.64	0.63	0.63
Total Emergency Dept. Visits	3.81	4.00	4.16	4.30	4.34
Total Outpatient Visits	16.83	17.53	18.51	19.78	19.56

Source: NCHA ANDI.
Notes: Missing values imputed from licensed beds.

Table 1: Estimated Total North Carolina Volume, 2006-2010

Trends in total NC volume do not describe the average NC hospital. They describe instead the trends of the largest hospitals, obscuring different trends of the smallest. To properly balance the story, all of the following figures in this section describe average rates for NC hospitals.

For the average NC hospital, inpatient volume has eroded slowly since 2006. In 2010, the average hospital provided 5.4% fewer days of care than in 2006. Hospitals provide care in addition to acute care; many have skilled nursing, behavioral or rehabilitation units. The following figure shows the change of days in each bed type, relative to 1,000 days in 2006 for the average hospital.

Inpatient Days: Bed Trends for the Average Hospital
*indexed to 1,000 FY 2006 days**

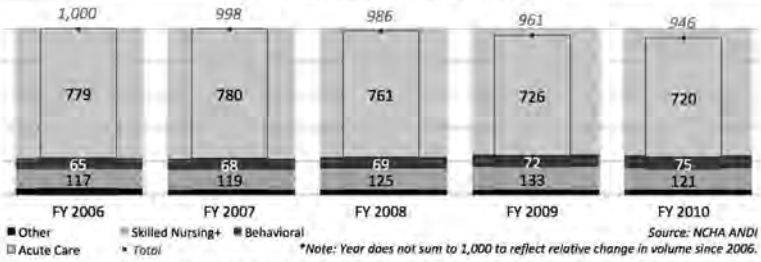


Figure 24: Trends in Average Days by Bed Type, 2006-2010.

Figure 24:

- The foreground columns with numbers show the scale of the change since 2006.
- The background columns sum to 100% to show the distribution within a given year.
- The days in gray indicate the total growth since 2006 per thousand days.
- The category-specific numbers allow for comparisons within a column and across columns, as they are indexed to 2006. For example:
  - In 2008, the average hospital had 986 days for every 1,000 days in 2006: It lost 14 days.
  - Some categories lost days and some gained, for a net gain 14 days per thousand: 18 days were lost due to declines in acute care days while 4 days were gained from behavioral health patients and 8 from skilled nursing. Other types of activity lost the remaining 8 days.

While general acute care continues to make up three-quarters of all days in the average hospital, it also is the category most responsible for the declining days.

- Over the last five years, NC hospitals lost an average 54 of every 1,000 days. It would have been 59 days if it were not for the 14 days gained from skilled nursing and behavioral health units. Other unit types lost 9 days per thousand.
- In 2010, an average 7.9% of all days in a hospital are from patients in behavioral health beds; up from 6.5% in 2006.

The largest trend difference in days is between large and small hospitals, and not between urban and rural hospitals.[12]

- Large hospitals provided an average 6 *more* days per thousand over the last five years. Losses in acute care days were offset by gains in other bed categories.
- Critical access hospitals provided an average 78 fewer days per thousand days, with acute care accounting for 63 of the 78. Increases in behavioral (12 days) and skilled nursing (19 days) units helped to offset losses in acute care and other beds. As with urban hospitals, behavioral volume increased in CAHs.
- Small, non-critical-access hospitals continue to see their inpatient days deeply affected by economic conditions. They provided an average 111 fewer days per thousand between 2006 and 2010. Of the 111, the majority were from losses in acute care (90), but losses were felt across every bed category.

Hospitals of all types continue to have acute care volume below that from 2006. Behavioral health has increased for all but the small, non-critical-access hospitals.

As described previously, the current economic climate will have different effects on each payor's utilization. The following figures document the relative increases or decreases in utilization by payor type across the following categories: Discharges, days, inpatient surgeries, outpatient surgeries, emergency department visits and total outpatient visits. As with the previous figure, these figures show the average growth of each category, relative to 1,000 units in 2006 for a hospital. The background columns that sum to 100% show the distribution of the payors within a given year. Scanning through and across the set reveals volume changes within a category, composition changes within a year and disproportionate use patterns by certain payor type across volume categories.

[12] Appendix C contains supplemental figures for urban, rural, large, small and critical access hospitals.

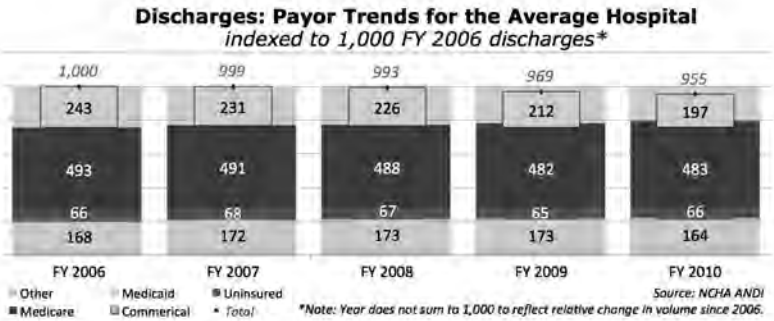


Figure 25: Trends in Discharges by Payor Type, 2006-2010.

Like days, average hospital all-payor discharges have declined every year since 2006.

- Hospitals have lost an average of 45 discharges per thousand since 2006.
- Commercial volume declines are responsible for the largest loss (46 discharges), with Medicare next (10 discharges) and then Medicaid (4 discharges).
- Gains from other payor classes helped to offset what would have been a decline of 60 discharges per thousand.
- Commercial discharges no longer represent an average 24.3% of all discharges; now it is 20.6%.

Because Medicare, Medicaid and uninsured declines were smaller than commercial, their proportions of yearly discharges increased. For the first time, Medicare accounts for more than half (50.6%) of an average hospital's discharges. Commercial continues to rank second in volume (20.6%), with Medicaid now in a close third place (17.2%).

While the average hospital had fewer discharges, total North Carolina volume of discharges increased (Table 1). This occurs when trends for the average hospital differ by hospital size:

- The average *large* hospital saw a 2.3% increase in discharges over the last five years. Losses in commercial volume would have decreased total discharges by 4.4%, but their declines were offset by increases in Medicare, Medicaid and other insurance payors. The uninsured remained at 2006 levels.
- Critical access hospitals lost the highest percent discharges: an average of 154 per thousand 2006 discharges. The losses were spread across every payor class: 96 from Medicare, 29 from commercial, 15 from uninsured, 12 from Medicaid and the remaining from other payor sources. A disproportionate share was lost from commercial payors and Medicaid.
- Small, non-critical-access hospitals have an average of 67 fewer discharges per thousand, with nearly all of it (60 of 67) attributable to a decline in commercial discharges. Medicare volumes remain about the same level as 2006 and Medicaid discharges declined. In 2006, an average of 23.3% of discharges were from commercial patients, now it is 19.9%.

Commercial volume declined across all three sizes of hospital, both from 2006 and in proportion to 2010 discharges. Medicaid volumes increased in large hospitals, declined at the same rate as total discharges in small hospitals and declined more slowly than total discharges in CAHs. Out of every 20 discharges, the number of discharges by commercial patients is 3 in a CAH, 4 in a small hospital and 5 in a large hospital. The number of those 20 discharges from Medicare patients is 13 in a CAH, 10 in a small

hospital and 9 in a large hospital. Medicare discharges make up the majority of discharges for the average CAH and small hospital.

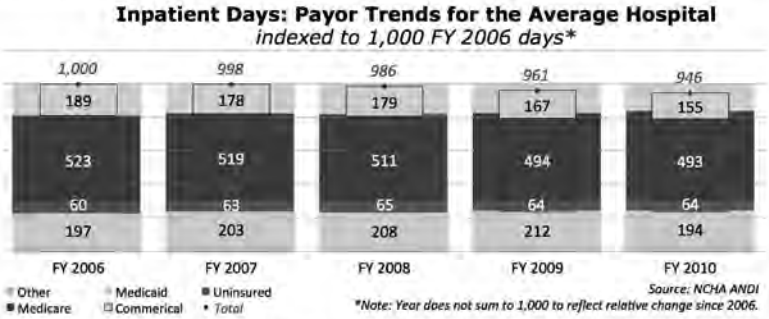


Figure 26: Trends in Days by Payor Type, 2006-2010.

Inpatient days, like discharges, have been declining for the average hospital.

- In 2010, there were an average 54 fewer days per thousand. Declining commercial and Medicare days drive the decrease.
- As with the discharge trends, commercial volumes declined, both compared with 2006 levels and as a percent of 2010 days.
- Unlike discharges, uninsured days are higher than 2006 levels.
- Average Medicaid 2010 days are just below 2006 levels, after first inching higher in 2007 and 2008. Medicaid patients account for more days than commercial patients in 2010 and the difference between them is growing.

Also as in discharges, more than half of days in 2010 are from Medicare patients in the average hospital.

While the average hospital sees declining days in volume, the total inpatient days in North Carolina climbed (Table 1) because small and large hospitals have different trends. Appendix C has the figures for trends of each hospital size. In general,

- CAH and small hospitals saw declines in total days.
- Large hospital days remained near 2006 levels.
- Commercial volumes fell across the board, both compared to 2006 levels and as a percent of 2010 totals.
- Uninsured volumes are up, except in CAHs, which saw virtually no change in uninsured levels.

The differences between hospital sizes are found in Medicare and Medicaid. Large hospitals saw nearly no change in Medicare days and an increase in Medicaid days. Small hospitals saw declines in Medicare and Medicaid days. CAHs saw Medicare days decline relative to 2006, but Medicaid days stayed the same as 2006 levels.

Figure 27: Trends in Inpatient Surgery Volume, by Payor Type, 2006-2010.

As with other inpatient volume, inpatient surgeries are down for the average hospital.

- The decline is an average 13 surgeries per thousand since 2006, with commercial volume responsible for the majority of the decline. Commercial declines alone would have driven down volume by 45 surgeries per thousand, but total declines were mitigated by increases in Medicare volumes (34 surgeries per thousand since 2006).
- While Medicare patients have the most inpatient surgeries, they account for less than half in the average hospital. Commercial patients have the second highest number of surgeries, followed by Medicaid patients. The numbers of uninsured surgeries rebounded from recent declines to numbers near 2006 levels.
- As with days, Medicaid volume, which increased in recent years, declined to just below 2006 levels in 2010.

Low response rates from hospitals regarding inpatient surgeries as well as outpatient volume measures prohibit comparisons across hospital sizes but are high enough to allow comparisons between urban and rural hospitals.

- The average urban hospital saw an increase in inpatient surgeries between 2006 and 2010 (92 surgeries per thousand).[13]
- While 9 per thousand were lost due to commercial declines, 100 per thousand were gained from increased Medicare (81), Medicaid (11) and uninsured (8) volume.
- Just under one third of inpatient surgeries in the average urban hospital are for commercial patients and 45% are for Medicare patients.

Rural hospitals saw inpatient surgeries decline by 129 surgeries per thousand over the last five years, with declines in every payor category.

- Commercial declines led the way, accounting for 71 of the 129 fewer surgeries.
- Instead of an average of 26.3% of surgeries for commercial patients, rural hospitals now see only 22%.
- More than half of rural surgeries are for Medicare patients.

[13] Appendix C contains supplemental figures for urban, rural, large, small and critical access hospitals.

Figure 28: Trends in Outpatient Surgery Volume, by Payor Type, 2006-2010.

Outpatient surgical volume is typically dominated by commercial payors.

- Like inpatient surgeries, in 2006 all-payor volume has declined slightly since 2006 (-11 surgeries per thousand), with commercial declines more than offsetting gains from Medicare (-62 versus +45 surgeries per thousand).
- Commercial coverage was responsible for the most outpatient surgeries in the average hospital (435 of every thousand), with Medicare in second place.
- Increased Medicaid outpatient surgeries replaced some of the lost commercial volume (+16 per thousand). Medicaid remains in third for volume, but at higher levels than in 2006.
- In 2010, Medicare overtook commercial payors in outpatient surgery volume.
- Uninsured outpatient surgery volume remains nearly unchanged across the years.

Comparing urban and rural hospitals reveals different trends across Medicaid, but similarities across the other categories.

- While average Medicaid outpatient surgeries have increased in urban hospitals (+28 surgeries per thousand), they remain nearly unchanged in rural hospitals.
- Across the board, commercial volume has declined, both compared with 2006 levels and percent of 2010 totals. The decline was more pronounced in rural hospitals (-69 surgeries per thousand versus -54 surgeries per thousand). Commercial volume remains the highest percent of outpatient surgeries in the average urban hospital (42.8%), but second place at less than a third of surgeries in rural hospitals.
- Also in common, Medicare volumes increased, both with respect to 2006 levels and percent of 2010 totals. The increase was higher in urban hospitals (+68 surgeries per thousand versus +14 surgeries per thousand). Medicare now represents 43.9% of rural outpatient surgeries and 35.8% of urban.
- Levels of uninsured outpatient surgeries have remained the same.

Figure 29: Trends in Emergency Dept. Visits, by Payor Type, 2006-2010.

Trends in emergency department visits are very different than the previous volume trends presented.

- Both total NC ED visits (Table 1) and the number for the average hospital increased. The number of visits has been increasing steadily and is up 154 visits per thousand since 2006.
- As with other volume, commercial ED volume dropped compared with 2006 levels. Unlike the other volume trends, 2010 is the first year of lower commercial usage. **Commercial patients are no longer the biggest users of the ED, dropping three places to fall behind Medicare, Medicaid and uninsured.**
- The new leader is Medicaid, which now accounts for a quarter of the average hospital's ED visits.
- Unlike any other category, ED usage is nearly evenly spread between Medicare, Medicaid, uninsured and commercially insured patients.
- Relative to total patients, there are almost twice as many Medicaid and four times as many uninsured patients in the ED as there are discharges, days, or either surgery volumes.

The pattern of ED utilization and trends over the last five years are generally the same across urban and rural hospitals. The biggest difference between urban and rural ED trends is that in rural hospitals, Medicare patients are now on average the top visitor of rural EDs, with Medicaid in second place. In urban hospitals Medicaid and the uninsured compete for the top spot. In both settings, commercial patients, who held the top spot until recently, are now fourth in volume.

The disproportionately high ED use of Medicaid and uninsured presents an opportunity for hospitals, physicians, health systems, policymakers, public health departments and educators. Likely their high utilization rates represent more utilization of the ED for non-emergency conditions than other patients. If Medicaid and uninsured ED utilization could be reduced to levels proportional with Medicare and commercial volumes, ED costs could be reduced by a quarter in the average hospital.

The high utilization rate of EDs by Medicaid and uninsured patients is related to their ability to pay for non-emergency care and access to that care. These populations seek the ED more often because they do not have access to maintenance healthcare that keeps them healthy enough to avoid the ED; leaving

them with only the ED for both non-emergency conditions and emergency conditions made much worse by lack of regular care.

Given this and the low income levels of the Medicaid population, it is unlikely that the current regulatory Medicaid plan to deter ED usage with increased out of pocket co-pays for non-emergent ED visits, will affect the desired change. Instead these patients will continue to go to the ED unless and until there are other community choices. The non-emergent co-pays will be reflected in higher hospital charity care. Without an unlikely change to EMTALA[14] that would allow hospitals to deny service for non-emergent care without pre-payment, the distribution and volume of ED patients will continue as is. Change will occur only with delivery system change, education and more non-ED alternatives for non-emergent conditions.

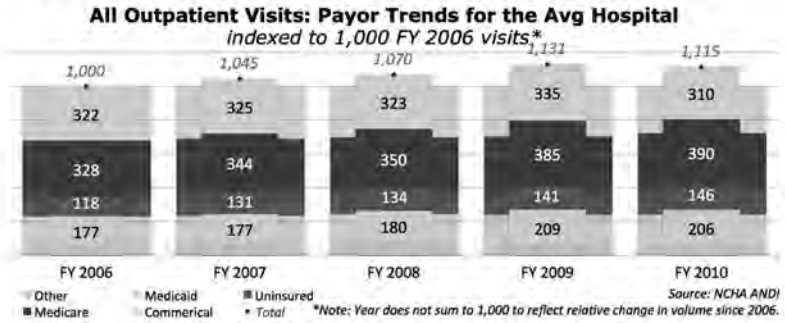


Figure 30: Trends in Outpatient Visits, by Payor Type, 2006-2010.

As with and partially due to ED visits, the combination of all outpatient visits increased over 2006 levels. Compared with 2009, levels in 2010 were lower, but the difference was small (16 visits per thousand).

- Unlike the payor trends in ED visits, Medicare continues its lead in sheer volume. It represents over a third of all visits in the average hospital, unlike inpatient volume measures where it is closer to half.
- Commercial volume declined in 2010, as it did in all other volume categories, but it maintains its position as the second highest category.
- Medicaid followed in a distant third position, with volume levels higher than in 2006.
- The uninsured volume increased, but not enough to overtake Medicaid. As a percent of all outpatient visits, the uninsured remains at 13% of the average hospital's 2010 outpatient visit total.

The urban and rural stories are similar. Both saw increases in total outpatient visits until a small dip in 2010. The drop was smaller in urban hospitals.

- Since 2006, urban hospitals grew by an average of 129 visits per thousand, of which Medicare accounted for the most growth, followed by Medicaid and the uninsured.

[14] Emergency Medical Treatment and Active Labor Act.

- Rural hospitals saw similar growth (100 visits per thousand over 2006 levels) and Medicare gains led the way.
- Commercial volume declined from 2006 levels in both urban and rural hospitals.
- Both show Medicare as the largest payor source for visits. Medicare patients represent an average of 39% of all outpatient visits for rural hospitals; 31% for urban. The difference in the distribution is absorbed by commercial patients, which averages 25% of rural hospital visits and 30% of urban.

High Medicare use is a familiar pattern for rural hospitals, but new for urban, where, until 2010 commercial volume was higher. Until 2009, commercial volume was responsible for a third of outpatient visits in urban hospitals.

In summary, volume fell from 2006 to 2010 for the average hospital. Commercial volume fell across all types of services, hospital sizes and locations. Larger and urban hospitals were better able to make up that difference and offer higher volumes from other payor sources, usually Medicare. Most larger and urban hospitals saw total volumes improve, while smaller and rural hospitals saw volumes decline. The emergency department continues to be an opportunity for system improvement because it is over-utilized by Medicaid and uninsured populations. These populations are the least able to pay for any care, especially the most expensive care that occurs in an ED. They represent an area of potential cost-savings for hospitals as well as communities.

Medicare and Medicaid Reimbursement Trends

Hospitals cannot turn away Medicare and Medicaid patients. As noted previously, the North Carolina population covered by Medicare and Medicaid is increasing. Medicare and Medicaid reimbursement rates are set by the government, often via politics, and are non-negotiable. The programs add huge administrative burden and costs to hospitals. There is no requirement that either program reimburse hospitals their actual costs for providing required care.

Because of these factors, Medicare and Medicaid represent an area of chronic losses for hospitals. Both continue to pay less than their fair share of the costs to care for their patients. Because hospitals reigned in expenses in 2010, the hospital's cost to provide an average patient with care dipped. Effectively, care was "cheaper" to produce. The result was some of the dip in reimbursement rates from both Medicare and Medicaid was absorbed by this cost differential and the average percent of hospitals' costs paid remains about the same as last year.

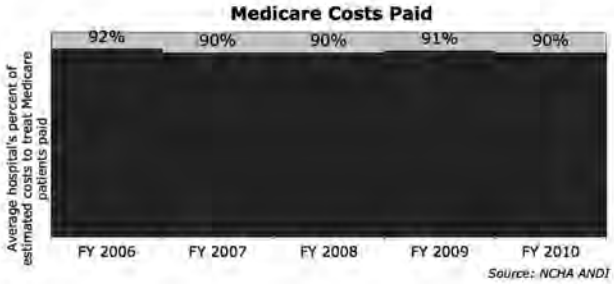


Figure 31: Average Hospital's Percent of Medicare Costs Paid, 2006-2010.

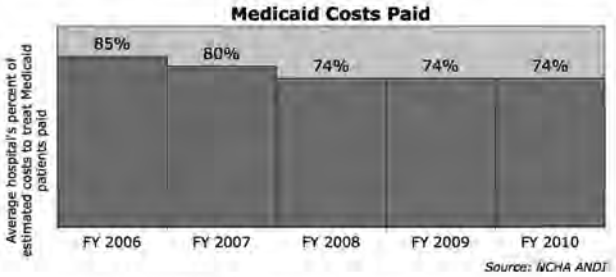


Figure 32: Average Hospital's Percent of Medicaid Costs Paid, 2006-2010.

The percent of costs paid averages varies by size and location of hospital. Appendix C contains these figures for urban, rural and size of hospital. CAHs benefit by being reimbursed at allowable costs. As a result, they have the highest average Medicare percent of costs paid: 96%. It is not 100% because some costs that are necessary to run a hospital are disallowed by CMS and also, estimates of patient care costs within a hospital are not precise.

Unlike manufacturing, about half a hospital's expense is labor and the "production line" produces unique patient outcomes with unpredictable recovery and reaction capabilities for each incoming patient. Obtaining manufacturing-compatible, highly accurate measures of visit-specific costs would require a time measurement system similar to consulting industries where clinical employees clock into and out of each patient's chart to accurately reflect how much time he/she spent delivering care on which patients. Because hospitals do not use these types of systems, they estimate patient costs to varying degrees of accuracy. Costs estimated using a standard methodology are comparable and provide a guide, but are not precise.

Across all types of hospitals, Medicaid pays a significantly lower portion of hospital costs of care provided than Medicare. Rural hospitals get paid the least for Medicaid (average of 69% of costs) and small hospitals the least for Medicare (average of 87% of costs). Large and urban hospitals fair better, partly because some of them are teaching hospitals so they receive extra payments. Despite recent cost containment efforts, hospitals still see a general downward trend in Medicaid reimbursement coverage as reimbursement rates fall faster than costs.

Charity Care and Bad Debt Cost Trends

Charity care and bad debt represent the portions of unreimbursed care that are deemed the patient's responsibility. Charity care is care written off for patients too poor to pay what they owe, bad debt is the amount that is potentially collectable from the patient, but not paid. Together these are usually referred to as "uncompensated care," although there are many more categories of care for which the hospital goes un- or under-compensated. For example, losses from under-payments by Medicare and Medicaid programs are not included in "uncompensated care," though they too represent care that technically was uncompensated.

The amounts reported below reflect estimated costs of care incurred by the hospital; not charges. These costs have not been adjusted for inflation. Across all patients, bad debt costs have slowly crept higher over the past three years, while charity care costs have increased at a more rapid pace. Combined, the average hospital incurs a cost of $41,000/day for care that is not compensated.

Figure 33: Trends in Total Uncompensated Care, April 2008-June 2011.

This trend of increasing uncompensated care is consistent across all types of hospitals.[15] Rural hospitals typically have twice as much bad debt as charity care because they have fewer resources dedicated to documenting charity care patients. As a result, these amounts show up in their bad debt category. Large and urban hospitals document more charity care than bad debt.

The uninsured are the obvious source of bad debt and charity care. Both bad debt and charity care can occur from patients in any payor class. Unpaid co-pays, deductibles and uncovered services from the insured get classified as either bad debt or charity care. During periods of high unemployment, commercial coverage declines and more patients are uninsured, resulting in increasing bad debt and charity care. In addition, those with insurance face higher co-pays and deductibles as employers and government seek ways to shift increasing healthcare costs to consumers.

[15] Appendix C contains supplemental figures for urban, rural, large, small and critical access hospitals.

The figure below shows the estimated total uncompensated care costs across all NC hospitals for the past three years. For Medicare and the uninsured, total uncompensated care costs increased in 2010. For those with commercial insurance, uncompensated care declined because the numbers of patients with commercial insurance declined. The total dollars are dominated by the largest, mostly urban, hospitals. Totals across all rural hospitals show commercial uncompensated care unchanged and Medicare uncompensated care slightly lower in 2010.

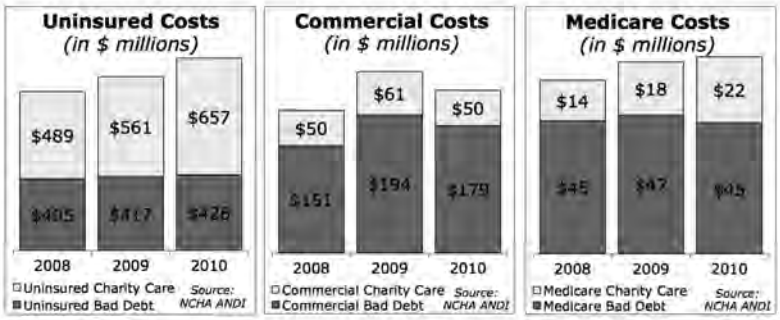
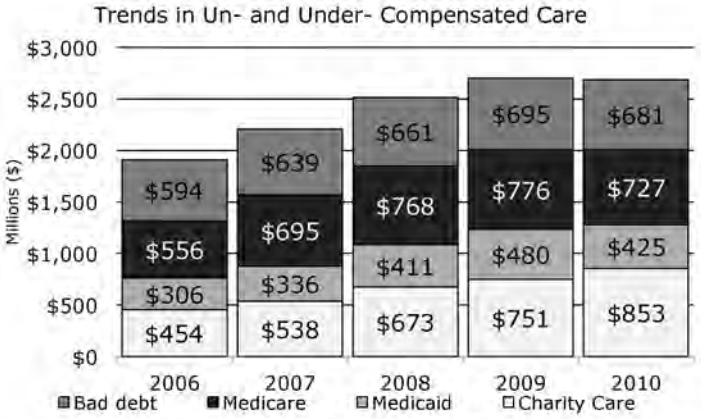


Figure 34: Trends in Total Hospital Uncompensated Care, by Payor Type, 2008-2010.

Looking Forward

Federal and state budgets have been getting tighter each year with no end in sight. It is likely that neither of the healthcare reimbursement programs they fund (Medicare/Medicaid) will ever pay their fare share for the costs incurred by their beneficiaries. Hospitals cover many unpaid and underpaid services, most of which are listed on a hospital's community benefit report. The largest categories of unpaid or underpaid services are charity care, Medicare losses, bad debt and Medicaid losses, in that order. The following figure documents the North Carolina trends of these four. The amounts are the estimated totals of costs (not charges) for the state and are not adjusted for inflation.



Prepared by Sarah Broome, PhD, Director of Economic Research, NCHA, June 3, 2011. Response rate: 87%; missing responses imputed using beds. Data source: NCHA ANDI.

Figure 35: Medicare Losses, Medicaid Losses, Charity Care and Bad Debt Costs, 2006-2010.

The growth of these four categories has been mitigated by hospitals reducing the unit cost of care, as they have done in the last few years. However, it is expected that each them will continue to grow as Medicare and Medicaid continue to cut reimbursement rates, the population in each category increases, and hospitals fail to match the rate of losses with continued efficiency gains.

The losses represented in these categories arise from three payor classifications: Medicare, Medicaid and the uninsured (MMU). The figure below shows the large size of MMU volumes in hospitals and the declining size of commercial volume. What was nearly a 2:1 ratio between MMU and commercial volumes is quickly approaching a 3:1 ratio.

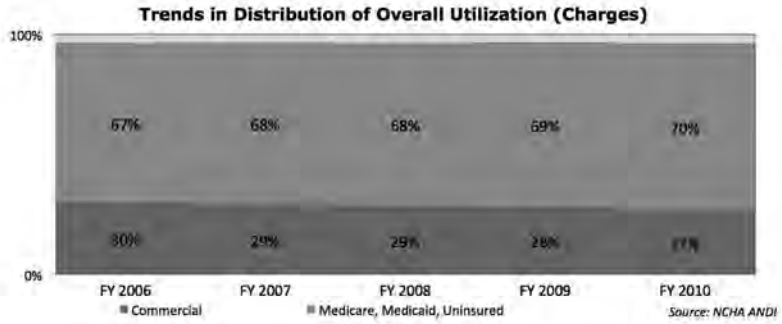
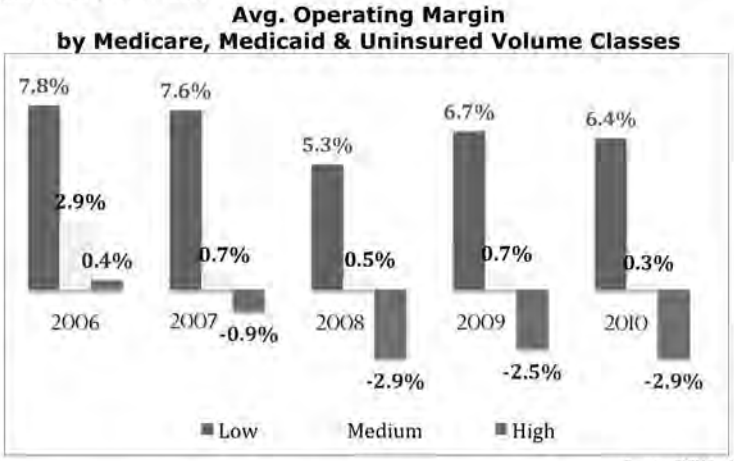


Figure 36: Trends in Commercial versus Medicare, Medicaid and Uninsured Volume, 2006-2010.

In large hospitals, the average percent of MMU volume is now 67% and commercial payors is 29% (2.3 to 1 ratio)[16]. For smaller hospitals, the average MMU volume is now 70% and their commercial volume is 27% (2.6 to 1 ratio). CAHs have the highest average MMU volume at 76% and the lowest commercial volume at 23% (3.3 to 1 ratio).



Source: NCHA ANDI.
Notes: Hospitals with <66% charges in MMU are in the low volume group, high volume group has >75% MMU.
Figure 37: Impact of Medicare, Medicaid and Uninsured on Operating Margins, 2006-2010.

[16] Appendix C contains supplemental figures for urban, rural, large, small and critical access hospitals.

Hospitals with high MMU volumes have lower average operating margins. The previous figure divides hospitals into high, medium and low MMU volume and then charts the average operating margin for each set of hospitals.

In 2010, the average operating margin of hospitals with lowest levels of MMU volumes was 6.4%, versus -2.9% for those with the highest volumes of MMU. The relationship between volume of patients in financial classes that do not reimburse all costs and a hospital's bottom line is clear, and to a large degree dependent on factors beyond a hospital's immediate control, such as location. Hospitals continue to focus on increasing efficiency to control costs, reducing ED utilization for non-emergent care and improving population health and health education. All of these will help, but none will eliminate uncompensated care.

Understanding the dramatic effect unreimbursed care has on hospital financials is important for another reason. For a hospital to survive, commercial payor reimbursement rates must make up the difference. As reimbursement rates for MMU populations decline, an upward pressure is applied to commercial rates. That pressure is intensified when the population covered by commercial payors shrinks. For a delivery system to stay viable, increases in commercial rates would have to adjust for both the decline in MMU reimbursement rates and the shrinking commercial volume. The following figure demonstrates two scenarios: One based on a break-even assumption and one on a 5% patient margin assumption.

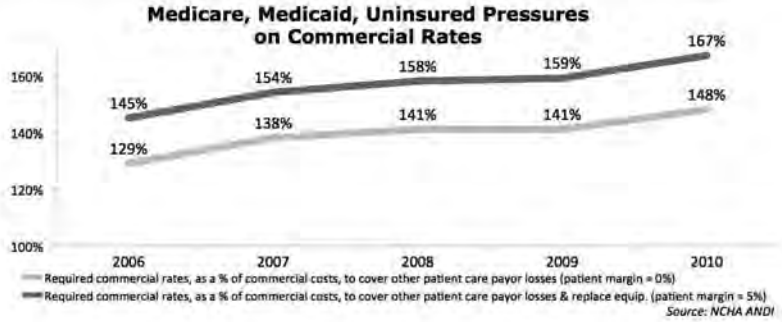


Figure 38: Pressure of Medicare, Medicaid and Uninsured on Commercial Rates, 2006-2010.

Both scenarios compute a commercial revenue goal as a percent of the average hospital costs to provide care to its commercial patients. They capture the combined effect of increasing MMU and declining commercial volumes. In the first scenario (dark yellow line), commercial reimbursements have been increased so that the average hospital breaks even (patient margin of 0%). In 2006 this would happen under an average commercial reimbursement rate of 129% of costs. For the average hospital to get enough revenue to break even, it would have to receive from each commercial patient enough revenue to cover the costs of care for that commercial patient, *plus* an extra 29% "social contract" tax. In 2010, with fewer commercial patients and increasing Medicare, Medicaid and uninsured losses, the rate jumps

to 148%. It now would take a 48-cent "social contract" tax on every dollar of costs on those patients with commercial insurance for the average hospital to break even.

Everyone needs local hospitals to do more than break even. Communities need their hospitals to be able to adopt the best technologies, stay abreast of the latest medical developments and make available the current standard of care. Hospitals need access to capital to build infrastructure and that requires hospitals to show lenders a higher margin than break-even. The rate of 5% is considered a margin of a healthy hospital. The second scenario (green line) demonstrates the commercial rates needed to support an average hospital earning a 5% patient margin. In 2010, this would have required a 67-cent "social contract" tax on each dollar of commercial cost.

As stated previously, the average hospital had a patient margin in 2010 of -1.8%, well below the 0% patient margin modeled in the first scenario. Hospitals have been unable to extract the average 48 extra cents they need from commercial payors to break even. Instead, hospitals are delaying important capital projects and acquisitions and implementing other measures to remain financially afloat. Delays are not sustainable. Hospitals now wait on national efforts to cover the uninsured and state-level efforts to mitigate Medicaid losses with a provider assessment plan. Additionally, hopes continue for rapid job growth and a return of commercial coverage in the general population. In the meantime, hospitals must continue their recent success in reducing costs of care while policymakers and public health officials seek delivery reform that re-routes Medicaid and uninsured patients needing urgent care to settings other than the ED – improving the care they receive while lowering healthcare costs. These are the familiar goals espoused by both US DHHS' National Quality Strategy and IHI's Triple Aim: Improve population health and quality of care while lowering costs.

Appendix A: Annual Inflation Rates Indexed to 2006

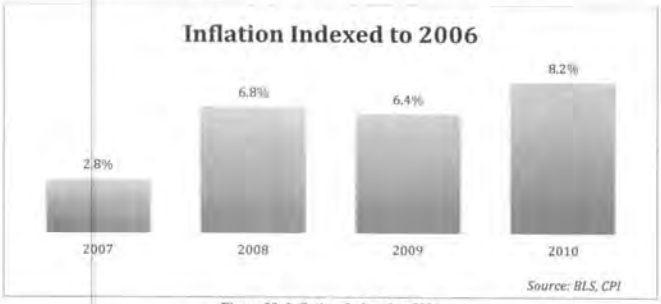


Figure 39: Inflation, Indexed to 2006.

The Consumer Price Index rose 2.8% between 2006 and 2007. In 2008, it rose again so that 2008 prices were 6.8% higher than 2006 prices. By 2010, the CPI had risen 8.2% over 2006 levels.

Appendix B: Demographics of Hospitals by Location and Size

The following table describes the demographics of six categories of hospitals (all, urban, rural, large, small and CAH).

Description	All	Urban	Rural	Large: 120+ Staffed Hosp. Beds	Small: < 120 Staffed Hosp. Beds (no CAHs)	Critical Access
Count	125	69	56	51	51	23
Urban	55%	100%	0%	78%	45%	26%
Rural	45%	0%	100%	21%	54%	73%
120+ Staffed Hosp. Beds	41%	57%	19%	100%	0%	0%
< 120 Staffed Hosp. Beds (no CAHs)	41%	33%	50%	0%	100%	0%
Critical Access Hospitals	18%	8%	30%	0%	0%	100%
Avg Staffed Total Beds	195	264	110	366	91	45
Avg Licensed Total Beds	220	292	131	405	106	62
Avg Licensed General Acute Beds	170	228	97	321	78	37
Avg Licensed Psychiatry Beds	23	31	13	48	7	1
Avg Licensed Rehabilitation Beds	8	13	2	16	3	0
Avg Licensed Skilled Nursing Beds	15	13	16	11	15	21
Has Licensed Psych Beds	36%	43%	26%	62%	23%	4%
Has Lic. Detox or Sub. Abuse Beds	5%	10%	0%	9%	3%	0%
Has Lic. Hospice, SNF or Adult Beds	29%	20%	41%	21%	27%	52%
Has Licensed Rehab Beds	20%	26%	12%	37%	11%	0%
General Acute Care Hospitals	88%	81%	96%	88%	82%	100%
Psychiatric (Behavioral) Hospitals	4%	5%	1%	5%	3%	0%
Rehabilitation Hospitals	1%	2%	0%	1%	1%	0%
Specialty and Federal Hospitals	6%	10%	1%	3%	11%	0%
West (District 1)	19%	15%	23%	13%	19%	30%
Northern Piedmont (District 2)	16%	20%	12%	11%	19%	21%
Southern Piedmont (District 3)	16%	20%	10%	23%	15%	0%
North Central (District 4)	14%	21%	5%	19%	13%	4%
South Central (District 5)	13%	8%	19%	9%	15%	17%
East (District 6)	19%	11%	28%	19%	15%	26%
Independent Hospitals	24%	20%	28%	29%	19%	21%
Hospitals in Multi-Hospital Systems	76%	79%	71%	70%	80%	78%

Table 2: Demographics of Hospitals by Location and Size.

Appendix C: Supplemental Figures by Hospital Location and Size

The following figures follow the same sequence of the figures in the text and show trends in the averages for urban, rural, large, small and critical access hospitals. Here is a description of each group:

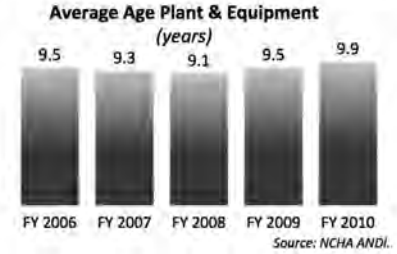
Group	*Description*
Urban	Urban hospitals are hospitals that reside in counties categorized by a Metropolitan Statistical Area, as defined by the US Office of Management and Budget (http://www.census.gov/population/www/metroareas/metrodef.html). It does not include Micropolitan Statistical Areas. These counties are: Alamance, Alexander, Anson, Brunswick, Buncombe, Burke, Cabarrus, Caldwell, Catawba, Chatham, Cumberland, Currituck, Davie, Durham, Edgecombe, Forsyth, Franklin, Gaston, Greene, Guilford, Haywood, Henderson, Hoke, Johnston, Madison, Mecklenburg, Nash, New Hanover, Onslow, Orange, Pender, Person, Pitt, Randolph, Rockingham, Stokes, Union, Wake, Wayne, Yadkin. Three hospitals that OBM would classify as rural were reclassified as urban in ANDI, per their requests. There are 69 NC facilities in this group.
Rural	Rural hospitals are hospitals that do not reside in a county classified as urban. There are 56 NC facilities eligible to be in this group.
Large	Large hospitals have 120-999 staffed hospital beds. Hospital beds are all beds except skilled nursing and adult care beds. There are 51 NC facilities in this group.
Small	Small hospitals have 15-119 staffed hospital beds. Hospital beds are all beds except skilled nursing and adult care beds. There are 51 NC facilities eligible to be in this group.
CAH	Critical access hospitals are hospitals that have been classified by CMS as "Critical Access Hospitals." CAHs receive cost-based reimbursement from Medicare. There are 23 NC facilities eligible to be in this group.

Due to low response rates, some figures are unavailable at the urban/rural level and at the bed size level. All other figures are included.

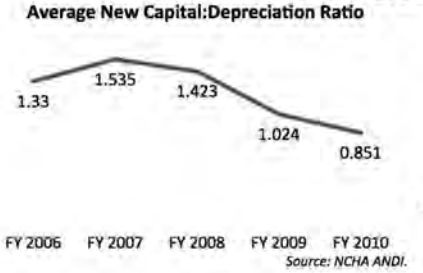
Hospital Financial Figures

The following are the figures available that are discussed in "The Impact of the Economy on NC Hospital Finances" section.

Urban



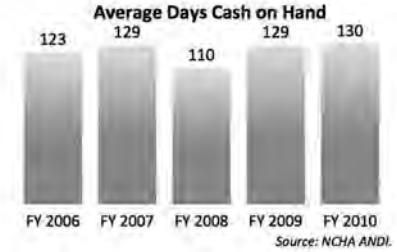
Urban

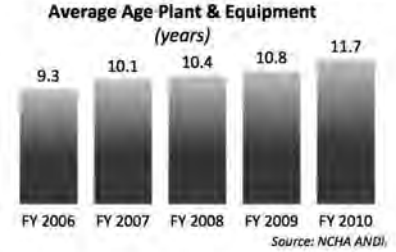


Rural

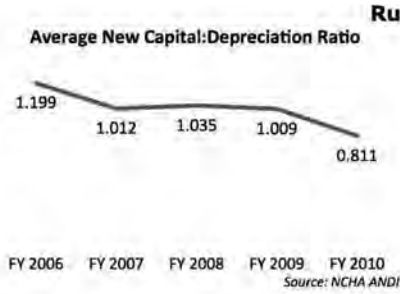
Average Margins
4%
2%
0%
-2%
-4%
0.8%
0.2%
-0.8%
-0.2%
-1.3%
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Patient Margin
Operating Margin
Total Margin
Source: NCHA ANDI.

Average Operating Cash Flow Margin
10.8%
10.4%
6.3%
7.5%
6.6%
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Source: NCHA ANDI.


Average Days Cash on Hand
123
129
110
129
130
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Source: NCHA ANDI.

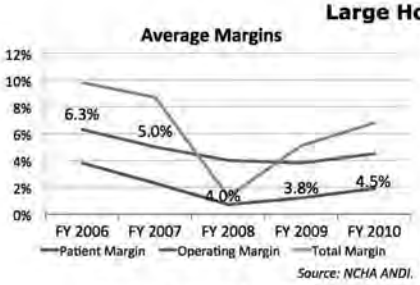

Average Age Plant & Equipment
(years)
9.3
10.1
10.4
10.8
11.7
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Source: NCHA ANDI.

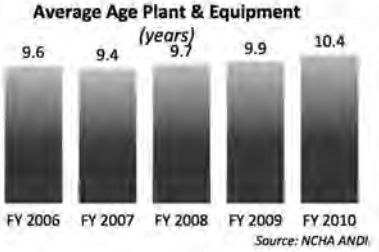
Rural


Average New Capital:Depreciation Ratio
1.199
1.012
1.035
1.009
0.811
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Source: NCHA ANDI.

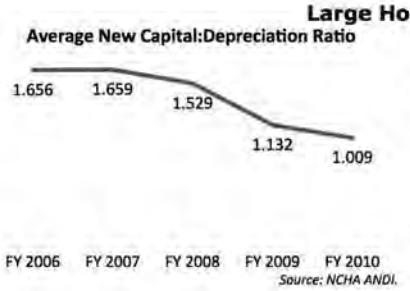
Average Non-Operating Revenue
as a percent of total revenue
2.9%
3.3%
0.3%
1.4%
3.4%
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Source: NCHA ANDI.

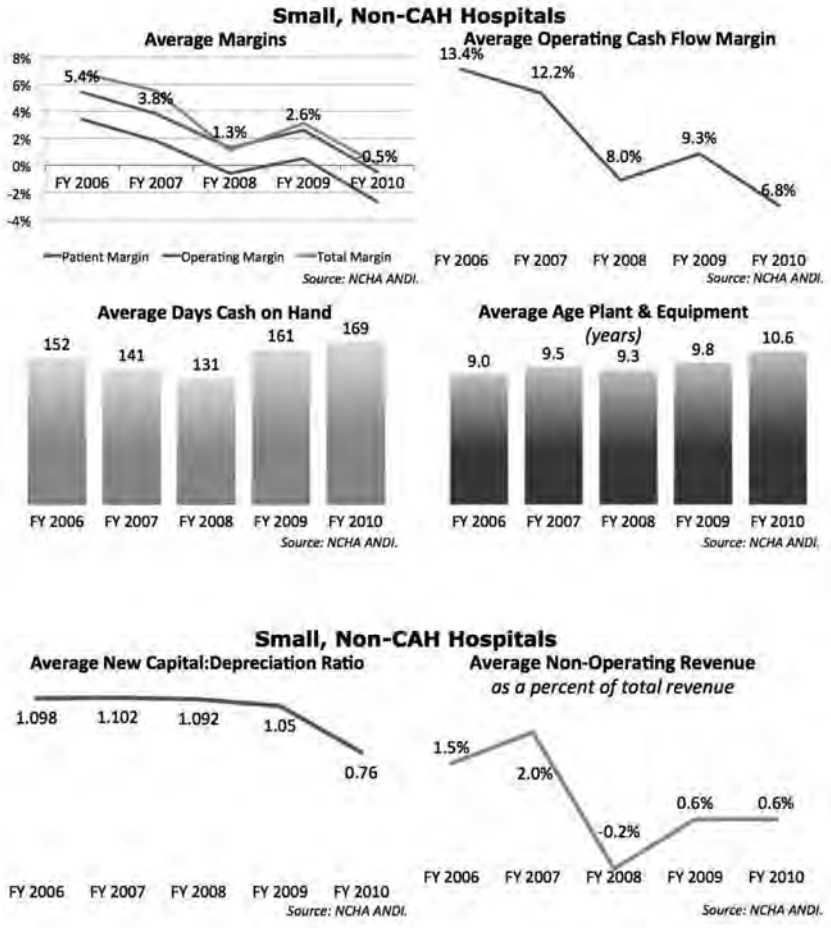
Large Hospitals





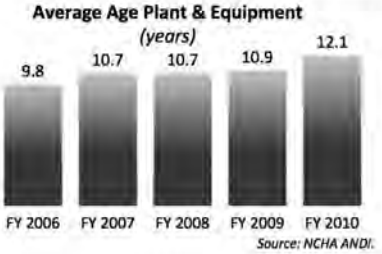
Large Hospitals



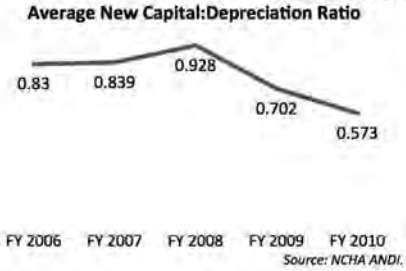

Small, Non-CAH Hospitals
Average Margins
8%
6%
4%
2%
0%
-2%
-4%
5.4%
3.8%
1.3%
2.6%
0.5%
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Patient Margin
Operating Margin
Total Margin
Source: NCHA ANDI.
Average Operating Cash Flow Margin
13.4%
12.2%
8.0%
9.3%
6.8%
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Source: NCHA ANDI.
Average Days Cash on Hand
152
141
131
161
169
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Source: NCHA ANDI.
Average Age Plant & Equipment
(years)
9.0
9.5
9.3
9.8
10.6
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Source: NCHA ANDI.

Small, Non-CAH Hospitals
Average New Capital:Depreciation Ratio
1.098
1.102
1.092
1.05
0.76
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Source: NCHA ANDI.
Average Non-Operating Revenue
as a percent of total revenue
1.5%
2.0%
-0.2%
0.6%
0.6%
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Source: NCHA ANDI.

Critical Access Hospitals

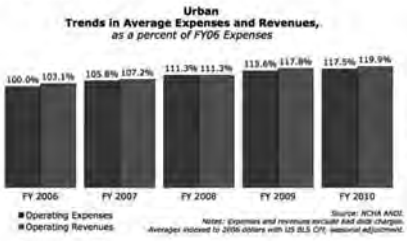


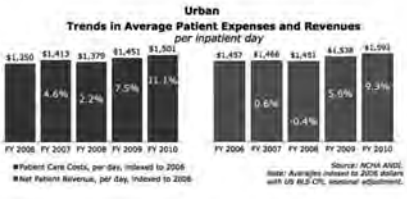
Critical Access Hospitals

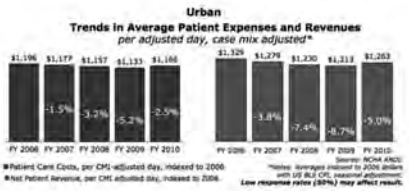


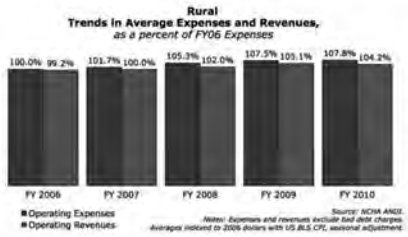
Hospital Expense and Revenue Figures

The following are the figures available that are discussed in the "Trends in Hospital Expenses and Revenues" section.

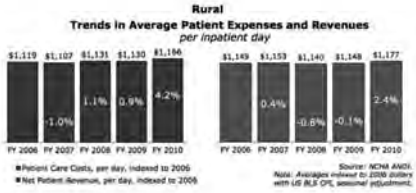






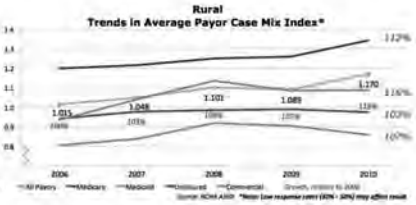

Rural
Trends in Average Expenses and Revenues,
as a percent of FY06 Expenses
100.0% 99.2%
101.7% 100.0%
105.3% 102.0%
107.5% 105.1%
107.8% 104.2%
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Operating Expenses
Operating Revenues
Source: NCHA ANDI.
Notes: Expenses and revenues exclude bad debt charges.
Averages indexed to 2006 dollars with US BLS CPI, seasonal adjustment.

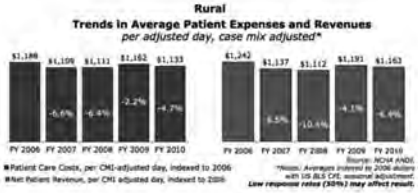
Rural Hospitals
Net Patient Revenue Payor Mix Trends for the Average Hospital
indexed to $1,000 FY 2006*
$365
$376
$371
$375
$356
$437
$433
$449
$476
$475
$127
$122
$124
$125
$132
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Other
Medicaid
Uninsured
Medicare
Commercial
Total

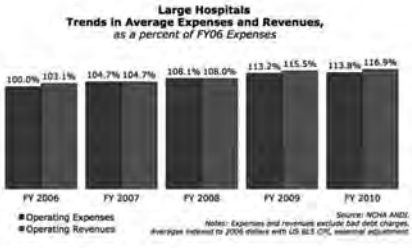

Rural
Trends in Average Patient Expenses and Revenues
per inpatient day
$1,119 $1,107 $1,131 $1,130 $1,166
-1.0%
1.1%
0.9%
4.2%
$1,149 $1,153 $1,140 $1,148 $1,177
0.4%
-0.8%
-0.1%
2.4%
FY 2006 FY 2007 FY 2008 FY 2009 FY 2010
Patient Care Costs, per day, indexed to 2006
Net Patient Revenue, per day, indexed to 2006
Source: NCHA ANDI.
Note: Averages indexed to 2006 dollars
with US BLS CPI, seasonal adjustment.

Rural Hospitals
Expense Trends for the Average Hospital
indexed to $1,000 FY 2006*
$519
$546
$560
$580
$590
$31
$32
$37
$36
$36
$369
$385
$387
$379
$370
$64
$66
$67
$68
$66
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Interest expense
Depreciation
Other expenses
Contract labor
Labor costs
Total

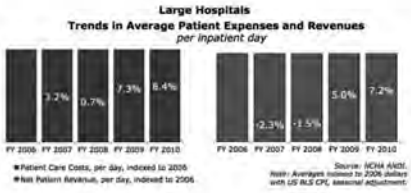
Rural
Trends in Average Patient Expenses and Revenues
per adjusted day
$1,119 $1,107 $1,131 $1,130 $1,166
-1.0%
1.1%
0.9%
4.2%
$1,149 $1,153 $1,140 $1,148 $1,177
0.4%
-0.8%
-0.1%
2.4%
FY 2006 FY 2007 FY 2008 FY 2009 FY 2010
Patient Care Costs, per adjusted day, indexed to 2006
Net Patient Revenue, per adjusted day, indexed to 2006
Source: NCHA ANDI.
Note: Averages indexed to 2006 dollars
with US BLS CPI, seasonal adjustment.


Rural
Trends in Average Payor Case Mix Index*
1.4
1.3
1.2
1.1
1.0
0.9
0.8
1.015
1.048
1.101
1.089
1.170
2006
2007
2008
2009
2010
All Payors
Medicare
Medicaid
Uninsured
Commercial

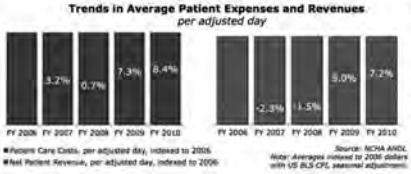

Rural
Trends in Average Patient Expenses and Revenues
per adjusted day, case mix adjusted*
$1,188 $1,199 $1,111 $1,162 $1,133
-6.6%
-6.4%
-2.2%
-4.7%
$1,242 $1,137 $1,112 $1,191 $1,163
-8.5%
-10.4%
-4.1%
-6.4%
FY 2006 FY 2007 FY 2008 FY 2009 FY 2010
Patient Care Costs, per CMI-adjusted day, indexed to 2006
Net Patient Revenue, per CMI adjusted day, indexed to 2006
Source: NCHA ANDI.
*Notes: Averages indexed to 2006 dollars
with US BLS CPI, seasonal adjustment.
Low response rates (30%) may affect result.

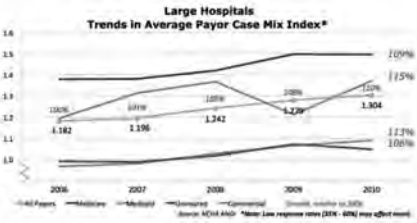

Large Hospitals
Trends in Average Expenses and Revenues,
as a percent of FY06 Expenses
100.0% 103.1%
104.7% 104.7%
108.1% 108.0%
113.2% 115.5%
113.8% 116.9%
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Operating Expenses
Operating Revenues
Source: NCHA ANDI.
Notes: Expenses and revenues exclude bad debt charges.
Averages indexed to 2006 dollars with US BLS CPI, seasonal adjustment

Large Hospitals
Net Patient Revenue Payor Mix Trends for the Average Hospital
indexed to $1,000 FY 2006*
$1,000
$1,078
$1,047
$1,120
$1,214
$430
$445
$459
$498
$481
$372
$375
$394
$432
$443
$121
$114
$124
$120
$139
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Other
Medicaid
Uninsured
Medicare
Commercial
Total
Source: NCHA ANDI.
*Notes: Year dors not sum to $1,000 to reflect relative change since 2006.
Inflation-related effects on revenues removed with US BLS CPI, seasonal adjustment.

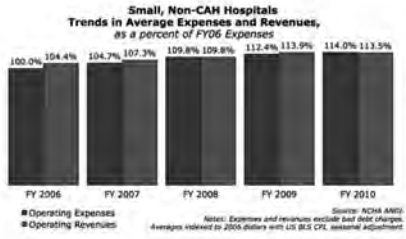

Large Hospitals
Trends in Average Patient Expenses and Revenues
per inpatient day
3.2%
0.7%
7.3%
8.4%
-2.3%
-1.5%
5.0%
7.2%
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Patient Care Costs, per day, indexed to 2006
Net Patient Revenue, per day, indexed to 2006
Source: NCHA ANDI.
Note: Averages indexed to 2006 dollars
with US BLS CPI, seasonal adjustment.

Large Hospitals
Expense Trends for the Average Hospital
indexed to FY 2006*
$1,000
$1,047
$1,081
$1,132
$1,118
$310
$547
$560
$579
$587
$23
$17
$22
$21
$21
$390
$401
$413
$440
$441
$61
$67
$67
$73
$70
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Interest expense
Depreciation
Other expenses
Contract labor
Labor costs
Total
Source: NCHA ANDI
*Note: Year does not sum to $1,000 to reflect relative change since 2006.
Inflation-related effects on revenues removed with US BLS CPI, seasonal adjustment.

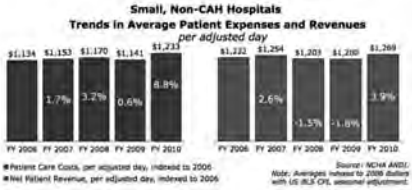

Large Hospitals
Trends in Average Patient Expenses and Revenues
per adjusted day
3.2%
0.7%
7.3%
8.4%
-2.3%
-1.5%
5.0%
7.2%
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Patient Care Costs, per adjusted day, indexed to 2006
Net Patient Revenue, per adjusted day, indexed to 2006
Source: NCHA ANDI.
Note: Averages indexed to 2006 dollars
with US BLS CPI, seasonal adjustment.


Large Hospitals
Trends in Average Payor Case Mix Index*
1.6
1.5
1.4
1.3
1.2
1.1
1.0
109%
115%
113%
108%
1.182
1.196
1.242
1.304
2006
2007
2008
2009
2010
All Payors
Medicare
Medicaid
Uninsured
Commercial
Source: NCHA ANDI
*Note: Low response rates (35% - 60%) may affect result.

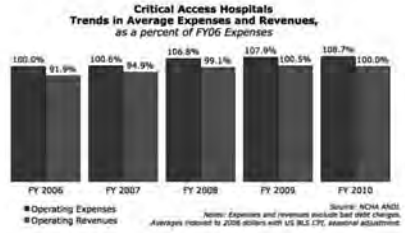
Large Hospitals
Trends in Average Patient Expenses and Revenues
per adjusted day, case mix adjusted*
$1,244
$1,182
$1,168
$1,201
$1,194
-5.0%
-6.1%
-3.3%
-4.1%
$1,354
$1,254
$1,224
$1,257
$1,264
-7.4%
-9.6%
-7.1%
-6.7%
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
Patient Care Costs, per CMI-adjusted day, indexed to 2006
Net Patient Revenue, per CMI adjusted day, indexed to 2006
Source: NCHA ANDI.
*Notes: Averages indexed to 2006 dollars
with US BLS CPI, seasonal adjustment.
Low response rates (60%) may affect result.


Small, Non-CAH Hospitals
Trends in Average Expenses and Revenues,
as a percent of FY06 Expenses
100.0% 104.4% 104.7% 107.3% 109.8% 109.8% 112.4% 113.9% 114.0% 113.5%
FY 2006 FY 2007 FY 2008 FY 2009 FY 2010
Operating Expenses
Operating Revenues
Source: NCHA ANDI.
Notes: Expenses and revenues exclude bad debt charges.
Averages indexed to 2006 dollars with US BLS CPI, seasonal adjustment.

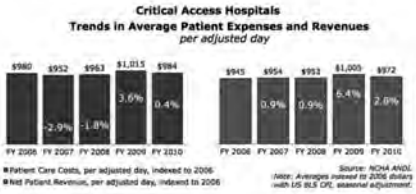
Small, Non-CAH Hospitals
Net Patient Revenue Payor Mix Trends for the Average Hospital
indexed to $1,000 FY 2006*
$411 $432 $429 $448 $440
$383 $387 $405 $423 $431
$134 $127 $125 $134 $126
FY 2006 FY 2007 FY 2008 FY 2009 FY 2010
Other
Medicaid
Uninsured
Medicare
Commerical
Total
Source: NCHA ANDI.


Small, Non-CAH Hospitals
Trends in Average Patient Expenses and Revenues
per adjusted day
$1,134 $1,153 $1,170 $1,141 $1,213
1.7% 3.2% 0.6% 6.8%
$1,222 $1,254 $1,203 $1,200 $1,269
2.6% -1.5% -1.8% 3.9%
FY 2006 FY 2007 FY 2008 FY 2009 FY 2010
Patient Care Costs, per adjusted day, indexed to 2006
Net Patient Revenue, per adjusted day, indexed to 2006
Source: NCHA ANDI.
Note: Averages indexed to 2006 dollars with US BLS CPI, seasonal adjustment.

Small, Non-CAH Hospitals
Expense Trends for the Average Hospital
indexed to $1,000 FY 2006*
$572 $564 $582 $602 $607
$24 $28 $26 $22 $20
$376 $376 $402 $416 $421
$60 $65 $70 $70 $71
FY 2006 FY 2007 FY 2008 FY 2009 FY 2010
Interest expense
Other expenses
Labor costs
Depreciation
Contract labor
Total


Critical Access Hospitals
Trends in Average Expenses and Revenues,
as a percent of FY06 Expenses
100.0% 91.9% 100.6% 94.9% 106.8% 99.1% 107.9% 100.5% 108.7% 100.0%
FY 2006 FY 2007 FY 2008 FY 2009 FY 2010
Operating Expenses
Operating Revenues
Source: NCHA ANDI.
Notes: Expenses and revenues exclude bad debt charges.
Averages indexed to 2006 dollars with US BLS CPI, seasonal adjustment.

Critical Access Hospitals
Net Patient Revenue Payor Mix Trends for the Average Hospital
indexed to $1,000 FY 2006*
$321 $341 $345 $350 $326
$498 $488 $511 $511 $547
$124 $133 $144 $149 $151
FY 2006 FY 2007 FY 2008 FY 2009 FY 2010
Other
Medicaid
Uninsured
Medicare
Commerical
Total
Source: NCHA ANDI.

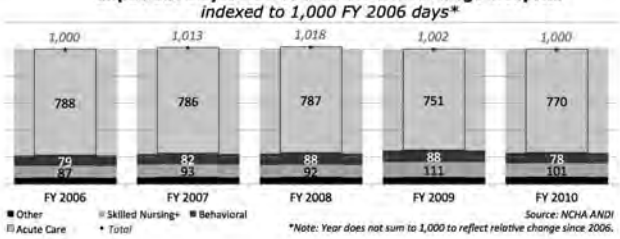

Critical Access Hospitals
Trends in Average Patient Expenses and Revenues
per adjusted day
$980 $952 $963 $1,015 $984
-2.9% -1.8% 3.6% 0.4%
$945 $954 $953 $1,005 $972
0.9% 0.9% 6.4% 2.8%
FY 2006 FY 2007 FY 2008 FY 2009 FY 2010
Patient Care Costs, per adjusted day, indexed to 2006
Net Patient Revenue, per adjusted day, indexed to 2006
Source: NCHA ANDI.
Note: Averages indexed to 2006 dollars with US BLS CPI, seasonal adjustment.

Critical Access Hospitals
Expense Trends for the Average Hospital
indexed to $1,000 FY 2006*
$501 $527 $562 $574 $573
$43 $37 $48 $47 $43
$379 $363 $381 $378 $391
$61 $63 $67 $65 $66
FY 2006 FY 2007 FY 2008 FY 2009 FY 2010
Interest expense
Other expenses
Labor costs
Depreciation
Contract labor
Total
Source: NCHA ANDI.

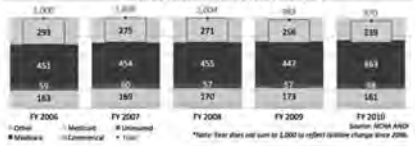
Payor Volume Figures

The following are the figures available that are discussed in the "Trends in Volume" section. Due to low response rates, no outpatient figures are available for small and critical access hospitals.

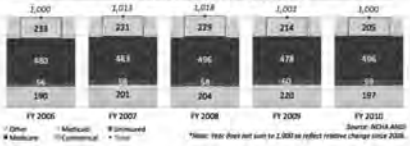
Urban Hospitals
Inpatient Days: Bed Trends for the Average Hospital
*indexed to 1,000 FY 2006 days**



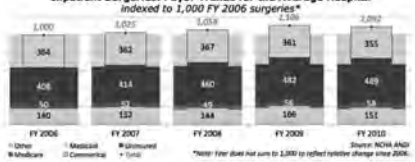
Urban Hospitals
Discharges: Payor Trends for the Average Hospital
*indexed to 1,000 FY 2006 discharges**



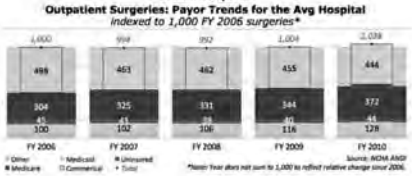
Urban Hospitals
Inpatient Days: Payor Trends for the Average Hospital
*indexed to 1,000 FY 2006 days**



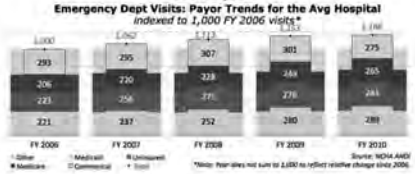
Urban Hospitals
Inpatient Surgeries: Payor Trends for the Average Hospital
*indexed to 1,000 FY 2006 surgeries**



Urban Hospitals
Outpatient Surgeries: Payor Trends for the Avg Hospital
*indexed to 1,000 FY 2006 surgeries**

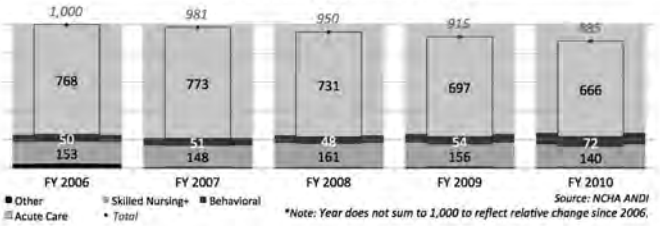


Urban Hospitals
Emergency Dept Visits: Payor Trends for the Avg Hospital
*indexed to 1,000 FY 2006 visits**

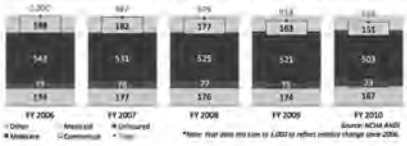


Urban Hospitals
All Outpatient Visits: Payor Trends for the Avg Hospital
*indexed to 1,000 FY 2006 visits**

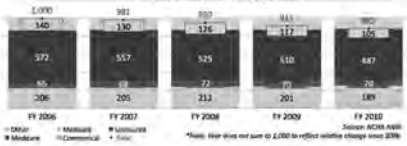
Rural Hospitals
Inpatient Days: Bed Trends for the Average Hospital
*indexed to 1,000 FY 2006 days**



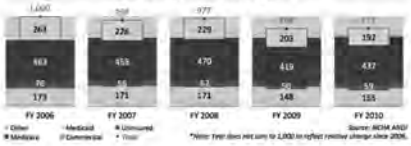
Rural Hospitals
Discharges: Payor Trends for the Average Hospital
*indexed to 1,000 FY 2006 discharges**



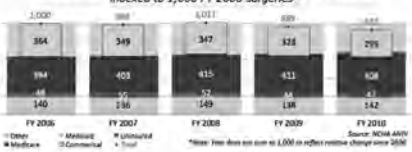
Rural Hospitals
Inpatient Days: Payor Trends for the Average Hospital
*indexed to 1,000 FY 2006 days**



Rural Hospitals
Inpatient Surgeries: Payor Trends for the Average Hospital
*indexed to 1,000 FY 2006 surgeries**

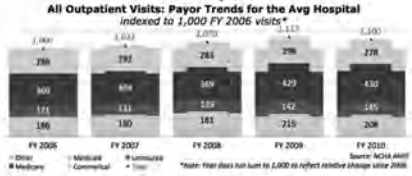


Rural Hospitals
Outpatient Surgeries: Payor Trends for the Avg Hospital
*indexed to 1,000 FY 2006 surgeries**

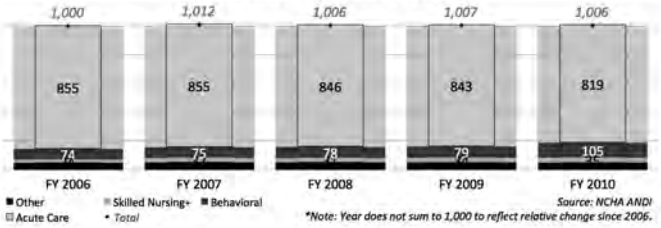


Rural Hospitals
Emergency Dept Visits: Payor Trends for the Avg Hospital
*indexed to 1,000 FY 2006 visits**

Rural Hospitals
All Outpatient Visits: Payor Trends for the Avg Hospital
*indexed to 1,000 FY 2006 visits**

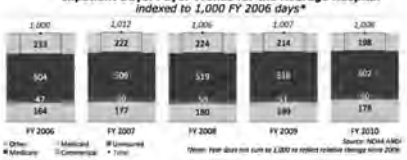


Large Hospitals
Inpatient Days: Bed Trends for the Average Hospital
*indexed to 1,000 FY 2006 days**



Large Hospitals
Discharges: Payor Trends for the Average Hospital
*indexed to 1,000 FY 2006 discharges**

Large Hospitals
Inpatient Days: Payor Trends for the Average Hospital
*indexed to 1,000 FY 2006 days**



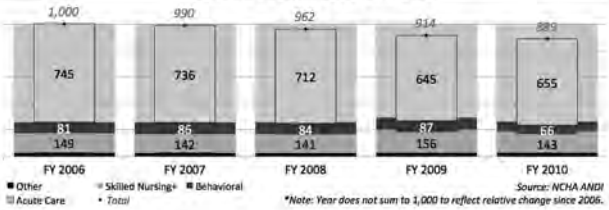
Large Hospitals
Inpatient Surgeries: Payor Trends for the Average Hospital
*indexed to 1,000 FY 2006 surgeries**

Large Hospitals
Outpatient Surgeries: Payor Trends for the Avg Hospital
*indexed to 1,000 FY 2006 surgeries**

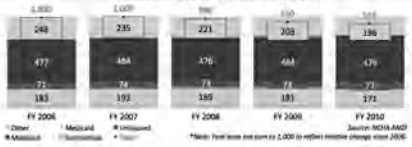
Large Hospitals
Emergency Dept Visits: Payor Trends for the Avg Hospital
*indexed to 1,000 FY 2006 visits**

Large Hospitals
All Outpatient Visits: Payor Trends for the Avg Hospital
*indexed to 1,000 FY 2006 visits**

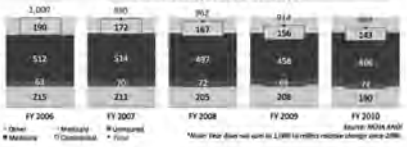
Small, Non-CAH Hospitals
Inpatient Days: Bed Trends for the Average Hospital
*indexed to 1,000 FY 2006 days**



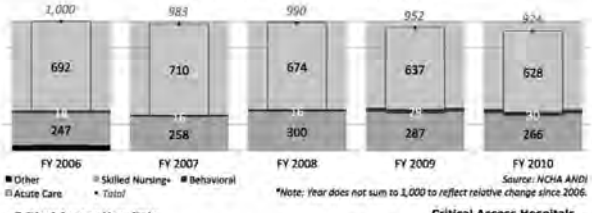
Small, Non-CAH Hospitals
Discharges: Payor Trends for the Average Hospital
*indexed to 1,000 FY 2006 discharges**



Small, Non-CAH Hospitals
Inpatient Days: Payor Trends for the Average Hospital
*indexed to 1,000 FY 2006 days**

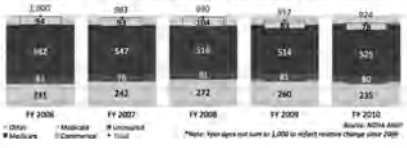


Critical Access Hospitals
Inpatient Days: Bed Trends for the Average Hospital
*indexed to 1,000 FY 2006 days**

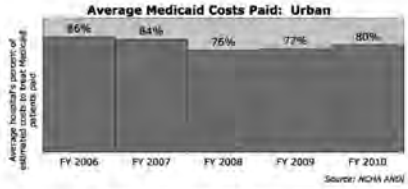


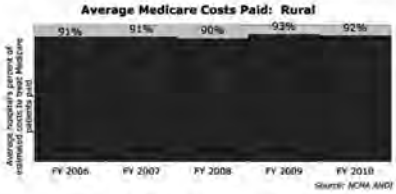
Critical Access Hospitals
Discharges: Payor Trends for the Average Hospital
*indexed to 1,000 FY 2006 discharges**

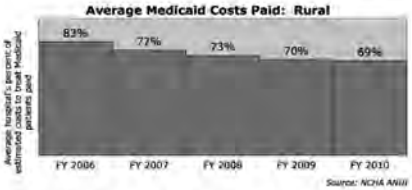
Critical Access Hospitals
Inpatient Days: Payor Trends for the Average Hospital
*indexed to 1,000 FY 2006 days**

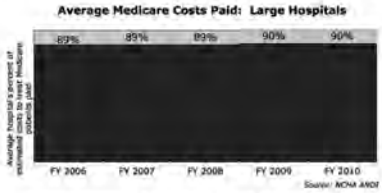


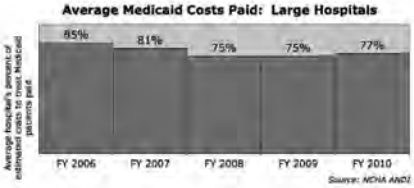
Medicare and Medicaid Reimbursement Figures

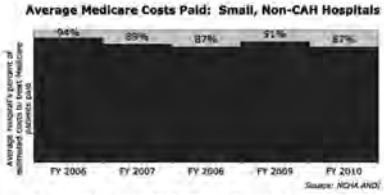


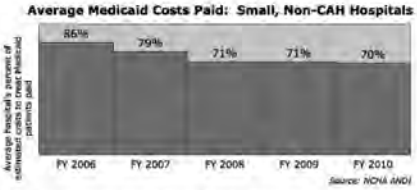


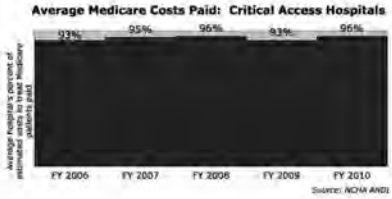


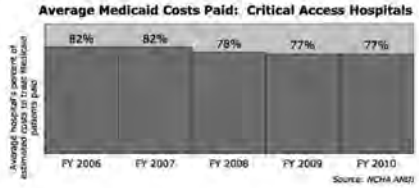






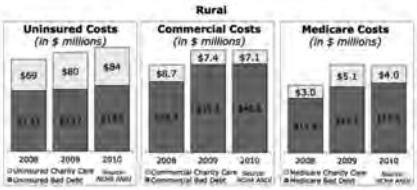


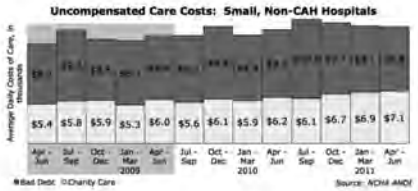




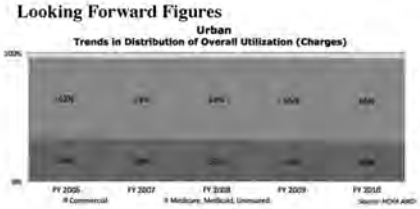
Uncompensated Care Figures

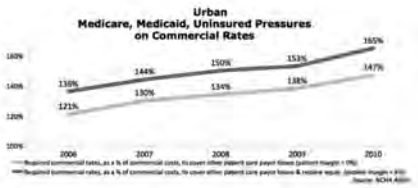
The following are the figures available that are discussed in the "Trends in Charity Care and Bad Debt" section. Due to low response rates, some figures are unavailable for small and critical access hospitals.

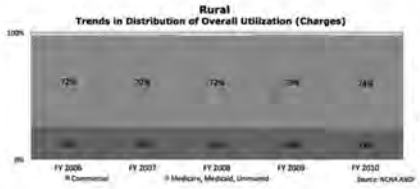


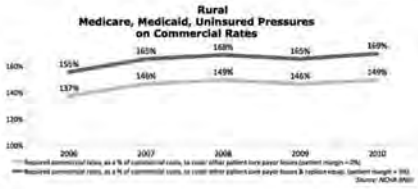


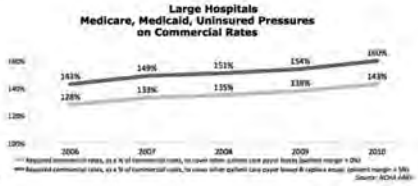
Looking Forward Figures

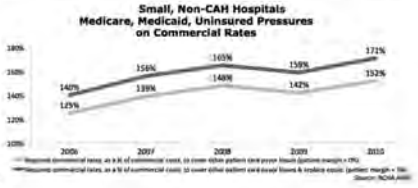


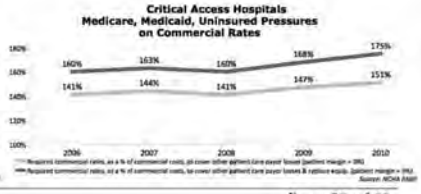












Appendix D: Measure Definitions

Overall Financial Health

Patient Margin

Full Name: Patient Margin

Definition: Patient Margin is the percent of total net patient revenues that cleared expenses, or,
(Total Net Patient Revenue - Total Operating Expenses) / (Total Net Patient Revenue)

Operating Margin

Full Name: Operating Margin

Definition: Operating Margin is the percent of total operating revenues that were cleared from operating sources, or,
(Total Net Patient Revenue** + Other Operating Revenues - Total Operating Expenses) / (Total Net Patient Revenue** + Other Operating Revenues)
**Including all Medicaid/Medicare payments.
This is the same as

$$\frac{\text{(Total Revenues - Non-Operating Revenues - Total Operating Expenses)}}{\text{(Total Revenues - Non-Operating Revenues)}}$$

Days Cash On Hand

Full Name: Days Cash On Hand

Definition: (cash & cash equivalents + LT Investment) / ((total expenses - depreciation- Bad Debt) / Days in Quarter)

Average Age of Plant (years) - Buildings and Equipment

Full Name: Average Age of Plant (years) - Buildings and Equipment

Definition: (Accumulated Depreciation * percent of the year in the survey) / Depreciation. Accounting estimate of age of capital (in years).

Operating Cash Flow Margin

Full Name: Operating Cash Flow Margin

Definition: Operating Cash Flow Margin is (Profits plus interest expense plus depreciation) divided by operating revenues. Used by Standard and Poor's for bond ratings.

New Capital Expenses to Depreciation Ratio

Full Name: New Capital Expenses to Depreciation Ratio

Definition: Percent of your capital expenses (Property, Plant and Equipment) of your depreciation expense. This gives an idea to bond issuers on how much of your capital expenses is going to replacing old capital versus expanding in to new areas.

Non-Operating Revenue *as a percent of total GASB revenues*

Full Name: Non-Operating Revenue *as a percent of total GASB revenues*

Definition: Non-Operating Revenues as a percent of all revenues. Used by Standard and Poor's for bond ratings.

Total Margin

Full Name: Total Margin

Definition: (Net Income) / (Total Revenue)

Revenues

Medicare *as a percent of Net Revenues, net of estimated bad debt*

Full Name: Medicare *as a percent of Net Revenues, net of estimated bad debt*

Definition: % All Net Revenues that is Medicare, net of estimated bad debt

Medicaid *as a percent of Net Revenues, net of estimated bad debt*	
Full Name:	Medicaid *as a percent of Net Revenues, net of estimated bad debt*
Definition:	% All Net Revenues that is Medicaid, net of estimated bad debt
Self-Pay (Uninsured) *as a percent of Net Revenues, net of estimated bad debts*	
Full Name:	Self-Pay (Uninsured) *as a percent of Net Revenues, net of estimated bad debts*
Definition:	% All Net Revenues that is Self Pay, net of estimated bad debt (Uninsured)
Commercial/Third Party *as a percent of Net Revenues, net of estimated bad debt*	
Full Name:	Commercial/Third Party *as a percent of Net Revenues, net of estimated bad debt*
Definition:	% All Net Revenues that is Commercial Payor, net of estimated bad debt
Net Patient Revenue, *as a percent of total revenues, excluding bad debt*	
Full Name:	Net Patient Revenue, *as a percent of total revenues, excluding bad debt*
Definition:	Net patient revenues, excluding bad debt (GASB definition) as a percent of all revenues, excluding bad debt
Other Operating Revenue *as a percent of total GASB revenues*	
Full Name:	Other Operating Revenue *as a percent of total GASB revenues*
Definition:	Other Operating Revenues as a percent of all revenues, excluding bad debt charges.
Non-Operating Revenue *as a percent of total GASB revenues*	
Full Name:	Non-Operating Revenue *as a percent of total GASB revenues*
Definition:	Non-Operating Revenues as a percent of all revenues. Used by Standard and Poor's for bond ratings.
Total Revenue, excluding bad debt *per $1M CY06 total expenses (GASB)*	
Full Name:	Total Revenue, excluding bad debt *per $1M CY06 total expenses (GASB)*
Definition:	Total Revenues, excluding bad debt charges, divided by calendar year 2006 total expenses. The latter controls for relative hospital size differences. This uses the GASB definition of revenues and expenses.
Operating Revenues, excluding bad debt charges *per $1M CY06 total expenses (GASB)*	
Full Name:	Operating Revenues, excluding bad debt charges *per $1M CY06 total expenses (GASB)*
Definition:	Net patient revenues, excluding bad debt, plus other operating revenues, divided by calendar year 2006 total expenses. The latter controls for relative hospital size differences. This uses the GASB definition of revenues and expenses.
Net Patient Revenue, excluding bad debt *per $1M CY06 total expenses (GASB)*	
Full Name:	Net Patient Revenue, excluding bad debt *per $1M CY06 total expenses (GASB)*
Definition:	Net patient revenues, excluding bad debt (GASB defn), per CY06 $1M total expenses (GASB)
Net Patient Revenue *(excluding bad debt)* per Inpatient Day	
Full Name:	Net Patient Revenue *(excluding bad debt)* per Inpatient Day
Definition:	Net Patient Revenue (GASB) per inpatient day. The formula is: Total Net Patient Revenue (excluding bad debt) / { Total Inpatient Days }
Net Patient Revenue *(excluding bad debt)* per Adjusted Day	
Full Name:	Net Patient Revenue *(excluding bad debt)* per Adjusted Day
Definition:	Total Net Patient Revenue (GASB) per day (adjusted to reflect outpatient volume). The Adjustment Factor is the ratio of Total Charges to Inpatient Charges. Therefore the formula is: Total Net Patient Revenue / { Inpatient Days * (Total Charges / Inpatient Charges) }
Net Patient Revenue *(excluding bad debt)* per Adjusted Day, adjusted by Case Mix Index	
Full Name:	Net Patient Revenue *(excluding bad debt)* per Adjusted Day, adjusted by Case Mix Index
Definition:	Total GASB Net Patient Revenues per day (adjusted to reflect outpatient volume and all-payor case mix differences).

Expenses

Labor costs (payroll and benefits), *as a percent of total GASB expenses*

Full Name: Labor costs (payroll and benefits), *as a percent of total GASB expenses*

Definition: Payroll and Benefits (excluding contract labor), divided by GASB expenses

Contract Labor Expenses *as a percent of total GASB expenses*

Full Name: Contract Labor Expenses *as a percent of total GASB expenses*

Definition: Total Contract Labor Expenses divided by total facility expenses (GASB).

Depreciation Expense *as a percent of total GASB expenses*

Full Name: Depreciation Expense *as a percent of total GASB expenses*

Definition: Depreciation Expense divided by total GASB Expenses

Interest Expense *as a percent of total GASB expenses*

Full Name: Interest Expense *as a percent of total GASB expenses*

Definition: Interest Expenses divided by total GASB Expenses

Other Expense *as a percent of total GASB expenses*

Full Name: Other Expense *as a percent of total GASB expenses*

Definition: Other Expense divided by total GASB Expenses

Total Expenses, excluding bad debt *per $1M CY06 total expenses (GASB)*

Full Name: Total Expenses, excluding bad debt *per $1M CY06 total expenses (GASB)*

Definition: Total expenses, less bad debt charges, per CY06 $1M total expenses (GASB)

Patient Care Cost per Inpatient Day

Full Name: Patient Care Cost per Inpatient Day

Definition: Average GASB patient care costs of an inpatient day. The formula is:
Total Operating Expenses (excluding bad debt charges) / { Inpatient Days }

Patient Care Cost per Adjusted Day

Full Name: Patient Care Cost per Adjusted Day

Definition: Average GASB patient care costs of a day (adjusted to reflect outpatient volume). The Adjustment factor is the ratio of Total Charges to Inpatient Charges. Therefore the formula is:
Total Operating Expenses (GASB)
/ { Inpatient Days * (Total Charges / Inpatient Charges) }

Patient Care Cost per Adjusted Day, adjusted by Case Mix Index

Full Name: Patient Care Cost per Adjusted Day, adjusted by Case Mix Index

Definition: Total Patient Care Expenses per inpatient day (adjusted to reflect outpatient volume and adjusted by all-payor case mix index).

Volume – Inpatient Discharges

Medicare Discharges, as a percent of all discharges

Full Name: Medicare Discharges, as a percent of all discharges

Definition: % All Discharges that are Medicare

Medicaid Discharges, as a percent of all discharges

Full Name: Medicaid Discharges, as a percent of all discharges

Definition: % All Discharges that are Medicaid

Self-Pay (Uninsured) Discharges, as a percent of all discharges

Full Name: Self-Pay (Uninsured) Discharges, as a percent of all discharges

Definition: % All Discharges that are Self-Pay (Uninsured)

Commercial Discharges, as a percent of all discharges

Full Name: Commercial Discharges, as a percent of all discharges

Definition: % All Discharges that are Commercial

Growth in total discharges from last year

Full Name: Growth in total discharges from last year

Definition: Change in Total Number of Discharges over Last Year's amount.

Volume – Inpatient Days

Percent of Inpatient Days in General Acute Care

Full Name: Percent of Inpatient Days in General Acute Care

Definition: Percent of Inpatient Days in General Acute Care

Percent of Inpatient Days in Psychiatry

Full Name: Percent of Inpatient Days in Psychiatry

Definition: Percent of Inpatient Days in Psychiatry

Percent of Inpatient Days in Adult Care, Hospice & Skilled Nursing

Full Name: Percent of Inpatient Days in Adult Care, Hospice & Skilled Nursing

Definition: Percent of Inpatient Days in Adult Care, Hospice & Skilled Nursing

Percent of Inpatient Days in Rehabilitation

Full Name: Percent of Inpatient Days in Rehabilitation

Definition: Percent of Inpatient Days in Rehabilitation

Percent of Inpatient Days in Detoxification & Substance Abuse

Full Name: Percent of Inpatient Days in Detoxification & Substance Abuse

Definition: Percent of Inpatient Days in Detoxification & Substance Abuse

Percent of Inpatient Days in All Other

Full Name: Percent of Inpatient Days in All Other

Definition: Percent of Inpatient Days in All Other

Medicare Inpatient Days *percent of all days*

Full Name: Medicare Inpatient Days *percent of all days*

Definition: % All Inpatient Days that are Medicare

Medicaid Days *percent of all inpatient days*

Full Name: Medicaid Days *percent of all inpatient days*

Definition: % All Inpatient Days that are Medicaid

Self-Pay (Uninsured) Days, as a percent of all inpatient days

Full Name: Self-Pay (Uninsured) Days, as a percent of all inpatient days

Definition: % All Inpatient Days that are Self-Pay (Uninsured)

Commercial Days *percent of all inpatient days*

Full Name: Commercial Days *percent of all inpatient days*

Definition: % All Inpatient Days that are Commercial

Change in Inpatient Days from Last Year

Full Name: Change in Inpatient Days from Last Year

Definition: Percent change in Inpatient Days over Last Year's amount.

Volume – Inpatient Surgeries

Medicare Inpatient Surgical Operations, as a percent of all inpatient surgical operations

Full Name: Medicare Inpatient Surgical Operations, as a percent of all inpatient surgical operations

Definition: % All Inpatient Surgical Operations that are Medicare

Medicaid Inpatient Surgical Operations, as a percent of all inpatient surgical operations

Full Name: Medicaid Inpatient Surgical Operations, as a percent of all inpatient surgical operations

Definition: % All Inpatient Surgical Operations that are Medicaid

Self-Pay (Uninsured) Inpatient Surgical Operations, as a percent of all inpatient surgical operations

Full Name: Self-Pay (Uninsured) Inpatient Surgical Operations, as a percent of all inpatient surgical operations

Definition: % All Inpatient Surgical Operations that are Self-Pay (Uninsured)

Commercial Inpatient Surgical Operations, as a percent of all inpatient surgical operations

Full Name: Commercial Inpatient Surgical Operations, as a percent of all inpatient surgical operations

Definition: % All Inpatient Surgical Operations that are Commercial

Growth in total inpatient surgeries *from last year*

Full Name: Growth in total inpatient surgeries *from last year*

Definition: Change from last year in total inpatient surgical operations.

Volume – EDV

Medicare ED Visits, as a percent of total ED visits

Full Name: Medicare ED Visits, as a percent of total ED visits

Definition: % All Emergency Visits that are Medicare

Medicaid ED Visits, as a percent of total ED visits

Full Name: Medicaid ED Visits, as a percent of total ED visits

Definition: % All Emergency Visits that are Medicaid

Self-Pay (Uninsured) ED Visits, as a percent of total ED visits

Full Name: Self-Pay (Uninsured) ED Visits, as a percent of total ED visits

Definition: % All Emergency Visits that are Self-Pay (Uninsured)

Commercial ED Visits, as a percent of total ED visits

Full Name: Commercial ED Visits, as a percent of total ED visits

Definition: % All Emergency Visits that are Commercial

Total ED visit growth, from last year

Full Name: Total ED visit growth, from last year

Definition: Percent change in number of total Emergency Dept Visits from last year. See U.10 definition.

Volume – Outpatient Surgeries

Medicare outpatient surgeries, as a percent of all outpatient surgeries

Full Name: Medicare outpatient surgeries, as a percent of all outpatient surgeries

Definition: % All Outpatient Surgical Operations that are Medicare

Medicaid outpatient surgeries, as a percent of all outpatient surgeries

Full Name: Medicaid outpatient surgeries, as a percent of all outpatient surgeries

Definition: % All Outpatient Surgical Operations that are Medicaid

Self-Pay (Uninsured) Outpatient Surgeries, as a percent of all outpatient surgeries

Full Name: Self-Pay (Uninsured) Outpatient Surgeries, as a percent of all outpatient surgeries

Definition: % All Outpatient Surgical Operations that are Self-Pay (Uninsured)

Commercial outpatient surgeries, as a percent of all outpatient surgeries

Full Name: Commercial outpatient surgeries, as a percent of all outpatient surgeries

Definition: % All Outpatient Surgical Operations that are Commercial

Growth in total outpatient surgical operations *from last year*

Full Name: Growth in total outpatient surgical operations *from last year*

Definition: Change from last year in total outpatient surgical operations.

Volume - Outpatient Visits

Medicare Outpatient Visits, as a percent of all outpatient visits

Full Name: Medicare Outpatient Visits, as a percent of all outpatient visits

Definition: % All Outpatient Visits that are Medicare

Medicaid Outpatient Visits, as a percent of all outpatient visits

Full Name: Medicaid Outpatient Visits, as a percent of all outpatient visits

Definition: % All Outpatient Visits that are Medicaid

Self-Pay (Uninsured) Outpatient Visits, as a percent of all outpatient visits

Full Name: Self-Pay (Uninsured) Outpatient Visits, as a percent of all outpatient visits

Definition: % All Outpatient Visits that are Self-Pay (Uninsured)

Commercial Outpatient Visits, as a percent of all outpatient visits

Full Name: Commercial Outpatient Visits, as a percent of all outpatient visits

Definition: % All Outpatient Visits that are Commercial

Change in Outpatient Visits from Last Year

Full Name: Change in Outpatient Visits from Last Year

Definition: Percent change in Outpatient Visits over Last Year's amount.

Case mix Index

All Payor Case Mix Index

Full Name: All Payor Case Mix Index

Definition: Case Mix Index for All Payor Patients

Medicare Case Mix Index

Full Name: Medicare Case Mix Index

Definition: Case Mix Index for Medicare Patients

Medicaid Case Mix Index

Full Name: Medicaid Case Mix Index

Definition: Case Mix Index for Medicaid Patients

Self-Pay (Uninsured) Case Mix Index

Full Name: Self-Pay (Uninsured) Case Mix Index

Definition: Case Mix Index for Self-Pay and Indigent Patients

Commercial Case Mix Index

Full Name: Commercial Case Mix Index

Definition: Case Mix Index for Commercial Payor Patients

Community Benefit

Percent of estimated Medicare Costs Paid*

Full Name: Estimated Pct Medicare Costs Paid*

Definition: This is the estimated payments (less any bad debt), divided by the estimated costs. It estimates the cost of care for these patients by multiplying Gross Revenue (Charges) by an AHA Cost to Charge Ratio (All Operating Costs without Bad Debt / All Charges, plus other operating revenues).

Percent of estimated Medicaid costs paid*

Full Name: Percent of estimated Medicaid costs paid*

Definition: This is the estimated payments (less any bad debt), divided by the estimated costs. It estimates the cost of care for these patients by multiplying Gross Revenue (Charges) by an AHA Cost to Charge Ratio (All Operating Costs without Bad Debt / All Charges, plus other operating revenues).

What private-pay payments, as a % of costs, **should** be to cover other patient care losses* (patient margin = 0%)

Full Name: What private-pay payments, as a % of costs, **should** be to cover other patient care losses* (patient margin = 0%)

Definition: How much private pay should pay as a percent of the costs incurred by the hospital to treat them, in order for the hospital to break even. Private pay must pick up the tab of patients for which the hospital is underpaid or not at all paid. In other words, Medicare losses, Medicaid losses, Charity care and bad debt.

What private-pay payments, as a % of costs, **should** be to cover other patient care losses* (patient margin = 5%)

Full Name: What private-pay payments, as a % of costs, **should** be to cover other patient care losses* (patient margin = 5%)

Definition: How much private pay should pay as a percent of the costs incurred by the hospital to treat them, in order for the hospital to earn a 5% patient margin. Private pay must pick up the tab of patients for which the hospital is underpaid or not at all paid. In other words, Medicare losses, Medicaid losses, Charity care and bad debt.

Commercial Gross Revenue (Charges), as a percent of Total Gross Revenue

Full Name: Commercial Gross Revenue (Charges), as a percent of Total Gross Revenue

Definition: % All Gross Revenue that is Commercial

Medicare, Medicaid and Uninsured *as a percent of Gross Revenues (Charges)*

Full Name: Medicare, Medicaid and Uninsured *as a percent of Gross Revenues (Charges)*

Definition: Percent of all gross revenue (charges) by patients with a primary payor of one of these categories: Medicare, Medicaid, Uninsured

Estimated Daily Costs of Providing Charity Care

Full Name: Estimated Daily Costs of Providing Charity Care

Definition: This is charity care charges reduced to costs via the AHA Cost-to-charge ratio, divided by the number of days in the survey period.

Daily Costs of Bad Debt Care, using AHA CCR formula

Full Name: Daily Costs of Bad Debt Care, using AHA CCR formula

Definition: Bad debt charges reduced to costs using the AHA CCR, divided by the number of days in the period.

Measures Totaled for North Carolina

New Capital Expenditures

Full Name: New Capital Expenditures

Definition: New purchases of property, plant or equipment.

Estimated Costs of Medicare Bad Debt

Full Name: Estimated Costs of Medicare Bad Debt

Definition: What are the costs (to the hospital) of the services associated with bad debt from Medicare Patients? Costs are estimated using the AHA's cost-to-charge ratio, applied to the proportion of all bad debt that is from patients with Medicare.

Estimated Costs of Self-Pay (Uninsured) Bad Debt

Full Name: Estimated Costs of Self-Pay (Uninsured) Bad Debt

Definition: What are the costs (to the hospital) of the services associated with bad debt from Uninsured Patients? Costs are estimated using the AHA's cost-to-charge ratio, applied to the proportion of all bad debt that is from patients with no insurance.

Estimated Costs of Commercial Insurance Bad Debt

Full Name: Estimated Costs of Commercial Insurance Bad Debt

Definition: What are the costs (to the hospital) of the services associated with bad debt from Commercial Insurance Patients? Costs are estimated using the AHA's cost-to-charge ratio, applied to the proportion of all bad debt that is from patients with Commercial Insurance.

Estimated Costs of Medicare Charity Care

Full Name: Estimated Costs of Medicare Charity Care

Definition: What are the costs (to the hospital) of the services associated with charity care from Medicare Patients? Costs are estimated using the AHA's cost-to-charge ratio, applied to the proportion of all charity care that is from patients with Medicare.

Estimated Costs of Self-Pay (Uninsured) Charity Care

Full Name: Estimated Costs of Self-Pay (Uninsured) Charity Care

Definition: What are the costs (to the hospital) of the services associated with charity care from Uninsured Patients? Costs are estimated using the AHA's cost-to-charge ratio, applied to the proportion of all charity care that is from patients with no insurance.

Estimated Costs of Commercial Insurance Charity Care

Full Name: Estimated Costs of Commercial Insurance Charity Care

Definition: What are the costs (to the hospital) of the services associated with charity care from Commercial Insurance Patients? Costs are estimated using the AHA's cost-to-charge ratio, applied to the proportion of all charity care that is from patients with Commercial Insurance.

Total Discharges

Full Name: Total Discharges

Definition: Total Number of Discharges.

All Inpatient Days

Full Name: All Inpatient Days

Definition: Total Number of Inpatient Days.

Inpatient Surgical Operations

Full Name: Inpatient Surgical Operations

Definition: Total Number of Inpatient Surgical Operations.

Total outpatient surgeries

Full Name: Total outpatient surgeries

Definition: Number of outpatient visits that were outpatient surgeries.

Outpatient Emergency Department Visits

Full Name: Outpatient Emergency Department Visits

Definition: Number of Emergency Department Outpatient Visits

Outpatient Visits

Full Name: Outpatient Visits

Definition: Number of total outpatient visits

Total Expenses, excluding bad debt

Full Name: Total Expenses, excluding bad debt

Definition: Total Expenses, less bad debt charges. GASB total expenses.

Total Operating Revenue (GASB)

Full Name: Total Operating Revenue (GASB)

Definition: Patient net revenues plus other operating revenues, less bad debt charges

Distribution Statistics

Percent of hospitals with Operating Margins 5% or higher

Full Name: Percent of hospitals with Operating Margins 5% or higher

Definition: The average represents the percent of hospitals in the chosen group with an operating margin >= 5%

Percent of hospitals with Operating Margins 0% to 5%

Full Name: Percent of hospitals with Operating Margins 0% to 5%

Definition: The average represents the percent of hospitals in the chosen group with an operating margin 0% to 5%. While positive, these margins are still unhealthy because they prohibit the hospital from upgrading or replacing existing technologies and capital equipment.

Percent of hospitals with negative Operating Margins

Full Name: Percent of hospitals with negative Operating Margins

Definition: The average represents the percent of hospitals in the chosen group with an operating margin < 0%. These hospitals are not able to meet all their expenses with their operating revenues. They are relying on investments to cover daily expenses.

UNIVERSITY OF OREGON
Eugene, Oregon

OREGON

OREGON LAW REVIEW

2011

VOLUME 89
NUMBER 3

The Affordable Care Act and Competition Policy: Antidote or Placebo?

Thomas L. Greaney

Reprinted from
OREGON LAW REVIEW
Volume 89, Number 3
Copyright © 2011, University of Oregon

THOMAS L. GREANEY*

The Affordable Care Act and Competition Policy: Antidote or Placebo?

I. Health Care: Regulation, Deregulation, and Reregulation 813
II. The Case for Competition-Fostering Regulation 817
A. Economic Theory: Coping with Market Failure in Health Care 817
B. Structure and Performance 821
III. The Affordable Care Act: An Antidote to Market Imperfections 825
A. Payment and Insurance Reforms 826
B. Delivery System Reform 832
IV. Obstacles to Inducing Improved Competitiveness in Health Care Markets 836
A. Regulation: Not Too Much but Not Too Little? 836
B. Concentrated Markets and Entry Barriers 839
V. ACOs May Be the Answer, but What Is the Question? 843
Conclusion 845

In the run-up to its enactment, the Patient Protection and Affordable Care Act (ACA)[1] elicited howls of protest from opponents who claimed the federal government was taking over the American

* Chester A. Myers Professor of Law and Co-Director, Center for Health Law Studies, Saint Louis University School of Law. This Article grew out of the American Antitrust Institute's 11th Annual Conference, *Are the Boundaries Between Public and Private in Transition?* Many thanks to the AAI and Bert Foer for focusing national attention on antitrust policy.

[1] Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

healthcare system, micromanaging medicine, and generally exposing the nation to the bête noire of socialized medicine.[2] Hyperbole, misrepresentation, and chauvinism aside,[3] these sound bites suffer from a deeper flaw: they mischaracterize the fundamental thrust of the new law. Though the ACA establishes significant new regulatory authority, this is not a new development (indeed it can be faulted for preserving pre-existing regulatory regimes), nor does it impair market competition. To the contrary, much of the law aims at improving conditions conducive to effective competition. With numerous programs designed to correct perverse incentives in the payment system, to mitigate market imperfections, and to make the delivery system responsive to market signals, the ACA might well be rechristened as the "Accommodation of Competition Act."

That said, it is far from clear that market competition will work out as scripted by theorists and proponents of the new law. Myriad market imperfections still complicate market interactions, and regulations need to be carefully tailored to assure effective implementation and to minimize unintended consequences. Of even greater concern are the problematic market structures that pervade provider and payer markets. Concentration, embedded practices, and professional norms may cause markets to operate suboptimally even

---

[2] *See, e.g.*, Jim Meyers, *Kit Bond: Obamacare's Financial Cost to States Will Be 'Horrific,'* NEWSMAX.COM (Mar. 22, 2010), http://www.newsmax.com/Headline/bond-healthcare-states-mandates/2010/03/22/id/353529 (quoting Republican Senator Kit Bond stating that passage of the health care reform bill sets the stage for turning the United States into a socialist country); SenJimDeMint, *DeMint Speech Against Socialized Medicine*, YOUTUBE (Sept. 28, 2007), http://www.youtube.com/watch?v=9RPOwGTv6uQ ("[W]e're turning this country into a socialistic style of government taking away peoples' freedom. . . . This is a decision to become more like socialized Europe to sell out our freedoms to give government control of our health care."). Such claims are not new. Speaking against an early version of the Medicare legislation in 1962, Ronald Reagan warned, "One of the traditional methods of imposing statism or socialism on a people has been by way of medicine. It's very easy to disguise a medical program as a humanitarian project." Wyattmcintyre, *Ronald Reagan Speaks Out Against Socialized Medicine*, YOUTUBE (Aug. 1, 2007), http://www.youtube.com/watch?v=fRdLpem-AAs&playnext=1&list=PL52AA90A05E7AE899.

[3] Leading in the hyperbole department was Rush Limbaugh. *See* Pharmacist, *Rush Limbaugh Quotes on Obamacare*, HUBPAGES, http://hubpages.com/hub/Rush-Limbaugh-Quotes-on-Obamacare (last visited Mar. 24, 2011) ("America is hanging by a thread," and "[President Obama's] desire is to have as many people on federal dependency as possible."). Less than temperate assessments could be heard on the floor of the Senate as well, such as Senator Tom Coburn's statement, "[to] our seniors . . . I have a message for you: [if the health care bill passes] you're gonna die sooner." MediaMattersAction, *Sen. Coburn's Message to Seniors: "You're Going to Die Sooner,"* YOUTUBE (Dec. 1, 2009), http://www.youtube.com/watch ?v=B_U1mQF9ZCw.

if reform is implemented smoothly. Finally, the ACA's effectiveness in achieving its goals depends on the executive branch's maintaining a steady hand in countless regulatory determinations. This Article surveys some of the misconceptions about health reform and the challenges proponents confront in realizing their goals.

I

HEALTH CARE: REGULATION, DEREGULATION, AND REREGULATION

Regulation in one form or another has long guided the development of health care markets in the United States. In certain respects, government regulation and private self-regulation have worked hand in hand. For many years, a "professional paradigm" prevailed, under which physicians effectively controlled payment systems, health care institutions, and conditions of entry.[4] Physician norms, ethical codes, and rules governing behavior in payment and delivery settings effectively established a system of self-regulation. These institutional and social structures found support in legal regimes that reinforced their authority. For example, laws exempting hospitals from federal and state taxation provided physicians access to free capital and enabled them to exercise control over the operations of those organizations.[5] Licensure, accreditation, and certificate of need (CON) laws reduced supply, limited rivalry, and set terms governing the conditions of competition in the professions and among hospitals.[6] Numerous other laws and conditions of payment have

---

[4] The seminal work on professional dominance is PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982). *See also* CARL F. AMERINGER, THE HEALTH CARE REVOLUTION: FROM MEDICAL MONOPOLY TO MARKET COMPETITION (2008) (tracing evolution in law and norms leading to market-based health policy).

[5] *See* Robert Charles Clark, *Does the Nonprofit Form Fit the Hospital Industry?* 93 HARV. L. REV. 1416 (1980).

[6] *See* ROBERT I. FIELD, HEALTH CARE REGULATION IN AMERICA: COMPLEXITY, CONFRONTATION, AND COMPROMISE 19–40 (2007) (describing the scope and history of regulation of professionals); *id.* at 41–73 (discussing regulation of hospitals and other institutions); *see also* James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1470 (1994) (concluding that the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (now called the Joint Commission)—which are given deemed status for hospital certification under Medicare—"institutionalize physician autonomy within hospitals by requiring that the medical staff have an independent organization and structure").

served to cement professional judgments and limit consumers' abilities to make desired trade-offs between costs and benefits.[7]

To be sure, legal doctrine has also directly shaped the development of health care organizations and reimbursement. The rapid expansion of hospitals following World War II is in part attributable to the Hill Burton Act, which provided $3.7 billion in funding between 1947 and 1971 for hospital construction and imposed important and long-lasting obligations to provide charity care on grant recipients.[8] Perhaps most significantly, in setting the conditions for reimbursement under Medicare and Medicaid, the federal government has exerted significant control over the structure of provider organizations, their internal operations, and the nature and volume of services that are provided.[9] States have wide authority to regulate hospitals under the police power, and they exercise that authority through licensure, which imposes specific operational, clinical, and administrative requirements on practitioners. The era of regulation reached its zenith in 1974 with the National Health Resources Planning and Development Act, which sought to develop standards for controlling the supply, distribution, and organization of health resources, especially acute care hospitals.[10] That law created incentives for states to establish state health planning and development agencies to adopt health-planning strategies and to enact CON laws to assure an appropriate distribution of resources pursuant to the state plan.[11] Although the federal planning law was repealed in 1986, thirty-six states continue to operate CON regulatory schemes that require prior approval for various undertakings, such as new hospital construction or expansion and significant capital investments.[12] During this era, over thirty states also engaged in

---

[7] *See* Symposium, *Who Pays? Who Benefits? Distributional Issues in Health Care*, 69 LAW & CONTEMP. PROBS., Autumn 2006, at 1.

[8] *See* FIELD, *supra* note 6, at 56–57.

[9] *See id.* at 58–60 (describing the "profound effect" on hospitals of Medicare's change to prospective payment); *id.* at 34 (oversight authority of Centers for Medicare and Medicaid Services "effectively makes Medicare another arbiter of physician quality").

[10] National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975) (repealed 1987).

[11] 1 BARRY R. FURROW ET AL., HEALTH LAW 32–36 (2d ed. 2000). Prior approval by a state agency empowered to issue a CON was required for all new institutional health services (e.g., hospitals, nursing homes, and ambulatory surgery centers) and for all capital expenditures in excess of $150,000. *Id.*

[12] *Certificate of Need: State Health Laws and Programs*, NAT'L CONFERENCE OF STATE LEGISLATURES (Jan. 28, 2010), http://www.ncsl.org/IssuesResearch/Health/CONCertificateofNeedStateLaws/tabid/14373/Default.aspx.

direct regulation of hospital rates, many using prospective payment methodologies to assert control over explosive growth in costs attributable to fee-for-service payments.[13]

Regulation of private insurance has long been the province of the states, which typically exercise control over capitalization, solvency, mandated services and providers, marketing, and claims processing, but states generally do not engage in direct rate regulation.[14] However, federal authority over private insurance has also been exercised on numerous occasions. The Health Maintenance Organization (HMO) Act of 1973 required employers offering health insurance to include an HMO in the options offered to employees, and it provided subsidies for HMOs that met detailed standards regarding coverage, physician networks, and patient appeals.[15] Over the last twenty years, the federal government has expanded its role, requiring insurers to offer coverage in certain circumstances[16] and placing specific requirements on their handling of information and new technology.[17] Significant legal regimes, including fraud and abuse laws, false claims laws, and the Stark law, emerged as necessary to police abuse arising from the perverse incentives of fee-for-service medicine.[18] Likewise, the prevalence of tax-exempt institutions delivering health care services gave rise to a large body of federal and state law that governs the charitable practices of those institutions and restricts diversion of their assets to private interests. In the 1990s, states responded to perceived abuses and consumer dissatisfaction with managed care by unleashing a new wave of regulations that

---

[13] *See* John E. McDonough, *Tracking the Demise of State Hospital Rate Setting*, 16 HEALTH AFF. 142, 142 (1997).

[14] *See* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 654 (6th ed. 2008).

[15] 42 U.S.C. § 300e-9 (2006).

[16] Omnibus Budget and Reconciliation Act (OBRA) of 1986, Pub. L. No. 99-509, 100 Stat. 1874. Congress required temporary continuation of group health coverage for employees who lose coverage through termination of employment. *See* FURROW ET AL., *supra* note 14, at 751–52.

[17] The Health Insurance Portability and Accountability Act (HIPAA) of 1996, Pub. L. No. 104-191, 110 Stat. 1936, established minimum federal standards and requirements concerning guaranteed issue and renewability of health coverage, prohibited discrimination based on health factors, and limited disclosure of personal information. With the OBRA of 1986, Congress required continuation of group health coverage under certain circumstances. *See* FURROW ET AL., *supra* note 14.

[18] These laws share a common purpose of curbing incentives for providers to bill, refer, and practice medicine in a manner that serves their own interests to the detriment of consumer welfare. *See generally* FURROW ET AL., *supra* note 14, at 1023–94.

provided patients rights of appeal and other processes, that mandated coverage of specific services and inclusion of certain providers, and that regulated many other aspects of managed care.[19] The federal-state regulatory borders have frequently been a source of conflict. Significantly, federal law preempts much state regulation that would apply to self-insured employers, essentially creating a dual regulatory system in which state regulation imposes stringent limitations on some plans while others enjoy what has come to be known as a regulatory "vacuum."[20]

Thus, regulation of health care providers and payers historically has been something of a roller coaster ride. The era of self-regulation (supported by government deference and facilitating law) lasted until the 1970s when direct intervention became more common. State and federal governments stepped up their efforts to control costs and restrict the supply of health resources, but they never fully supplanted private markets. As dissatisfaction with "command-and-control" regulation grew in the 1980s, what came to be known as the "competitive revolution" began, and antitrust laws helped depose private regulatory regimes while CON statutes and other laws were repealed or fell into disuse.[21] Again, however, this "revolution" never amounted to a coup d'état. Government supervision of providers under Medicare and Medicaid payment policies intensified, and laws necessary to encourage managed care as envisioned by its principal theorists[22] never were adopted. A counterrevolution ensued as public dissatisfaction with managed care and the defeat of the Clinton administration health reforms (which ironically fell victim to perceptions of being overly regulatory but in fact relied heavily on managed care theory) signaled to politicians and insurers that it was time to back off managing care. Numerous laws and judicial interpretations restricted managed care, as a "managed care backlash"

---

19 *See* Mark A. Hall, *The Death of Managed Care: A Regulatory Autopsy*, 30 J. HEALTH POL. POL'Y & L. 427 (2005); Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365 (2003).

20 *See* Andrew L. Oringer, *A Regulatory Vacuum Leaves Gaping Wounds—Can Common Sense Offer a Better Way to Address the Pain of ERISA Preemption?*, 26 HOFSTRA LAB. & EMP. L.J. 409 (2008).

21 *See* Clark C. Havighurst, *How the Health Care Revolution Fell Short*, 65 LAW & CONTEMP. PROBS., Autumn 2002, at 55.

22 *E.g.*, Alain C. Enthoven, *Employment-Based Health Insurance Is Failing: Now What?*, 28 HEALTH AFF. WEB EXCLUSIVE w3-237, *available at* http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.237v1/DC1.

imposed regulatory obstacles that impeded the market-based approach to health care.

What messages might be gleaned from the ebb and flow of regulatory activity? The nation has been ambivalent about the role of competition in health care but, at the same time, has resisted command-and-control regulation, at least to the extent that such regulation was apparent to it. While policy makers have broadly endorsed market-based approaches, they have been reluctant to provide the legal infrastructure necessary for effective competition and have cluttered the landscape with a maze of complex and conflicting laws and regulations.

II
THE CASE FOR COMPETITION-FOSTERING REGULATION

Justification for regulation to promote competition can be found in virtually every economic analysis of health care. Markets for providing and financing health care are beset with myriad market imperfections: inadequate information, agency, moral hazard, monopoly, and selection in insurance markets that greatly distort markets. Add to that governmental failures—for example, payment systems that reward intensity and volume but not accountability for resources or outcomes, restrictions on referrals that impede efficient cooperation among providers, and entry impediments in the form of licensure and CON—and toss in a strain of professional norms that are highly resistant to marketplace incentives, and you have the root causes of our broken system.

A. Economic Theory: Coping with Market Failure in Health Care

Since Kenneth Arrow's seminal 1963 essay,[23] economic analyses have properly focused on the significant market failures that beset health care markets. Arrow's principal culprits, "uncertainty in the incidence of disease and in the efficacy of treatment," information asymmetries between patient and physician, and the "nonmarketability of the bearing of suitable risks" still collude to prevent optimal resource allocation.[24] Though differing to some

[23] Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

[24] *Id.* at 947 ("The failure of one or more of the competitive preconditions has as its most immediate and obvious consequence a reduction in welfare below that obtainable

extent in the severity to which they attach individual failures and the extent to which social institutions may rectify problems, health economists uniformly stress that information, agency, and insurance vastly complicate applying microeconomic principles to analyze the welfare effects of transactions or policy changes.[25] While the causes of market failure may be defined in several ways,[26] four factors appear to have the greatest impact: information deficits, product differentiation, agency relationships, and insurance market imperfections.

First, asymmetrics in information and uncertainty as to diagnosis, treatment, and outcome are critical to understanding the health care marketplace. A variety of circumstances undermine the neoclassical assumption that buyers and sellers possess adequate information to assess the quality and costs of the services provided. Because of the technical nature of medical information and the complexity of diagnoses and treatment alternatives, patients and third-party payers find it difficult to evaluate the cost and quality of health services. Indeed, the considerable uncertainty that attends medical treatment makes judgments on causation (and hence costs and benefits of the treatment) difficult. In addition, information is asymmetrically distributed among providers, patients, and payers. This characteristic may permit physicians to induce demand for their services, and at a minimum, it makes information costly for buyers to acquire.[27]

---

from existing resources and technology, in the sense of a failure to reach an optimal state in the sense of Pareto.").

[25] A leading text summarizes market failure in health care as follows:

> Health markets fail to satisfy the substantial list of requirements that must be met to be classified as perfectly competitive: large numbers of consumers and firms, free entry and exit, marketability of all goods and services including risk, symmetric information with zero search costs, and no increasing returns, externalities, or collusion. While health markets satisfy none of these requirements fully, they fail the requirements of symmetric information, zero search costs, and the marketability of all products most dramatically.

David Dranove & Mark A. Satterthwaite, *The Industrial Organization of Health Care Markets*, *in* 1 HANDBOOK OF HEALTH AND ECONOMICS 1093, 1095 (A.J. Culyer & J.P. Newhouse eds., 2000).

[26] *Id.*; *see also* THE CONCISE ENCYCLOPEDIA OF ECONOMICS 235, 235–41 (David R. Henderson ed., 2008); PAUL J. FELDSTEIN, HEALTH CARE ECONOMICS 468–74 (5th ed. 1999).

[27] Although the phenomenon of demand inducement has generated considerable debate over its extent and definition, economists broadly concur that physicians exert their power to supply services beyond the level that would be demanded by fully informed consumers. *See* Henry J. Aaron, *To Find the Answer, One Must Know the Question: Health Economics and Public Policy*, *in* INCENTIVES AND CHOICE IN HEALTH CARE 21, 30 (Frank A. Sloan

Second, product differentiation among physicians and hospitals along a number of dimensions is widely recognized.[28] Hospitals vary widely based on quality, reputation, geographic location, amenities, and other features. Likewise, physicians are differentiated by their training, reputations, locations, hospital affiliation, and many other aspects. On the demand side, the heterogeneous preferences of consumers are manifest, with varying preferences or "tastes" for travel, amenities, reputation, and "caring" service. These preferences interact with heterogeneous product characteristics in health services to contribute to reducing substitutability among providers of essentially the same services.[29] The quality of services sold by health care providers also may vary considerably, depending upon the professionals' talents, training, attention to interpersonal relationships, communication skills, and other factors. Product differentiation that grows out of the heterogeneity of consumer preferences is a source of market power in health services markets.[30] Finally, sellers of health services are subject to impediments to mobility, both in the form of regulatory entry barriers imposed by governmental licensure and private certification and practice requirements and in the form of switching costs, such as those resulting from steep learning curves and changing technology.

Third, agency relationships, which pervade health markets, are highly influential in health care transactions.[31] A large majority of consumers (patients) purchase health care through multiple agents—

& Hirschel Kasper eds., 2008) ("[I]f physicians are willing to do more of certain things when paid well to do them, it is hard to see why the idea that physicians might induce demand was ever controversial.").

[28] *See* Martin Gaynor & William B. Vogt, *Antitrust and Competition in Health Care Markets*, *in* 1 HANDBOOK OF HEALTH ECONOMICS, *supra* note 25, at 1405, 1410–12. *See generally* Seth Sacher & Louis Silvia, *Antitrust Issues in Defining the Product Market for Hospital Services*, 5 INT'L J. ECON. BUS. 181 (1998).

[29] *See* Gaynor & Vogt, *supra* note 28, at 1411.

[30] *See id.*

> It is th[e] combination of a heterogeneous product with heterogeneous preferences which is key. . . . [T]his bestows the seller with market power. Patients choose sellers who produce the type of services and have characteristics which best match their preferences. The fact that patients choose sellers who give them the highest utility gives sellers market power, since switching to another seller will reduce a patient's utility.

Id.; *see also* Mark A. Satterthwaite, *Consumer Information, Equilibrium Industry Price and the Number of Sellers*, 10 BELL J. ECON. 483 (1979).

[31] Lawrence Casalino, *Managing Uncertainty: Intermediate Organizations as Triple Agents*, 26 J. HEALTH POL. POL'Y & L. 1055, 1055–57 (2001).

their employers, the plans or insurers chosen by their employers, and the physicians who guide patient choice through referrals and the selection of treatment modalities. For most consumers, choice is limited to a small number of plans; most small employers offer only one plan, and large employers rarely offer more than three.[32] The number of plans and benefits offered by each employer is strongly affected by the possibility of risk selection and the employer's transaction costs in administering health plan coverage. Thus, to some extent, the employer acts as an agent for its employees in purchasing health insurance by choosing plans that afford the mix of quality, price, and geographic coverage that best suits most of its employees. This multiplicity of agents greatly complicates antitrust analyses of consumer behavior and is a principal source of market failure in health care.[33]

Health insurance markets also exhibit conditions that give rise to market failures. Moral hazard, for example, refers to the overuse of medical care resulting from the fact that insurance lowers the cost of each purchase for insureds. Overuse causes inefficiency, as insured individuals purchase more services than they would if they had to bear the entire cost; hence, true marginal costs exceed marginal benefits.[34] Risk selection also may undermine health insurance markets. That is, insurers have strong incentives to seek a favorable, or low-risk, pool of insureds. Acting on that incentive can cause an unraveling of risk spreading as the sick and the healthy become divided into different market segments.[35] By the same token, adverse selection may occur as patients switch plans and adjust coverage according to anticipated needs.

---

[32] *See* Alain Enthoven, *Managed Competition of Delivery Systems*, 13 J. HEALTH POL. POL'Y & L. 305 (1988).

[33] *See* Casalino, *supra* note 31, at 1061–62. Gaynor and Vogt summarize the multiple agent relationship: "In practice hospital choice is a complex combination of the consumer's choice of health plan, the health plan's choice of providers to contract with, the consumer's choice of physician, and the consumer-physician-health plan choice of whether and where to admit the consumer." Gaynor & Vogt, *supra* note 28, at 1431.

[34] Seminal contributions on moral hazard are by Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531 (1968), and Mark V. Pauly, *Overinsurance and Public Provision of Insurance: The Roles of Moral Hazard and Adverse Selection*, 88 Q.J. ECON. 44 (1974). Analysts question the extent and welfare effects of moral hazard in health care. *See, e.g.*, John A. Nyman, *The Economics of Moral Hazard Revisited*, 18 J. HEALTH ECON. 811 (1999); *see also* Malcom Gladwell, *The Moral-Hazard Myth*, NEW YORKER, Aug. 29, 2005, at 44.

[35] *See* David M. Cutler & Sarah J. Reber, *Paying for Health Insurance: The Trade-off Between Competition and Adverse Selection*, 113 Q.J ECON. 433, 434 (1998).

B. Structure and Performance

Turning to the structure and performance of health care markets, one finds additional evidence that conditions precedent for effective competition are lacking and that markets have fallen short of advancing consumer welfare. In short, as I have suggested elsewhere, provider markets evidence the worst of both worlds—hospital and physician markets that are *both* concentrated *and* fragmented.[36] Owing in part to several misguided court decisions and the enforcers' seven-year hiatus on challenging hospital mergers, hospital markets have become highly concentrated around the country. By one estimate, ninety-three percent of the nation's 2006 population lived in concentrated hospital markets.[37] Further, abundant evidence shows that consumers have borne the brunt of hospitals' exercise of market power. The Synthesis Project's summary of empirical studies of the effects of hospital consolidation in the 1990s indicates that anticompetitive horizontal mergers raised overall inpatient prices by at least five percent and by forty percent or more when merging hospitals were closely located.[38]

The causal connection between provider concentration and increasing health care costs finds further support in an important study by the Attorney General of Massachusetts. The report, which closely examined private insurance prices, offers a number of significant conclusions.[39] First, it found that prices paid to hospitals and physicians vary significantly and that higher prices are not associated with quality, complexity, proportion of government patients, or academic status.[40] Second, provider prices in Massachusetts are correlated to market leverage.[41] Hospitals and physician groups with bargaining power extracted higher prices that are not explained by the factors mentioned above. Third, more

---

[36] Thomas (Tim) Greaney, *Competition Policy and Organizational Fragmentation in Health Care*, 71 U. PITT. L. REV. 217, 231–35 (2009).

[37] CLAUDIA H. WILLIAMS ET AL., ROBERT WOOD JOHNSON FOUND., HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE 2 (2006), *available at* http://www.rwjf.org/files/research/no9policybrief.pdf.

[38] *Id.*

[39] OFFICE OF THE ATT'Y GEN. MARTHA COAKLEY OF MASS., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (2010), *available at* http://www.mass.gov/Cago/docs/healthcare/final_report_w_cover_appendices_glossary.pdf.

[40] *Id.* at 3.

[41] *Id.* at 7–9.

expensive providers appear to gain market share at the expense of less expensive providers.[42] Fourth, the report concluded that a variety of contractual devices, such as payment parity agreements and product participation provisions, have reinforced and perpetuated pricing disparities.[43]

Another study, drawing on site visits by the Center for Studying Health System Change to six California markets in 2008, found that provider leverage has had a "major impact on California premium trends."[44] Interviews in these markets revealed that the bargaining power of hospitals has been enhanced by extensive horizontal consolidation. Consolidation and other factors, such as system bargaining on an all-or-nothing basis, led to a sharp increase in the number of "must have" facilities in the state.[45] In addition, large, multispecialty group practices and independent practice associations also exercise market power by virtue of a lack of price competition for their services. In a remarkable twist, the study found some situations in which the market power of large groups outweighed the advantages for health plans of entering into capitation for insurers.[46]

Other, subtler results have also flowed from the wave of consolidations and the marginalization of managed care. Besides price increases owing to enhanced bargaining power, growth in hospital costs appear to have been driven by strategic decisions that take advantage of market imperfections and the absence of effective monitoring by payers. By some accounts, the "medical arms race" has resurfaced.[47] That is, hospitals have undertaken significant expansions in high-margin services and have accelerated technology acquisitions, a phenomenon attributable in part to providers' capacity to induce demand.

Concentrated private-provider markets also impact government payers. Examining the effect of hospital concentration on Medicare payments, the Medicare Payment Advisory Commission (MedPAC) has found that high hospital margins on private-payer patients tend to

---

[42] *Id.* at 38–40.

[43] *Id.* at 40–43.

[44] Robert Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. 699, 704 (2010).

[45] *Id.* at 702.

[46] *Id.* at 703–04

[47] *See* Robert A. Berenson et al., *Hospital-Physician Relations: Cooperation, Competition, or Separation?*, 26 HEALTH AFF. WEB EXCLUSIVE w31 (2006), *available at* http://content.healthaffairs.org/content/26/1/w31.full.pdf.

induce more construction and higher hospital costs and that, "when non-Medicare margins are high, hospitals face less pressure to constrain costs, [and] costs rise."[48] These factors, MedPAC observes, explain the counterintuitive phenomenon that hospital Medicare margins tend to be low in markets in which concentration is highest, while margins are higher in more competitively structured markets.[49]

While provider concentration is pervasive, health delivery is also highly fragmented. Primary care practices remain small and isolated with little integration or coordination with specialty physician practices or between physicians and hospitals.[50] Even more damning is the fact that vertical integration is also lacking, or as David Hyman characterized it, "[h]ospitals and physicians occupy separate organizational universes."[51] The case for integrating care across physician specialties and institutions rests on evidence of higher quality of care, opportunities for deployment of evidence-based medicine at the clinical level, and enhanced means of controlling costs by locating responsibility with an organization or team of accountable providers.[52]

The payer side has become more concentrated, at least in the individual and small group market, where, according to some data, two firms have greater than fifty percent of the market in twenty-two states, and one firm has more than fifty percent in seventeen states.[53] The results in these markets appear to confirm what economic theory predicts: higher premiums for consumers and high profits for the insurance industry. Summarizing studies indicating that private

---

[48] MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: IMPROVING INCENTIVES IN THE MEDICARE PROGRAM xiv (2009) *available at* http://www.medpac.gov/documents/mar09_entirereport.pdf.

[49] *Id.*

[50] *See* Thomas Bodenheimer, *Coordinating Care—A Perilous Journey Through the Health Care System*, 358 NEW ENG. J. MED. 1064 (2008); Randal Cebul et al., *Organizational Fragmentation and Care Quality in the U.S. Health Care System*, *in* THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS 55–57 (Einer R. Elhauge ed., 2010).

[51] David A. Hyman, *Health Care Fragmentation: We Get What We Pay for*, *in* THE FRAGMENTATION OF U.S. HEALTH CARE, *supra* note 50, at 23.

[52] *See* Alain C. Enthoven & Laura A. Tollen, *Competition in Health Care: It Takes Systems to Pursue Quality and Efficiency*, 24 HEALTH AFF. WEB EXCLUSIVE w5-420 (2005), *available at* http://content.healthaffairs.org/content/early/2005/09/07/hlthaff.w5.420.full.pdf.

[53] Karen Davenport & Sonia Sekhar, *Interactive Map: Insurance Market Concentration Creates Fewer Choices*, CTR. FOR AM. PROGRESS (Nov. 5, 2009), http://www.americanprogress.org/issues/2009/11/insurance_market.html.

insurance revenue increased even faster than medical costs, economists John Holahan and Linda Blumberg of the Urban Institute concluded that "the market power of insurers meant that they were not only able to pass on health care costs to purchasers but to increase profitability at the same time."[54] While some other studies conclude that dominant insurers extract monopoly rents,[55] the extent of their exercise of market power has been questioned.[56] Finally, experience suggests that entry into concentrated insurance markets is far from easy and may be unlikely to occur in markets with few insurers. A recent study by the Antitrust Division of the Department of Justice found that entry in such insurance markets was impeded by the difficulty of securing provider contracts.[57]

The existence of oligopolies or monopolies in both the provider and insurance sectors creates opportunities for anticompetitive mischief. As mentioned earlier, dominant hospital systems and dominant single-specialty physician groups have been able to charge higher prices, which in turn result in higher insurance premiums (and, as some studies show, increased disparities in access to care). But

---

[54] JOHN HOLAHAN & LINDA BLUMBERG, URBAN INST., HEALTH POLICY CTR., CAN A PUBLIC INSURANCE PLAN INCREASE COMPETITION AND LOWER THE COSTS OF HEALTH CARE REFORM? 3 (2008), *available at* http://www.urban.org/health_policy/url.cfm?ID=411762.

[55] Leemore S. Dafny, *Are Health Insurance Markets Competitive?*, 100 AM. ECON. REV. 1399 (2010) (finding that health insurers charge higher premiums to more profitable firms, suggesting that they possess and exercise market power).

[56] *E.g.*, Martin Gaynor & Deborah Haas-Wilson, *Change, Consolidation, and Competition in Health Care Markets*, 13 J. ECON. PERSP. 141 (1999); Martin Gaynor, *Why Don't Courts Treat Hospitals Like Tanks for Liquefied Gases? Some Reflections on Health Care Antitrust Enforcement*, 31 J. HEALTH POL. POL'Y & L. 497, 507 (2006) (asserting "that it is not at all clear that private health insurers systematically possess monopsony power"). The government antitrust enforcement agencies have on occasion opined that health insurance markets are generally competitive. *See* FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004). *But see* Christine A. Varney, Assistant Att'y Gen., Antitrust Div., U.S. Dep't of Justice, Remarks as Prepared for the American Bar Association/American Health Lawyers Association Antitrust and Healthcare Conference (May 24, 2009), *available at* http://www.justice.gov/atr/public/speeches/258898.pdf (promising "measured enforcement" of the antitrust laws involving the health insurance industry).

[57] The Department of Justice's study concluded:

> [T]he biggest obstacle to an insurer's entry or expansion in the small- or mid-sized-employer market is scale. New insurers cannot compete with incumbents for enrollees without provider discounts, but they cannot negotiate for discounts without a large number of enrollees. This circularity problem makes entry risky and difficult, helping to secure the position of existing incumbents.

Varney, *supra* note 56, at 9.

what happens when dominant insurers face dominant providers—what economists call bilateral monopoly? The outcome depends on the strategic interactions of the parties. For example, in the now notorious episode involving Partners Health Care and Blue Cross of Massachusetts, the parties reached a mutually beneficial understanding (a "market covenant") to maintain high premiums and high hospital charges. More generally, it appears the dynamics of bargaining may often result in higher prices for consumers. As Holahan and Blumberg summarized industry tendencies: "Dominant insurers do not seem to use their market power to drive hard bargains with providers," but "small insurers do not aggressively compete over price."[58] Holahan and Blumberg noted that "rising premiums and increased profitability of nondominant firms provide indirect evidence of shadow pricing by smaller insurers; that is, smaller insurers do not seem to compete on premiums to gain market share but rather seem to follow the pricing of the dominant insurer."[59]

In sum, it is hard to ignore the claim that markets as we have known them have not performed well. Whether measured by cost, outcomes, or customer satisfaction, the health care industry's record is one that merits intervention.[60] The following section assays the ACA's prospects for making improvements by introducing regulations that may improve market competiveness.

III
THE AFFORDABLE CARE ACT: AN ANTIDOTE TO MARKET IMPERFECTIONS

The ACA's focus on improving competition is illustrated by the steps it takes to establish new markets that facilitate shopping for insurance and to mitigate market imperfections. Though perhaps counterintuitive to those who dichotomize between competition and regulation, law can sometimes foster competition by imposing rules and standards, by mandating purchasing, or by creating competition-fostering institutions. As I have argued since the early days of the

---

[58] HOLAHAN & BLUMBERG, *supra* note 54, at 3.

[59] *Id.* (footnote omitted).

[60] *See* Len M. Nichols, Director, Health Policy Program, New Am. Found., Statement Before the Senate Committee on Commerce, Science, and Transportation, Competition in the Health Care Marketplace 3 (July 16, 2009), *available at* http://www.newamerica.net/files/NICHOLS_Commerce.pdf (summarizing the costs of noncompetitive pricing, poor quality, and inefficiency in health care and concluding "[i]t is not unreasonable to argue that we pay roughly 2.4 times more than we should for health care").

"competitive revolution" in health care, such regulation is a condition precedent for effective markets.[61]

A. Payment and Insurance Reforms

Health insurance exchanges, which serve as the centerpiece of the ACA's attempt to move toward universal coverage, are at bottom markets for offering and purchasing health insurance. Like countless other forums for exchange, such as farmers' markets, stock markets, or online travel services, health insurance exchanges will afford individual consumers and small businesses the opportunity to examine and compare alternative insurance options and to purchase those that best suit their needs. The idea is hardly novel. Its ancestry can be traced to the concept of managed competition, as developed by economist Alain Enthoven and others,[62] and to numerous purchasing cooperatives, health alliances, and connectors—among states and private entities.[63] Past efforts to promote exchanges have floundered, however, primarily because of problems of adverse selection and a resulting inability to attract sufficiently large pools of customers to effectively spread risk.[64] The ACA requires that states establish individual and small group exchanges in each state,[65] and it mandates the purchase of insurance by individuals and encourages employers to purchase insurance for their employees. In doing so, lawmakers

---

[61] *See* Thomas L. Greaney, *Competitive Reform in Health Care: The Vulnerable Revolution*, 5 YALE. J. ON REG. 179 (1988) (predicting that competition in health care would not succeed if regulation and infrastructure do not support it).

[62] *See* Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy*, 320 NEW ENG. J. MED. 29 (1989).

[63] *See* TIMOTHY STOLTZFUS JOST, COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: KEY POLICY ISSUES (2010), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf.

[64] *Id.* at 3 (explaining that unsuccessful exchanges failed to succeed because they "attempted to offer better coverage, or more affordable coverage, to too many individuals or groups with unfavorable risk profiles and were unable to attract enough healthy enrollees"); *see also* LINDA J. BLUMBERG & KAREN POLLITZ, URBAN INST., ROBERT WOOD JOHNSON FOUND., HEALTH INSURANCE EXCHANGES: ORGANIZING HEALTH INSURANCE MARKETPLACES TO PROMOTE HEALTH REFORM GOALS (2009), *available at* http://www.urban.org/UploadedPDF/411875_health_insurance_marketplaces.pdf.

[65] While mandating that each state establish an exchange for individual purchasers ("American Health Benefit Exchange") and small groups ("SHOP" exchange), the law permits states to establish multiple regional exchanges or interstate exchanges. Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 1311, 124 Stat. 119, 173–82 (2010) (codified at 42 U.S.C.A. § 18031 (West 2010)).

hoped to create sizeable and stable risk pools that will reduce the risks of adverse selection, that will lower marketing and administrative costs, and that will enable consumers to have sufficient clout bargaining collectively with insurers. In structuring exchanges, the ACA's drafters were fully cognizant of the need to address market imperfections. For example, the law requires that exchanges establish risk-adjustment mechanisms,[66] and it bans discrimination based on age, disability, or expected length of life.[67] Those provisions also serve to lessen the risks of favorable selection problems and to potentially broaden the size of group and non-group insurance pools. In addition, these exchanges can serve to widen choice, improve transparency, and reduce search costs for individuals and employers, thereby enhancing the efficiency of the market.

The ACA also addresses insurance market imperfections through several prohibitions on specific industry practices.[68] For example, it sets rules that govern the terms of insurance policies by prohibiting much medical underwriting and premium pricing based on health status in the small group and non-group markets.[69] These changes are designed to counter the proclivity of insurers to seek out healthy individuals and to mitigate the risk selection phenomenon that impairs insurance market efficiency. In addition, the ACA deals with information deficits in several ways. First, it seeks to increase the amount and accessibility of information by requiring exchanges to perform a variety of functions, such as establishing a toll-free hotline[70] and maintaining a Web site that provides standardized comparative information on health plans[71] and rating plans[72] and that develops enrollee satisfaction surveys.[73] These changes counter well-documented difficulties encountered in the consumer market

---

[66] *Id.* §§ 1341–43, 124 Stat. at 208–12 (codified at 42 U.S.C.A. §§ 18061–63 (West 2010)).

[67] *Id.* § 2704, 124 Stat. at 323 (codified as note to 42 U.S.C.A. § 1396a (West 2010)).

[68] For summaries and analyses of the ACA, see BARRY R. FURROW ET AL., HEALTH REFORM SUPPLEMENT TO HEALTH LAW: CASES, MATERIALS AND PROBLEMS (2010).

[69] ACA § 2701, 124 Stat. at 317–18 (codified at 42 U.S.C.A. § 1320b-9b (West 2010)).

[70] *Id.* § 1311(d)(4)(B), 124 Stat. at 176 (codified at 42 U.S.C.A. § 18031(d)(4)(B) (West 2010)).

[71] *Id.* § 1311(d)(4)(C), 124 Stat. at 176 (codified at 42 U.S.C.A. § 18031(d)(4)(B) (West 2010)).

[72] *Id.* § 1311(c)(3), 124 Stat. at 175 (codified at 42 U.S.C.A. § 18031(c)(3) (West 2010)).

[73] *Id.* § 1311(c)(4), 124 Stat. at 175 (codified at 42 U.S.C.A. § 18031(c)(4) (West 2010)).

regarding the content and quality of health insurance plans.[74] Second, the ACA sets minimum standards for insurance policies in the individual and non-group market by requiring that they cover the "essential benefits package" (to be defined by the Secretary of the Department of Health and Human Services (HHS)) and that they standardize packages of insurance levels of coverage ("precious metal" plans).[75] In addition, the law imposes a number of limitations on the net amount that cost-sharing plans may require,[76] and it mandates that insurers provide annual rebates to their enrollees if their medical loss ratios (the ratio of amounts incurred for claims and paid for activities to improve health care quality to total premiums) are less than eighty-five percent in the large group market or eighty percent in the small group or individual market.[77]

These and other measures find support in the necessity of dealing with severe information, agency, and behavioral issues described earlier. In insurance markets, not only are policies complicated and highly heterogeneous, thus making informed comparisons difficult, but also they cause people to rely on unreliable decision aids. As Russell Korobkin has explained,[78] evidence drawn from behavioral psychology demonstrates that consumers have cognitive limitations that can cause them to make decisions in only a "boundedly rational" manner, and they use highly imperfect heuristics and other shortcuts in their decision making. As a consequence, they are likely to fail to

---

[74] *See* Karen Pollitz, Research Professor, Georgetown Univ. Health Policy Inst., Addressing Insurance Market Reform in National Health Reform (Mar. 24, 2009).

[75] ACA § 1302, 124 Stat. at 163 (codified at 42 U.S.C.A. § 18022 (West 2010)). Health plans offered in the individual and small group markets must cover specific percentages of actuarial value and are arrayed in "precious metal" categories: bronze plans must cover sixty percent of actuarial value, silver plans must cover seventy percent of actuarial value, gold plans must cover eighty percent of actuarial value, and platinum plans must cover ninety percent of actuarial value. Insurers may also offer a catastrophic plan to subscribers under thirty years of age (for a while the plan was referred to as the "young invincibles" plan because it is aimed at attracting younger subscribers inclined to doubt they need health insurance). *Id.* The actuarial value of services is essentially the net coverage offered by a plan taking into account cost-sharing responsibilities and determined on the basis of the average cost of providing the essential benefits to a standard population, not the actual population of the plan. *Id.*

[76] *Id.* § 1402, 124 Stat. at 220–24 (codified at 42 U.S.C.A. § 18071 (West 2010)).

[77] *Id.* § 2718(b)(1)(A), 124 Stat. at 886 (codified at 42 U.S.C.A. § 300gg-18(b)(1)(A) (West 2010)).

[78] *See* Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1 (1999); *see also* Frank A. Sloan & Mark A. Hall, *Market Failures and the Evolution of State Regulation of Managed Care*, 65 LAW & CONTEMP. PROBS., Autumn 2002, at 169.

make individual health insurance purchasing decisions in a way that promotes efficiency.[79] Given intractable difficulties of dealing with certain issues by contract and the absence of other institutional arrangements to assist consumers, legislation mandating coverage may be justified in some circumstances.

For some commentators, the prime culprit distorting markets is the moral hazard associated with health insurance.[80] Moral hazard operates not only in the economic dimension—encouraging overconsumption of services—but also in the regulatory area. Clark Havighurst has persuasively argued that consumers/voters in America are blinded to implications of costly regulations that inhibit insurers from managing care effectively:

> [I]gnorance of the *cost* of care . . . ensures that neither the choices [consumers] make in the marketplace nor the opinions they express in the political process reveal their true preferences. . . .
>
> . . . Even though moral hazard operates with particular vengeance in health insurance, it can be managed to some extent . . . . Inefficiency occurs, however, as soon as government or the legal system barges in to preclude financing intermediaries from effectively managing care—that is, from taking administrative and other actions to limit the impact of moral hazard—or requires them to honor costly entitlements prescribed by law or professional standards rather than set forth in freely negotiated contracts.[81]

The ACA attempts to mitigate the moral hazard problem in several ways. First, the so-called "Cadillac Tax"[82] operates to reduce

---

[79] These deficiencies have been applied to consumer decision making at the point of service in health care. Richard G. Frank, *Behavioral Economics and Health Economics*, *in* BEHAVIORAL ECONOMICS AND ITS APPLICATIONS 195, 195 (Peter Diamond & Hannu Vartiainen eds., 2007). In addition, there is considerable evidence that behavioral factors impair physician decision making. *See* Thomas L. Greaney, *Economic Regulation of Physicians: A Behavioral Economics Perspective*, 53 ST. LOUIS U. L.J. 1189 (2009).

[80] *See* Havighurst, *supra* note 21, at 78–82.

> [I]t should be obvious that the market failure most responsible for economic inefficiency in the health care sector is not consumers' ignorance about the quality of care, but their ignorance of the *cost* of care, which ensures that neither the choices they make in the marketplace nor the opinions they express in the political process reveal their true preferences.

Id. at 78.

[81] *Id.* at 78–79.

[82] The ACA imposes a forty percent excise tax on employment-related health coverage that costs more than $10,200 for individual coverage or $27,500 for family coverage beginning in 2018 subject to various adjustments and exceptions. Although the tax is levied on insurers, it will be passed on to employers and then to employees, and it is thereby likely to result in reduction in the generosity of insurance coverage for plans that exceed the thresholds. *See* FURROW ET AL., *supra* note 14.

incentives of employers to provide excessively generous insurance, incentivizes employers to shop more aggressively for plans that are cost-effective, and encourages employees to choose those plans. Indeed the "tax" is really a device to remove a costly and market-distorting tax benefit.[83] The ACA can be seen as combating moral hazard in other ways as well. Plans offered through exchanges will be structured in a manner that reflects the cost-saving incentives of co-payments and deductibles. Thus, plans in the "precious metal" categories with relatively generous coverage (i.e., lower co-pays and deductibles) will have higher premiums. In addition, although the ACA limits the level of out-of-pocket payments in plans, it sets those limits at the very high levels that current law sets for high-deductible plans under health savings accounts. As a result, high-deductible plans may prove to be popular under the ACA's rules requiring the purchase of health insurance. An individual needs only to select a bronze level plan to avoid the individual mandate penalty and may purchase a catastrophic policy either if under age thirty or if no other plan is available for under eight percent of the individual's household income.[84]

The ACA takes some steps to address the political aspect of moral hazard identified by Professor Havighurst. For example, the law discourages state mandates of benefits for plans participating in the exchange by requiring that any states that require benefits beyond the essential benefits package required by federal law must pay the additional cost of those benefits for individuals and families receiving federal subsidies.[85] Although such mandates will still apply to plans marketed outside the exchange, this provision is likely to sharply

---

[83] *See* Jonathan Gruber, *'Cadillac' Tax Isn't as Tax—It's a Plan to Finance Real Health Reform*, WASH. POST, Dec. 28, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/12/27/AR2009122701714.html (estimating the total cost to the Treasury of exclusion of employer contributions for health care to be $250 billion per year or twice the cost of providing universal care). Critics of this provision argue that high-cost plans generally insure sicker employees and those in risky occupations or in regions with high medical costs. Moreover critics assert that the money employers save by reducing health insurance coverage is unlikely to be passed on to employees for medically necessary as well as unnecessary services. *See* TIMOTHY S. JOST & JOSEPH WHITE, CUTTING HEALTH CARE SPENDING: WHAT IS THE COST OF AN EXCISE TAX THAT KEEPS PEOPLE FROM GOING TO THE DOCTOR? (2010), *available at* http://www.ourfuture.org/files/Jost-White_Excise_Tax.pdf.

[84] *See* FURROW ET AL., *supra* note 68, at 120.

[85] Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 1311(d)(3)(B)(ii), 124 Stat. 119, 176 (2010) (codified at 42 U.S.C.A. § 18031 (West 2010)); *id.* § 1334(c)(4), 124 Stat. at 904 (codified at 42 U.S.C.A. § 18054 (West 2010)).

curtail state benefit mandates, as states will likely be unwilling to impose costly mandates that may result in adverse selection and higher costs that will drive consumers away from choosing non-exchange participating plans.

As noted above, government policies, particularly payment methodologies, contribute significantly to the inefficiencies and distortions in the health care system. The ACA undertakes prodigious efforts to redirect federal payment away from fee-for-service payment. With many Medicare beneficiaries having complex health conditions and multiple co-morbidities, most observers agree that this system has significant cost and quality implications; the system provides no incentives for coordination of care, and it tolerates duplicative and costly provision of services.[86] These payment policies have played an important role in encouraging and ossifying a fragmented delivery system.[87] Thus, the ACA requires the Secretary of the HHS to establish, test, and evaluate a five-year pilot program "for integrated care during an episode of care . . . around a hospitalization in order to improve the coordination, quality, and efficiency of health care services."[88] Other reforms, many in the form of pilot programs or demonstrations, similarly attempt to rationalize government reimbursement so as to at least reduce the perverse incentives that have long plagued health care payment and delivery.[89]

Finally, the ACA deals with a very significant public goods market failure—the underproduction of research and the inadequate dissemination of information concerning the effectiveness and quality of health care services and procedures. The Act does so by subsidizing research and creating new entities to support such research[90] and to disseminate information about outcomes and

---

[86] *See* Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Comm'n, Reforming the Health Care Delivery (Mar. 10, 2009), *available at* http://www.medpac.gov/documents/20090310_EandC_Testimony_DeliveryReform.pdf.

[87] *See* HYMAN, *supra* note 51, at 21–22.

[88] ACA § 3023, 124 Stat. at 399 (codified at 42 U.S.C.A. § 1395cc-4 (West 2010)).

[89] *See, e.g.*, *id.* § 3022, 124 Stat. at 395 (codified at 42 U.S.C.A. § 1395jjj (West 2010)) (establishing a shared saving program, which creates reimbursement incentives for groups of providers establishing accountable care organizations); *id.* § 3025, 124 Stat. at 408 (codified at 42 U.S.C.A. § 1395ww (West 2010)) (creating a system that reduces payments to hospitals for excessive readmissions); *id.* § 3502, 124 Stat. at 513 (codified at 42 U.S.C.A. § 256a-1 (West 2010)) (establishing a program to provide grants to community health teams to support medical homes aimed at coordinating care for patients with chronic illnesses and reimbursement through bundled payments).

[90] *E.g.*, *id.* § 3013, 124 Stat. at 381–84 (codified in scattered sections of 42 U.S.C.A. (West 2010)) (establishing a Center for Quality Improvement and Patient Safety charged

medically effective treatments.[91] Numerous other provisions attempt to correct flaws in Medicare and Medicaid reimbursement methodologies, including those offering incentives to improve quality and induce reliance on "evidence-based medicine."[92]

B. Delivery System Reform

Considerable scholarship has identified fragmentation in health care delivery as a major source of inefficiency in the health care system.[93] The harms flowing from fragmentation can be observed at the clinical level (inadequate care attributable to lack of provider coordination)[94] and at the administrative level (high administrative and overall costs).[95] The causes of fragmentation are multifaceted and intertwined but aptly summarized by Einer Elhauge:

---

with identifying effective quality measures and best practices for treatment outcomes); *id.* § 6301, 124 Stat. at 727–47 (codified in scattered sections of 26 and 42 U.S.C.A. (West 2010)) (establishing a Patient-Centered Outcomes Research Institute "to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments [and] services"); *id.* § 10303, 124 Stat. at 937–38 (codified in scattered sections of 42 U.S.C.A. (West 2010)) (instructing the Secretary of the HHS to develop outcome measures for hospital physicians and to promote "best practices" in health care delivery); *id.* § 1204, 124 Stat. at 518 (codified at 42 U.S.C.A. § 300d-6 (West 2010)) (providing grants for research in emergency medical care systems to create "innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems"); *id.* § 3501, 124 Stat. at 507–13 (codified at 42 U.S.C.A. §§ 299b-33 to -34 (West 2010)) (providing grants for research into improving health care delivery systems).

[91] *See, e.g.*, *id.* § 3501, 124 Stat. at 508–11 (codified as amended at 42 U.S.C.A. § 299b-33 (West 2010)); *id.* § 6301, 124 Stat. at 738–39 (codified as amended at 42 U.S.C.A. § 299b-37 (West 2010)).

[92] *E.g.*, *id.* §§ 3001–08, 124 Stat. at 353–79 (codified in scattered sections of 42 U.S.C.A. (West 2010)) (establishing a value-based payment system for Medicare and Medicaid reimbursement).

[93] *See generally* THE FRAGMENTATION OF U.S. HEALTH CARE, *supra* note 50 (discussing analyses by fourteen contributors of causes, effects, and remedies to excessive fragmentation in American health system).

[94] Cebul et al., *supra* note 50, at 38–43.

[95] *Id.* at 44–45 (citing administrative costs of thirty-one percent of total health care expenditures); Alain Enthoven, *Curing Fragmentation with Integrated Delivery Systems: What They Do, What Has Blocked Them, Why We Need Them, and How to Get There from Here*, *in* THE FRAGMENTATION OF U.S. HEALTH CARE, *supra* note 50, at 65–68 (citing evidence of lower costs in prepaid multispecialty group practices).

> The dominant cause of fragmentation . . . appears to be the law, which dictates many of the fragmented features [of the health system] . . . and thus precludes alternative organizational structures. The law is the culprit even though the payment system is also an important cause of health care fragmentation . . . . The reason is that . . . the law dictates that payment system.[96]

The ACA heeds Elhauge's message by instituting new Medicare programs designed to reward integrated delivery of care. Prominent among these programs is the Medicare "Shared Savings Program," which will make groups of providers who voluntarily meet certain quality criteria eligible to share in the cost savings they achieve for the Medicare program.[97] To qualify, these "accountable care organizations" (ACOs) must agree to be accountable for the overall care of a defined group of Medicare beneficiaries, to have sufficient participation of primary care physicians, to have processes that promote evidence-based medicine, to report on quality and costs, and to be capable of coordinating care. Additionally, an ACO must be a group of providers and suppliers that has an established mechanism for joint decision making and may include practitioners (physicians, regardless of specialty; nurse practitioners; physician assistants; and clinical nurse specialists) in group practice arrangements, networks of practices, and partnerships or joint venture arrangements between hospitals and practitioners. The Medicare program will pay the ACOs a global payment for all services needed or, alternatively, share savings based on comparing the ACOs' cost to benchmark payments under traditional Medicare.

The idea, which carries the endorsement of MedPAC and the influential health service researchers at Dartmouth,[98] is not entirely novel. Indeed, if this sounds a lot like the HMO managed care model,

---

[96] Einer Elhauge, *Why We Should Care About Fragmentation?*, *in* THE FRAGMENTATION OF U.S. HEALTH CARE, *supra* note 50, at 11.

[97] ACA § 3022, 124 Stat. at 395–99 (codified at 42 U.S.C.A. § 1395jjj (West 2010)).

[98] MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 48, at 40–58; Elliott S. Fisher et al., *Fostering Accountable Health Care: Moving Forward in Medicare*, 28 HEALTH AFF. WEB EXCLUSIVE w219 (2009), *available at* http://tdi.dartmouth.edu/documents/publications/HA%20Fisher-McClellan%20art.pdf. In addition, a number of experiments involving bundled payments to the ACOs and to other innovative organizations (as in Medicare's Physician Group Practice demonstration) have been underway for some time. *See, e.g.*, JIM HESTER ET AL., THE COMMONWEALTH FUND, THE VERMONT ACCOUNTABLE CARE ORGANIZATION PILOT: A COMMUNITY HEALTH SYSTEM TO CONTROL TOTAL MEDICAL COSTS AND IMPROVE POPULATION HEALTH (2010).

that's because it is.[99] In many respects the ACO is the latest in a long line of efforts to develop integrated delivery systems that bear financial responsibility for treatment decisions. Benefiting from the nation's experience with managed care, there are plausible, market-based reasons for going in this direction. Making entities accountable for care via capitation or global payments mitigates agency and information problems to some extent as providers are given economic incentives to economize care.[100] Further, there is at least modest evidence from the managed care experience that these steps work to moderate cost while continuing to maintain quality of care.[101] But to get there, the new law leaves much detail to the discretion of the Secretary of the HHS, who is presumably informed by experience and learning as the program progresses. For example, the legislation delegates the development of standards for quality, use of evidence-based medicine, and "patient-centeredness" to the HHS.[102]

The ACA also seeks to spur competition by adjusting regulatory agency oversight in several areas. For example, the ACA institutes changes to the mechanics of bidding for Medicare Advantage contracts that attempt to move the benchmark bidding process closer to a competitive model. The ACA also expands competitive bidding for medical devices.[103] Further, the ACA created an abbreviated approval pathway for biologic drugs that were "biosimilar," or

---

[99] *See* KELLY DEVERS & ROBERT BERENSON, URBAN INST., ROBERT WOOD JOHNSON FOUND., CAN ACCOUNTABLE CARE ORGANIZATIONS IMPROVE THE VALUE OF HEALTH CARE BY SOLVING THE COST AND QUALITY QUANDARIES? 5 (2009), *available at* http://www.urban.org/uploadedpdf/411975_acountable_care_orgs.pdf (referring to the ACOs as "HMOs in drag").

[100] *See* DAVID DRANOVE, THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE: FROM MARCUS WELBY TO MANAGED CARE 9–15 (2000).

[101] *See* David M. Cutler et al., *How Does Managed Care Do It?*, 31 RAND J. ECON. 526, 526 (2000) (finding the HMOs have thirty percent to forty percent lower expenditures than traditional plans with little difference in outcomes).

[102] ACA § 3022, 124 Stat. at 395 (codified at 42 U.S.C.A. § 1395jjj (West 2010)); *see also* 1 FURROW ET. AL., *supra* note 11, at 141–43, 154–57; Thomas L. Greaney, *Accountable Care Organizations—The Fork in the Road*, 364 NEW ENG. J. MED. e1 (2011), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1013404.

[103] ACA § 6410, 124 Stat. at 773 (codified at 42 U.S.C.A. §§ 1395m, 1395w-3 (West 2010)) (expanding the Medicare competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies); *see also* Mike Lillis, *Battle Continues over Medicare Competitive Bidding Program*, HILL (July 2, 2010), http://thehill.com/blogs/healthwatch/medicare/107001-battle-continues-over-medicare-competitive-bidding-program (citing thirty-two percent cuts in purchases of durable medical equipment resulting from competitive bidding programs in nine cities and estimating that over 250 members of the House of Representatives support repeal of the program).

interchangeable with previously approved biologics ("follow on" biologics). Although the law was a precompetitive innovation, the law was subject to criticism from the Federal Trade Commission and others that it was unnecessarily protective of intellectual property rights by providing twelve years of market exclusivity to innovator biologics.[104]

Finally, a number of proposals designed to foster competition were not enacted. Noticeably absent is the creation of a "public option" insurance plan, a hotly debated reform, which proponents argued would introduce much-needed competition into concentrated insurance markets.[105] However, the ACA gives states various options to create their own new insurance plans and mandates that the Office of Personnel Management contract with insurance carriers to assure that at least two "multistate plans" are offered in every health insurance exchange in each state.[106] Another much-discussed reform, the partial repeal of the McCarran-Ferguson insurance exemption, garnered significant support but was nevertheless excluded in the ACA.[107]

In sum, those painting health reform legislation as abandoning market-based values in health policy are mistaken. The ACA undertakes enumerable steps designed to eliminate perverse incentives in government payment policies, to encourage development of a scientific and technological infrastructure

---

[104] A Federal Trade Commission report supported legislation that allows follow-on or biosimilar versions of biologic drugs, but it contended that the patent system would provide brand-name products all the protection they need without a period of exclusivity and that allowing for a period of patent exclusivity would be unnecessarily anticompetitive. MICHAEL S. WROBLEWSKI, FED. TRADE COMM'N, EMERGING HEALTH CARE ISSUES: FOLLOW-ON BIOLOGIC DRUG COMPETITION (2009).

[105] *See* Davenport and Sekhar, *supra* note 53 (discussing the public option plan debate).

[106] *See infra* note 136 and accompanying text.

[107] On February 24, 2010, the House of Representatives passed by a margin of 406–18 the Health Insurance Industry Fair Competition Act, repealing in part the McCarran-Ferguson Act's applicability to health insurers by providing that (1) nothing in the act shall modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance, and (2) Federal Trade Commission Act prohibitions against using unfair methods of competition shall apply to the business of health insurance without regard to whether such business is carried on for profit. Health Insurance Industry Fair Competition Act, H.R. 4626, 111th Cong. (2010). A number of observers have argued that, notwithstanding the advisability of repealing the McCarran-Ferguson exemption, it has had little application in health care matters and its importance should not be overstated. *See, e.g.*, Chris Sagers, *Much Ado About Probably Pretty Little: McCarran-Ferguson Repeal in the Pending Health Reform Effort*, 28 YALE L. & POL'Y REV. 325 (2010).

conducive to comparison shopping, and to spur development of delivery systems that can be accountable for cost and quality decisions. So what could possibly go wrong?

IV
OBSTACLES TO INDUCING IMPROVED COMPETITIVENESS IN HEALTH CARE MARKETS

A. Regulation: Not Too Much but Not Too Little?

The ACA's capacity to unleash competitive forces to control cost and improve quality of care is contingent on a number of factors. First, much depends on regulations to be promulgated by the HHS and other agencies and the implementation of those regulations by the federal government and the states. Administrative agencies will make a host of determinations crucial to the law's scheme to improve the competitiveness of markets. For example, the Secretary of the HHS is charged with establishing the criteria governing entry into exchange insurance markets. Thus she will set standards for "qualified health plans," ensuring that they adopt appropriate marketing practices, offer a sufficient choice of providers, afford access to essential community providers, and meet numerous other requirements.[108] The Secretary is also required to enhance consumers' opportunity for shopping for plans by developing a rating system that would rate qualified health plans offered through an exchange in each benefits level on the basis of the relative quality and price,[109] and standardizing plans by identifying "essential benefits" that must be offered by each plan.[110] States are expected to undertake significant regulation, subject in many cases to regulatory standards set by the HHS. For example, states are responsible for the complex and critical task of developing risk-adjustment programs.[111] Significantly, the ACA gives the Secretary of the HHS considerable latitude to exercise her discretion as to the substance, timing, and extent of most of these regulations.[112]

---

[108] ACA § 1311, 124 Stat. at 173–82 (codified at 42 U.S.C.A. § 18031 (West 2010)).

[109] *Id.* § 1311(d), 124 Stat. at 176–78 (codified at 42 U.S.C.A. § 18031(d) (West 2010)).

[110] *Id.* § 1311, 124 Stat. 119, 173–82 (2010) (codified at 42 U.S.C.A. § 18031 (West 2010)).

[111] *Id.* § 1343, 124 Stat. at 212–13 (codified at 42 U.S.C.A. § 18063 (West 2010)).

[112] *See* CURTIS W. COPELAND, CONG. RESEARCH SERV., R41180, REGULATIONS PURSUANT TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148) 3 (2010) (describing twenty-six provisions of the ACA mandating "federal agencies to issue regulations that define certain terms, establish substantive requirements, create certain programs, and determine the timing of particular events"; eleven provisions that permit

Most of the key regulatory determinations will be made over a period extending to 2014 and beyond and are likely to be the subject of intense political controversy and debate. The inevitably shifting political winds over this extended period of time[113] are likely to influence regulators and legislators as they implement the ACA.[114] Political turbulence might well cause regulators to dilute some of the features of the reform bill that are critical to maintaining competitive markets. For example, eliminating or weakening the individual mandate would likely cause severe disruptions in the insurance markets as a result of adverse selection. Inadequate risk-adjustment mechanisms would likely also permit insurance markets to unravel. In addition, indifferent attention to buyers' needs for standardization of choices and useable qualitative information will undermine the efficiency of comparative shopping.

States are also expected to assume significant responsibilities in implementing health reform.[115] For example, state legislative and regulatory actions are needed for setting up the local apparatus for new insurance markets, for implementing Medicaid expansion,[116] and for enforcing the ACA's requirements.[117] Whether the law will

---

such actions; and seven provisions that "appear to contemplate" such actions); *see also* Henry J. Aaron & Robert D. Reischauer, *The War Isn't Over*, 362 NEW ENG. J. MED. 1259 (2010), *available at* http://healthcarereform.nejm.org/?p=3223&query=home.

113 The period from 2010 through the end of 2014 includes three congressional elections, a presidential contest, and cycles of state legislative and gubernatorial contests in every state.

114 *See* Aaron & Reischauer, *supra* note 112 (predicting controversy over provisions that do not take effect until 2014, such as the insurance mandates, insurance subsidies for qualified families, Medicaid expansion, and the establishment of state health insurance exchanges).

115 *See* Alan Weil & Raymond Scheppach, *New Roles for States in Health Reform Implementation*, 29 HEALTH AFF. 1178 (2010); *see also* RACHEL MORGAN, NAT'L CONFERENCE OF STATE LEGISLATURES, STATE LEGISLATORS' CHECK LIST FOR HEALTH REFORM IMPLEMENTATION FY2010 (2010), *available at* http://www.ncsl.org/documents/health/2010CLHlthRef.pdf (listing dozens of provisions that require state legislative or administrative action or that merit state planning or consideration in fiscal year 2010). *See generally 2010 State Actions to Implement Federal Health Reform*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/default.aspx?tabid=20231 (last updated Jan. 5, 2011) (listing state legislation and executive orders implementing the ACA).

116 Sara Rosenbaum, *A "Customary and Necessary" Program—Medicaid and Health Care Reform*, 362 NEW ENG. J. MED. 1952 (2010).

117 Professor Elizabeth Weeks Leonard aptly summarized the allocation of responsibility: "the Exchanges impose massive financial, administrative, and enforcement burdens on states to operate the new individual and small-group health insurance marketplace and coordinate with other specific ACA components." Elizabeth Weeks

succeed in inducing "cooperative federalism"—partnership between federal and state governments to implement the new law—is a matter of serious question.[118] Given the strength of the "health reform nullification movement"[119] and efforts to get courts to overturn vital provisions of the new law,[120] there is a real possibility that some states may undertake half-hearted implementation efforts, provide limited funding, and make only lackadaisical enforcement efforts.

On the other side of the coin is the real risk that reform will produce what Professor Havighurst has called in another context "hyper-regulation" of health insurance markets.[121] That is, the far-reaching regulatory provisions of the ACA might result in a regulatory regime that distorts markets through "excessive" consumer safeguards or that undermines the ability of payers and providers to offer alternatives that appeal to different consumer groups.[122] For example, regulating network adequacy, specifying conditions of programs (e.g., "patient-centeredness"[123]), and dictating other terms

---

Leonard, *Rhetorical Federalism: The Role of State Resistance in Health Care Decision-Making*, 39 J.L. MED. & ETHICS 73 (2011).

[118] *See* Jessica Bulman-Pozen & Heather K. Gerken, *Uncooperative Federalism*, 118 YALE L.J. 1256 (2009). The ACA contains numerous "cooperative federalism arrangements" for implementing reform, such as conditional funding, conditional preemption, block grants, and contractual arrangements between states and the federal government. *See* Leonard, *supra* note 117, at 74.

[119] Leonard, *supra* note 117, at 3–9. Five states have enacted resolutions stating that their citizens would not be required to comply with the ACA's individual mandate, Missouri has passed a ballot measure prohibiting governments from mandating insurance, and lawmakers in over forty states have introduced bills asserting their States' rights to opt out of implementation of the ACA or otherwise nullify some or all of its provisions. *Id.*; *see also* Richard Cauchi, *State Legislation and Actions Challenging Certain Health Reforms, 2010-2011*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/default.aspx?tabid=18906 (last updated Mar. 22, 2011).

[120] As of this writing, twenty states have filed federal suits challenging the constitutionality of the ACA. *See* Kevin Sack, *Suit on Health Care Bill Appears Likely to Advance*, N.Y. TIMES, Sept. 15, 2010, at A20.

[121] *See* Havighurst, *supra* note 21, at 90.

[122] *See id.* at 84 (arguing that "the dynamics of the political market for consumer-protection regulation provide strong reasons to believe not only that standard-setting, command-and-control regulation systematically generates more social costs than benefits, but also that those costs are most likely to fall disproportionately on persons with lower incomes").

[123] Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 3021, 124 Stat. at 389–95 (2010) (codified in scattered sections of 42 U.S.C.A. (West 2010)) (patient-centeredness as one standard for evaluating models under new innovation center in the Centers for Medicare and Medicaid Services); *id.* § 3022, 124 Stat. at 395–99 (codified at 42 U.S.C.A. § 1395jjj (West 2010)) (ACOs must meet patient-centeredness criteria to be established by the Secretary).

of private insurance may unduly limit choice, unfairly burdening low-income groups with expenditures they may not otherwise choose to make. As some have argued, preserving choice within limits along the dimensions of quality, convenience, and cost provides the raison d'être for maintaining a private system of health care financing.[124]

Finally, one can safely predict that the ACA will give rise to unintended consequences (though identifying them is not so easy).[125] A key challenge for regulators will be to refrain from overprotective denials and to respond quickly to make necessary changes. However, when legislation is needed,[126] politics may intrude, and opponents may prefer to allow the statute's flawed provisions to remain in effect rather than fix what they regard as a wholly wrongheaded and unconstitutional enterprise.

B. Concentrated Markets and Entry Barriers

The high levels of concentration in hospital, specialty physician, and payer markets pose a serious problem for implementing reforms that rely on competition. As described above, the ACA relies on two important innovations to promote competition. First, it creates exchanges that will afford opportunities for comparative shopping by consumers and competition among health plans. Second, it supports development of new delivery systems, such as ACOs and medical homes, that can integrate care and take responsibility for managing care under budgetary constraints. Uncompetitive provider and payer markets may imperil both initiatives.

Achieving cost savings from competition among payers requires provider market competition. The effects of provider leverage on

---

[124] *See* Clark C. Havighurst, *Why Preserve Private Health Care Financing?*, *in* AMERICAN HEALTH POLICY: CRITICAL ISSUES FOR REFORM (Robert B. Helms ed., 1993).

[125] Academics and bloggers are lining up to predict such eventualities. *See, e.g.*, David A. Hyman, *Employment-Based Health Insurance: Is Health Reform a "Game Changer?"* (Univ. of Ill., Law and Econ. Research Paper No. LE10-010, 2010), *available at* http://ssrn.com/abstract=1624311 (recognizing the risk that employers will drop health insurance when the ACA reforms are implemented in 2014); Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125 (2011) (asserting that the ACA may induce employers to redesign their health plans to encourage employees who are likely to require extensive medical services to opt out of employer-provided coverage and instead acquire coverage from the individual market).

[126] *See, e.g.*, Monahan & Schwarcz, *supra* note 125, at 194–95 (describing the limitations of regulatory actions designed to correct the problem of employers dumping certain employees).

health costs are well documented,[127] and there is little in the reform legislation designed to change things. While returning insurers to the role of managing care can help mitigate the myriad market imperfections that complicate health care markets, it remains to be seen how effective regulations improving transparency, promoting evidence-based medicine, and curtailing insurance industry practices will be. Further, enforcement of antitrust law offers no panacea for the problems sketched above. Antitrust does not break up legally acquired monopolies or oligopolies, nor does it counter their exercise of market power through monopoly pricing, output restrictions, or quality degradation. Thus, to a considerable extent, the horse is out of the barn as far as consolidation in physician, hospital, and insurance markets that has already occurred.

To some commentators, embedded provider market concentration is an intractable problem that can be cured only by rate regulation.[128] An alternative approach recommends blending reliance on markets with steps to improve competition when possible and falling back on rate regulation when possible. For example, Len Nichols has framed this approach as follows:

> When prices are stuck far from the efficient cost level, policy makers have three basic tools at their disposal:
>
> (1) Change rules related to market entry and structure to engender more market competition (e.g., antitrust)
>
> (2) Use countervailing market buying power (monopsony) to counter local provider market power and resistance to change
>
> (3) Impose direct regulation of prices or specific behaviors of competitors.[129]

---

[127] *See supra* notes 38–46 and accompanying text.

[128] *See, e.g.*, Berenson et al., *supra* note 47.

> Unless market mechanisms can be found to discipline providers' use of their growing market power, it seems inevitable that policy makers will need to turn to regulatory approaches, such as putting price caps on negotiated private-sector rates and adopting all-payer rate setting. Indeed, some purchasers who believe strongly in the long-term merits of increased integration of care delivery believe that price regulation may be a prerequisite for payment reforms that encourage integration.

Id. at 705; *see also* Bruce C. Vladeck & Thomas Rice, *Market Failure and the Failure of Discourse: Facing Up to the Power of Sellers*, 28 HEALTH AFF. 1305, 1306 (2009) (arguing that high prices in American health care are the result of a "fundamental imbalance in power between buyers and sellers").

[129] Nichols, *supra* note 60, at 5.

Nichols's proposal merits consideration. However, given the difficulties associated with parts (1) and (2) of his concept, much of the burden may fall on item (3), rate regulation. Regulators and enforcers can take steps to encourage new entry; however, their tools are limited. While collusion to inhibit entry is actionable under antitrust law,[130] CON laws, laws governing the scope of practice for allied health practitioners, and other regulatory limitations on provider competition are the product of state and federal law. The ACA made no efforts to alter these limitations, and it is doubtful there is political will to do so. Indeed, the ACA all but put an end to one source of new competition in hospital markets by banning new physician-owned hospitals that depend on Medicare reimbursement.[131] Reliance on countervailing power is also open to question. As a matter of economic theory[132] and experience,[133] bilateral monopoly does not necessarily advance consumer welfare. Moreover, identifying the conditions in which bilateral monopoly should be encouraged (e.g., by countenancing otherwise anticompetitive mergers) is fraught with uncertainty.

The structure of insurance markets also poses an obstacle to reliance on competition. With one insurer controlling more than fifty

---

[130] *See, e.g.*, Press Release, U.S. Dep't of Justice, Justice Department Requires Two West Virginia Hospitals to End Illegal Market-Allocation Agreements (Mar. 21, 2005), *available at* http://www.justice.gov/atr/public/press_releases/2005/208209.htm. *See generally* 1 FURROW ET AL., *supra* note 11, at 206–07 (describing cases challenging concerted action to limit competition through abuse of the CON process).

[131] The ACA essentially bans future development of physician-owned hospitals that depend on Medicare reimbursement by eliminating the Stark Law exception for physicians who do not have an ownership or investment interest and a provider agreement in effect as of December 31, 2010, and it sharply curtails the ability of existing facilities to expand. Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 6001, 124 Stat. 119, 684–89 (2010) (codified at 42 U.S.C.A. § 1395nn (West 2010)); *see also* 1 FURROW ET AL., *supra* note 11, at 172.

[132] ROGER D. BLAIR & JEFFREY HARRISON, MONOPSONY IN LAW AND ECONOMICS 124–67 (2010).

[133] A notorious example of cooperation between dominant firms involved the so-called "market covenant" between the CEOs of Partners Health Care, the dominant hospital system in Massachusetts, and the State's largest insurer, Blue Cross Blue Shield (BCBS) of Massachusetts. As reported in *The Boston Globe*, BCBS agreed to a major payment increase for Partners, and in return, Partners "promised [it] would push for the same or bigger payment increases" from other insurers, thereby affording BCBS some insulation from competition from rival insurers. Scott Allen et al., *A Handshake That Made Healthcare History*, BOS. GLOBE, Dec. 28, 2008. *See generally* Robert Pitofsky, Chairman, Fed. Trade Comm'n, Thoughts on "Leveling the Playing Field" in Health Care Markets, Remarks Before the National Health Lawyers Association Twentieth Annual Program on Antitrust in the Health Care Field (Feb. 13, 1997).

percent of the market in seventeen states and at least twenty-two others states having two firms that dominate the market,[134] much attention during the reform debate focused on improving the competitiveness of insurance markets. Advocates claimed that offering a government-sponsored public plan option in each market would improve the dynamics of private plan competition in local and regional markets. The competition-based argument for the public option rested on the dynamics of rivalry in concentrated markets. When insurers were unable or unwilling to effectively bargain for discounts with hospitals,[135] the public plan would act as a "maverick" because it did not have incentives to go along with rivals that might be content to compete less vigorously.

While the foregoing arguments did not carry the day, Congress did adopt two proposals ostensibly designed to inject new competition into private insurance markets. The ACA authorizes the Office of Personnel Management (OPM) to enter into contracts with "multi-state insurance plans" to offer individual or small group coverage through the exchanges.[136] It requires the OPM to contract with at least two plans in each state, at least one of which must be a nonprofit.[137] Second, the ACA authorizes federal grants and loans to encourage the creation of nonprofit, member-owned consumer insurance cooperatives.[138] Cooperatives will be tax exempt, nongovernment entities, but they will be subject to a number of

---

[134] *See* Davenport and Sekhar, *supra* note 53.

[135] John Holahan explained the dynamic of hospital-payer bargaining as follows:

> In markets where there is little concentration among insurers but a concentrated hospital market, there is little ability to negotiate. Where there is a dominant insurer, it is possible to do better and obtain discounts from hospitals, but they still have little negotiating power with dominant hospital systems. In some markets, dominant insurers have no real incentive to be tough negotiators because they have no real competitors. Small insurers lack bargaining power with providers and thus cannot significantly compete with larger insurers on premiums. Finally, there is no real competition in many hospital markets because smaller hospitals have no ability to challenge the dominant system.

John Holahan, Dir., Health Policy Ctr., The Urban Inst., Statement at the Hearing on Health Reform in the 21st Century: Proposals to Reform the Health System (June 24, 2009).

[136] ACA § 10104, 124 Stat. at 902–06 (codified as amended at 42 U.S.C.A. § 18054 (West 2010)).

[137] The ACA empowers the Office of Personnel Management to negotiate with the plans concerning their medical loss ratio, profit margin, premium levels, and other terms and conditions as are in the interests of the enrollees. *Id.*

[138] *Id.* § 1332, 124 Stat. at 203–06 (codified at 42 U.S.C.A. § 18052 (West 2010)).

regulatory restrictions. The problem that both cooperative and multistate plans encounter is the obstacle that has stymied new entrants in the past: the entry barrier associated with obtaining provider discounts and assembling networks that will enable new plans to compete effectively with established incumbents.[139]

V

ACOs MAY BE THE ANSWER, BUT WHAT IS THE QUESTION?

ACOs have garnered much attention.[140] For many observers they hold out the prospect of rationalizing the delivery system by incentivizing providers to integrate their practices, make investments in technology and human capital, and ultimately change the way medicine is practiced. Under this Panglossian account, ACOs can provide a vehicle for lowering cost and improving quality, not only in Medicare but in the private sector as well. To meet the organizational and practical requirements of the ACA, providers will need to combine through merger or some other form of affiliation and make lasting commitments regarding their participation. There are already anecdotal reports of a pending merger and acquisition wave prompted by hospitals and physicians that want to position themselves to form ACOs,[141] even though, as of this writing, the HHS has yet to release rules or guidance.

---

[139] *See* Varney, *supra* note 56; *see also* Timothy S. Jost, *Are Cooperatives a Reasonable Alternative to a Public Plan?*, HEALTH REFORM WATCH (June 15, 2009), http://www.healthreformwatch.com/2009/06/15/jost-on-cooperatives (questioning the viability of cooperatives but allowing that they could succeed with "concerted and probably long-lasting support from the federal government").

[140] *See, e.g.*, Atul Gawande, *Testing, Testing*, NEW YORKER, Dec. 14, 2009, http://www.newyorker.com/reporting/2009/12/14/091214fa_fact_gawande; Reed Abelson, *A New Concept in Health Care*, N.Y. TIMES, July 8, 2010, http://prescriptions.blogs.nytimes.com/2010/07/28/a-new-concept-in-health-care (recognizing ACOs as "one of the hottest concepts to emerge from the discussions about how best to overhaul the nation's health care system"). For less sanguine views, see Jeff Goldsmith, *The Accountable Care Organization: Not Ready for Prime Time*, HEALTH AFF. BLOG (Aug. 17, 2009), http://healthaffairs.org/blog/2009/08/17/the-accountable-care-organization-not-ready-for-prime-time ("The problem with this movie is that we've actually seen it before, and it was a colossal and expensive failure."). *See also* Joe Carlson, *ACOs: A Mystery of Biblical Proportions*, MOD. HEALTHCARE (Aug. 9, 2010), http://www.modernhealthcare.com/article/20100809/NEWS/308099959.

[141] *See* Caralyn Davis, *Investors Expect Healthcare M&A Uptick Through 2Q 2011*, FIERCE HEALTHFINANCE (July 21, 2010, 11:05 AM), http://www.fiercehealthfinance.com/story/investors-expect-healthcare-m-uptick-through-2q-2011/2010-07-21#ixzz0zZ6qZLVp (predicting a sharp increase in consolidation among providers resulting from health reform).

From the perspective of the topic of this Article, a key issue is whether the movement to form ACOs will advance the competitive model or retard it. To a considerable extent, ACOs mirror the pro-competitive potential that HMOs brought to the table during the managed care era. That is, the ACO can serve as a locus of responsibility, accountable for maintaining quality and using evidence-based medicine and operating under financial incentives to control costs. As such, employers and insurers will be able to shop, compare, and bargain with ACOs to get the best deal for their insureds. Indeed, because they assume risk, ACOs can reduce the role of the insurer/middleman, offering presumed benefits to both providers and consumers who are suspicious of the insurance industry. But at the same time, the path of ACO development could prove profoundly anticompetitive. One concern flows from what might come to be called the "2010 Health Reform Merger Wave"—a rush to consolidation induced in part by hospitals and physicians wanting to be assured they will be in a strong bargaining position.[142] As hospitals buy up or otherwise affiliate with physician practices, as physician practices merge, and as hospitals merge with rivals, there may be little room for formation of competing ACOs in many markets. Whether the HHS will use its regulatory authority to discourage over-inclusive ACOs is still an open question.[143] Although the ACA contemplated that Medicare ACOs also serve the private insurance industry,[144] it gave no guidance as to whether the HHS should attempt to preserve conditions that are conducive to competition among ACOs. Thus, although ACOs are potentially the most potent mechanism for systemic change in the new law, Congress neglected to specifically charge the HHS with the responsibility for assuring that the Shared Savings Program does not enhance or entrench provider market power.

---

[142] *See* Robert Pear, *As Health Law Spurs Mergers, Risks Are Seen*, N.Y. TIMES, Nov. 21, 2010, at A1.

[143] Thomas L. Greaney, *Accountable Care Organizations—The Fork in the Road*, 364 NEW ENG. J. MED. e1 (2011), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1013404; Robert F. Leibenluft, *ACOs and the Enforcement of Fraud, Abuse, and Antitrust Laws*, 364 NEW ENG. J. MED. 99 (2011), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1011464.

[144] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10307, 124 Stat. 119, 941 (2010) (codified at 42 U.S.C.A. § 1315a (West 2010)) (stating that the Secretary of the HHS "may give preference to the ACOs who are participating in similar arrangements with other payers").

CONCLUSION

The interplay between competition and regulation has a long history in American healthcare. This Article has argued that, although the ACA takes important steps toward improving the prospects for competition, political and practical obstacles stand in the way of realizing that end. As we approach the forty-fifth anniversary of the passage of the last major health care reform in America, the adoption of Medicare and Medicaid, can one now say which side—competition or regulation—has prevailed? As Zhou En-lai answered when asked about the effect of the French Revolution, the answer seems to be "it's too soon to tell."[145]

[145] SIMON SCHAMA, CITIZENS: A CHRONICLE OF THE FRENCH REVOLUTION, at xiii (1989).

Statement of The Academy Advisors Before The
Subcommittee on Intellectual Property, Competition & the Internet
of the
Committee On The Judiciary
of the
U.S. House of Representatives

Hearing on "Health Care Consolidation and Competition after PPACA"

May 18, 2012

On behalf of our 13 member Leading Health Systems, with 209 hospitals in 28 states, The Academy Advisors thanks you for the opportunity to provide feedback on health care consolidation and competition after the Patient Protection & Affordable Care Act.

Leading Health Systems, a term we use to describe aligned and integrated health care delivery networks, were formed in the mid 1990s – barely 20 years ago. In that time the vision of Leading Health Systems has been focused on a higher standard of health care delivery, lower health care costs, and improved health outcomes. As the Subcommittee examines health industry consolidation, we want to highlight and distinguish between health industry consolidation and health industry clinical integration, which Leading Health Systems practice in an effort to deliver cost efficient and effective care to their communities.

Clinical integration can be defined as collaboration and alignment among hospitals, physicians and consumers, with the goal of providing health services across the continuum of care in a cost efficient manner that improves health outcomes. Clinical integration activity began in the 1990's, coinciding with the founding of many Leading Health Systems, and has continued in earnest over the last two decades. Primary drivers of clinical integration include the heightened focus on quality by health care providers, the adoption of technology such as electronic health records ("EHR's"), and the realization that clinical integration can lead to better and more efficient health outcomes. A clinically integrated health system is not only a provider of a full range of ambulatory and inpatient health care services; it provides services that span the entire continuum of care, including primary, secondary, tertiary, quaternary care, ambulatory care, home care, assisted living and rehabilitation care. Many clinically integrated health systems operate facilities across multiple states, communities and regions. Clinical integration among hospitals and physicians, along with coordination across the continuum of care, is necessary to improve the quality and efficient delivery of care.

Coordinating health care delivery across the continuum of care (e.g. ambulatory, inpatient, rehabilitation, home care, etc.) is a process of matching the needs of the health care consumer with the appropriate services. It also requires a necessary critical mass of infrastructure and relationships spanning the entire provider community. Achieving this successful care coordination is based upon substitution of more appropriate and less costly care, an emphasis on disease prevention rather than

disease treatment, ongoing provider training, and widespread health information technology ("HIT") adoption by the provider and the patient.[i] An important goal of coordinating care across the continuum is minimizing fragmentation, a longstanding impediment to improving health outcomes and providing responsible care. Fragmentation increases the "handoffs" in patient care, which decreases efficiency and patient safety, resulting in wasted resources, gaps in accountability, information loss and more opportunities for error.[ii] Fragmented health care delivery systems also lack peer accountability and quality improvement structures.[iii] Integrated or coordinated care, however, is positively correlated with improved quality. [iv] Specifically, integrated health care delivery systems are able to apply accountability metrics to their existing population, which is an efficient and practical way to improve quality and simultaneously lower costs for all payers.

While health care providers actively look to improve the quality of care, they continue to face internal pressure to reduce costs, combined with external pressure from state and federal government programs as well as private payers. As both government and private payers transition to pay-for-performance and other incentive programs, hospital-physician alignment and the ability to provide care across the continuum will be necessary for successful deployment. Hospitals, physicians and other health care providers must be incented to work toward the same quality, safety, and patient satisfaction goals, as well as cost efficient treatment and improved outcomes. As these collaborations progress, we support guidance from the Federal Trade Commission ("FTC") and the Department of Justice ("DOJ") to establish an easy to comprehend and consistent message regarding federal competition laws and regulations, eliminating the significant legal expense and time incurred by health systems and providers to collaborate within the proper parameters. Additionally, the sometimes inconsistent messages received from the legislative branch and regulatory agencies creates uncertainty and discourages integration activities.

Consolidation activity in any industry can be abused if engaged in solely for the purpose of anticompetitive activities. In the health care arena it is important for legislators and regulators alike to not lose sight of the distinction between consolidation and integration, along with the ability of integrated care delivery to reduce prices and improve outcomes across the care continuum. Without reducing fragmentation, controlling costs and improving outcomes in the U.S. health care system will be very difficult.

The Academy Advisors and its member health systems are appreciative of the opportunity to discuss these topics. We look forward to working with the Committee on the Judiciary to improve the quality and effectiveness of care, along with patient outcomes.

---

[i] Chuang, Kenneth H., Harold S. Luft and Dudley Adams. "The Clinical and Economic Performance of Prepaid Group Practices." *The Contributions and Potential of Prepaid Group Practice*. San Francisco: Jossey Bass, 2004.

[ii] "Crossing the Quality Chasm, Report Brief." *Institute of Medicine*, 2000. Accessed May 17, 2012. http://www.iom.edu/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.ashx

[iii] Shih, Anthony., Karen Davis., Stephen C. Shoenbaurm., Anne Gauthier., Rachel Nuzum., and Douglas McCarthy. Organizing the U.S. Health care System for High Performance." *The Commonwealth Fund*, 2008.

[iv] Cosson, Francis J. "21st Century Health Care – The Case for Integrated Delivery Systems." *New England Journal of Medicine*, September 23, 2009. Accessed May 17, 2012. http://www.nejm.org/doi/full/10.1056/NEJMp0906917

Statement of Joel C. White
Executive Director
Coalition for Affordable Health Coverage
to the
Committee on The Judiciary
Subcommittee on Intellectual Property, Competition and the Internet

Hearing on Health Care Consolidation and Competition After PPACA

May 18, 2012

Chairman Goodlatte, Ranking Member Watt, Members of the Subcommittee, thank you for holding this hearing on health care consolidation and competition after PPACA.

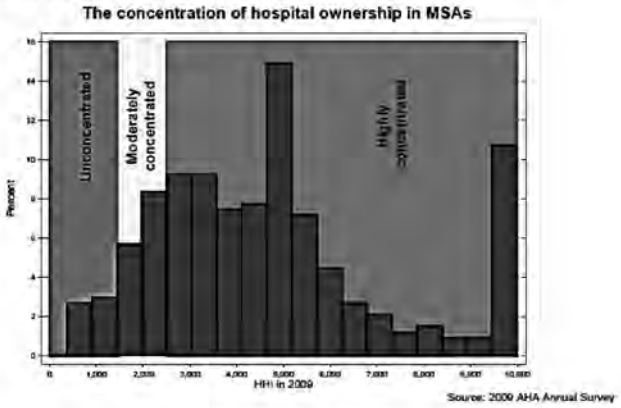
The Council for Affordable Health Coverage (CAHC) is a non-partisan alliance dedicated to bringing down the cost of health care for all Americans. Our membership reflects a wide range of interests—from organizations representing small and large employers, to sellers of health products and services, to insurers and agents, to physician organizations, to patients and consumers.

We commend the Judiciary Committee for holding this timely and essential hearing. America's health affordability crisis is rooted in uncompetitive markets. Without the Committee's leadership in tackling the problem of monopoly and oligopoly, all of the health reforms conducted in the private market or engineered by all of the other committees and subcommittees in Congress are bound to meet with frustration and disappointment. Absent a robust strategy to address market concentration, costs will be higher, and more will lack access to affordable health coverage.

Accountable Care Organizations are a case in point. In the current issue of *Health Affairs*, Glenn Melnick and colleagues document the early success of a private ACO organized by Calpers and Blue Cross Blue Shield in conjunction with a Sacramento area physician organization and hospital. An important aspect of that story is that Sacramento is one of the few competitive provider markets in the nation.

The following chart, developed by Cory Capps of the economic consulting firm Bates and White, illustrates the extent of the competitiveness challenge. More than 90 percent of

Americans live in hospital markets that meet the Federal Trade Commission's definition of "highly concentrated." Ten percent of hospital markets are outright monopolies. Market concentration mutes the demand-side signals that drive efficiency in every other sector of our economy. This unbalanced playing field between the suppliers and purchasers of health services has saddled American consumers with the least efficient, most expensive health system in the world.



Unfortunately, in the name of incentivizing Medicare ACOs, the Affordable Care Act (ACA) has loosened what few restraints remained on hospital and physician group consolidation. The predictable result has been a breathtaking wave of vertical consolidation, in which hospital systems are scooping up their independent competitors in the outpatient services market—an area of our health system where there does appear to be vestiges of competition.

Adverse Side Effects

The great contradiction in American medicine is that providers lose money by saving consumers money. Without strong competitive pressures, such a system morphs into something that is dangerously parasitic. The ACO, a highly integrated network led by risk-bearing hospitals and physician groups, has been offered as a response to this problem. According to this vision, a conscientious continuum of care would save money under a shared risk payment structure that permits some efficiency gains to flow to providers, thus helping them to offset in higher profits per patient what they lose in volume.

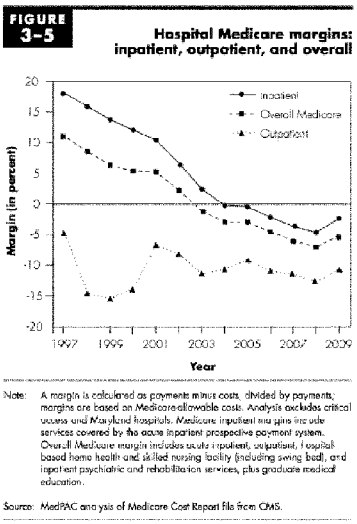
Yet the bifurcated nature of America's health markets makes ACOs uniquely susceptible to the law of unintended consequences. Different rules apply for different market segments. Policies that save the government money perversely can raise costs for private payers. As economic entities, providers charge the highest prices to those least able to resist them. There is nothing wrong with price discrimination, so long as it is constrained by the forces of competition. Unfortunately, such constraints do not exist in most local health markets.

For its part, Medicare's fee-for-service programs set prices administratively, rather than through bargaining. Viewed through this lens, it is easy to see why provider market concentration is, at best, a secondary concern for government. This may explain why ACO advocates are so eager to bet that collaboration among previously competing hospitals and physician groups will yield savings. History and economic theory suggest that this gamble entails real risks.

Indeed, this is not the first time regulators have wagered that market concentration will promote efficiency. In 1996, federal antitrust guidance was relaxed to favor hospital mergers that improved clinical integration. Thousands of mergers later, the results are painfully clear. Empirical studies show that the mergers significantly raised prices in the affected markets. An accepted rule of thumb is that private prices increase 40 percent when the merging hospitals are closely located. Meanwhile, efficiency gains from clinical integration have proven elusive, with estimates ranging range from slightly negative to slightly positive.

ACA further loosened antitrust standards to permit the creation of ACOs. Today ACOs are widely cited as a motivating factor in hospitals' current rush to acquire physician practices. The number of physicians employed by hospitals has tripled recent years. Accenture projects that two-thirds of physicians will work for hospitals in 2013.

The following chart, from the Medicare Payment Advisory Commission (MedPAC), suggests an alternative rationale for this acquisition frenzy. Competition from independent clinics has been partially responsible for turning Medicare outpatient services into big money-losers. This year, hospitals will lose an average of 13 percent providing outpatient services to Medicare patients. They will shift some of those losses on to the privately insured. This could not happen in perfectly competitive markets. Indeed, MedPAC has found that in competitive markets, where cost shifting is difficult, hospitals have found ways to make money on Medicare patients. In other words, hospitals' ostensible preparations to participate in ACOs may be nothing more than the time-tested business model of buying up competitors to enhance profits through cost shifting rather than cost management.



Cost Shifting

The CMS final rule on ACOs, issued last September, acknowledged the concern that "ACOs could have an enhanced incentive and ability to obtain shared savings payments by reducing Medicare expenditures to achieve 'savings' under the Shared Savings Program, while compensating for the reduced Medicare payments by charging higher rates and possibly reducing quality of care in the private market." CMS will refer ACO application letters and pricing data to the Department of Justice and Federal Trade Commission. CMS has also requested the antitrust agencies to conduct an after-the-fact study "examining how ACOs participating in the Shared Savings Program have affected the quality and price of health care in private markets." Yet if history is a guide, the agencies are poorly equipped to limit the damage.

In remarks before the American Bar Association's antitrust law forum last November, Federal Trade Commissioner J. Thomas Rosch warned of "a very real risk that some ACOs will be formed with an eye toward creating or enhancing market power." He went on to note that cost shifting—the practice of charging private payers more to make up for losses incurred treating Medicare beneficiaries—is already a problem. According to Rosch, "The ACO program may exacerbate this trend by causing providers to shift more of their costs to commercially insured patients in order to qualify for the Medicare cost-reduction bonuses."

For their part, DOJ and FTC have issued a tough-sounding antitrust statement that nevertheless fails to mention cost shifting. It advises ACO applicants that include

providers with more than 30 percent of the market in their respective Primary Service Areas "to avoid" the following (widespread) anticompetitive conduct:

- Preventing or discouraging private payers from directing or incentivizing patients to choose certain providers, including providers that do not participate in the ACO, through "anti-steering," "anti-tiering," "guaranteed inclusion," "most favored-nation," or similar contractual clauses or provisions.

- Tying sales (either explicitly or implicitly through pricing policies) of the ACO's services to the private payer's purchase of other services from providers outside the ACO (and vice versa), including providers affiliated with an ACO participant (e.g., an ACO should not require a purchaser to contract with *all* of the hospitals under common ownership with a hospital that participates in the ACO).

- Contracting on an exclusive basis with ACO physicians, hospitals, ASCs, or other providers, thereby preventing or discouraging those providers from contracting with private payers outside the ACO, either individually or through other ACOs or analogous collaborations.

- Restricting a private payer's ability to make available to its health plan enrollees cost, quality, efficiency, and performance information to aid enrollees in evaluating and selecting providers in the health plan, if that information is similar to the cost, quality, efficiency, and performance measures used in the Shared Savings Program.

Under this regulatory regime, the question of whether ACOs will directly drive up private premiums depends precariously on the regulatory agencies' tolerance of cost shifting. The preceding chart shows that the typical hospital lost money on Medicare patients during a period when per beneficiary expenditures were growing more than twice as fast as the CPI. During the next ten years under ACA's reimbursement restraints, per beneficiary spending will grow by less than the CPI, even as the Medicare and Medicaid/CHIP populations grow by roughly one third. Not only might hospitals lose more per beneficiary, there will be more money-losing beneficiaries. Cost shifting could explode.

The DOJ and FTC are silent on whether they plan to prohibit cost shifting under the ACO model. If they allow some cost shifting, then antitrust authorities will find themselves in the role of a shadow Internal Revenue Service, overseeing a system of regressive, hidden taxation. We have serious doubts that Congress will provide DOJ or FTC with the financial or the political resources to block or competently enforce limits on cost shifting.

Recommended Reforms

We agree that ACOs and other payment systems have the potential to save taxpayers and consumers enormous amounts of money. Dartmouth researcher John Wennberg and colleagues estimate that 60 percent of the services paid for by Medicare are "supply sensitive," meaning that they reflect only the capacity of the local health system, not patient

needs. If so, our health system is vastly overbuilt. To achieve large efficiency gains, we must idle this excess capacity.

We recommend a multi-pronged approach.

1. **Prohibit the anticompetitive conduct cited in the DOJ-FTC antitrust statement**. None of the practices listed in the aforementioned antitrust statement are defensible in today's highly concentrated markets. A number of states are taking steps to outlaw anticompetitive practices such as MFN and "anti-tiering." We recommend that Congress take steps to prohibit all such anticompetitive practices in all markets.

2. **Ensure price transparency for private consumers.** In an era when more and more employers are adopting high deductible and consumer directed plans, consumers need to be able to shop among providers for the best price and quality. This means making available providers' actual charges (as opposed to list prices) in a format that is accessible to the public. Some states are leading the way. Congress should as well.

3. **Enact premium support.** Take the Medicare program out of the business of price setting, and allow beneficiaries to select their health plans under competitive bidding rules that encourage efficiency and high quality. By purchasing health insurance rather than individual health services, Medicare would encourage ACOs, HMOs and other health plans to organize care around the most efficient delivery models.

4. **Empower local communities.** Not all communities are large enough to support competition among multiple health systems. In some markets, including many rural communities, it may be appropriate to carve out antitrust safe harbors to permit collective bargaining among payers and providers. In others, it may make sense to treat hospitals as common carriers, with only limited ability to practice discriminatory pricing. Some big cities have broken up public school monopolies by allowing competing charter schools to occupy common facilities. A similar approach may help to engender competition in communities where today consumers face few or no choices.

Mr. Chairman, we believe that the many efficiencies and high prices that plague our health system are traceable in large part to market concentration. Reintroducing competition into our highly concentrated health markets is sorely needed to promote cost restraint and affordable coverage. The Council for Affordable Health Coverage shares the Committee's concern that ACA has encouraged provider consolidation in ways that will harm consumers. There are a number of ways that Congress can improve competitiveness. We look forward to working with you and your colleagues in exploring creative solutions to this very important challenge.

AMGA American Medical Group Association

The Best Medicine *in* America.
The Best Medicine *for* America.

One Prince Street
Alexandria, VA 22314-3318
Phone: (703) 838-0033
Fax: (703) 548-1890
www.amga.org

CHAIR
Robert E. Nesse, MD
Mayo Clinic Health System

CHAIR ELECT
Michael W. Bukosky, MSHA
University of Louisville Physicians

SECRETARY
Howard D. Graman, MD
PeaceHealth Medical Group

TREASURER
Linda C. Leckman, MD
Intermountain Healthcare
Intermountain Medical Group

AT LARGE
Donn E. Sorensen, MBA
Mercy Clinic

IMMEDIATE PAST CHAIR
Scott D. Hayworth, MD
Mount Kisco Medical Group

PRESIDENT & CEO
Donald W. Fisher, PhD, CAE
American Medical Group Association

DIRECTORS
Jeffrey W. Ballet, MD
Aurora Health Care
Aurora Medical Group

Norman H. Chenven, MD
Austin Regional Clinic

Joseph Colbus, MD
NorthShore Medical Group
NorthShore University HealthSystem

Barry L. Gross, MD
Riverside Medical Group
Riverside Health System

A. Marc Harrison, MD
Cleveland Clinic Abu Dhabi

Larry J. Harrison, MBA, MPH
Scripps Medical Foundation

Margaret R. Head, RN, MBA
Vanderbilt Medical Group
The Vanderbilt Clinic

Jeffry G. James, MBA
Wilmington Health

Bernadette C. Loftus, MD
The Permanente Medical Group

Barbara Walters, DO, MBA
Dartmouth-Hitchcock

Don L. Wheless, MD
Sutter Medical Group

Statement for the Record
of the
American Medical Group Association
to the
Subcommittee on Intellectual Property, Competition, and the Internet
of the
Committee on the Judiciary

May 18, 2012

The American Medical Group Association (AMGA) is pleased to submit this statement for the record of the Subcommittee's hearing entitled, "Health Care Consolidation and Competition after PPACA."

AMGA represents multi-specialty medical groups and other organized systems of care, including some of the nation's largest, most prestigious integrated health care delivery systems. More specifically, AMGA represents 415 medical groups that employ nearly 125,000 physicians who annually treat more than 130 million patients in 49 states. We therefore have a strong interest in health care and sector consolidation efforts.

While health care consolidation is not a new phenomenon, we believe that it fosters care coordination, which significantly improves health outcomes and reduces costs. This team-based approach to medical care engages the patient, the clinician, and other health care professionals who are working at the top of their field to improve the patient's well-being.

A 2009 *Annals of Internal Medicine* article examined the fee-for service Medicare program and found that the typical primary care doctor may need to coordinate care with 229 doctors across 117 different practices.[1] The same article found that Medicare beneficiaries typically see seven different physicians from four different practices in a given year, and the care of patients with multiple chronic illnesses is even more fragmented.

High-performing health systems, multi-specialty medical groups, and other organized systems of care are the most effective and efficient delivery system model to coordinate care and provide high-quality, patient-centered health care to Americans. As such, it should be a significant national health care policy to stimulate formation, foster growth, and support development of organized systems of care.

1 Honagmai H. Pham, MD, MPH; Ann S. O'Malley, MD, MPH; Peter B. Bach, MD, Mapp; Cynthia Saiontz-Martinez, SeM; and Deborah Schrag, MD, MPH. (2009). "Primary Care Physicians' Links to Other Physicians Through Medicare Patients: The Scope of Care Coordination." *Annals of Internal Medicine* (2009).

AMGA members understand that patients often see multiple providers across different care settings. We believe that it is critical for providers to share clinical information with other providers, monitor patient status between visits, and fully communicate about self-care. Without such care management, patients are likely to be frustrated, medical errors are more likely to occur, and unnecessary utilization of medical services will take place. That is why AMGA members are committed to coordinating care across patient conditions, services, and settings over time.

Many AMGA members have been early adopters of health information technology, which assists in the implementation of quality measurement and improvement activities. This important technology helps AMGA members improve health care quality and reduce costs. It also allows AMGA members the ability to gather ongoing patient data, develop care plans, and analyze health care information that can be translated into actionable evidence-based practice. Moreover, health information technology allows AMGA members to engage in data comparison efforts, which help multi-specialty medical groups, and other organized systems of care, to discover new clinical processes and cost saving mechanisms.

Studies suggest that multi-specialty groups and other organized systems of care are more likely to use care management processes and may use fewer resources. Medical groups are more likely to invest in health information technology, form teams of providers, collect and analyze data, and provide direct physician feedback on clinical care. Further, evidence shows there is greater collaboration among physician specialties and allied health professionals in large multi-specialty medical groups, which is a key component to successful care coordination. This collaboration leads to improved quality and reduced costs.

An article published in *Health Affairs* (Weeks, et al) demonstrated that patients cared for in a multi-specialty medical group or other organized system of care received higher quality care at a lower cost.[1] The study collected ambulatory claims in 22 Hospital Referral Regions comparing data from physicians practicing in multi-specialty medical groups, and physicians not affiliated with multi-specialty medical groups. The authors found within the same referral area, Medicare beneficiaries cared for by physicians practicing in multi-specialty medical groups received 5-15 percent higher quality of care at a cost that was $272 (3.6 percent) lower."

These findings provide strong support for the multi-specialty medical group and other organized system of care model. The authors estimate that the 3.6 percent cost savings across all physicians could save Medicare $15 billion in a year or $150 billion over a decade, a sizeable contribution to the almost $1 trillion health care reform law enacted in March, 2010 (P.L. 111-148).

Congress has established an accountable care organization program in the health care reform law, which rewards organized medicine for providing high quality care. The program is an advance in the course of action to increase high quality, coordinated care; however, Congress needs to do more. Incentives must be provided to shift the trend from physicians practicing fragmented medicine to physicians practicing integrated care provided in multi-specialty medical groups and other organized systems of care.

In summary, AMGA believes that 21st Century care - as well as that of the future - demands a broad spectrum of diverse resources be brought to bear, and that requires integration of care. This integration, fostered by providers understanding and anticipating the demands of their patient populations, should be a vital part of any evaluation of this issue, and we would respectfully ask that the Congress and Administration keep this perspective in mind going forward.

[1] William B Weeks, Daniel J. Gottlieb, David E. Nyweidi, Jason M. Sutherland, Julie Bynum, Lawrence P. Casalino, Robin R. Gillies, Stephen M. Shortell, and Elliot S. Fisher. "Higher Health Care Quality and Bigger Savings Found At Large Multispecialty Medical Groups." *Health Affairs*, 29:5, 991-997. (May 2010).

Statement by the Association of American Medical Colleges on

Health Care Consolidation and Competition After PPACA

submitted to the

Committee on Judiciary, Subcommittee on Intellectual Property, Competition and the Internet

United States House of Representatives

May 18, 2012

This statement is submitted on behalf of the Association of American Medical Colleges (AAMC). The AAMC is a not-for-profit association representing all 137 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 59 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians.

Multiple pressures are causing major changes in the American health system, with many teaching hospitals and health systems leading the way. They are participating in models that allow for the delivery of team-based care that is patient-centered and emphasizes quality improvement, incorporates the use of electronic health records, and seeks to reduce costs. All of this is in response to the need to find an approach to care that is designed to:

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care

Many AAMC members have embraced new and challenging opportunities that allow them to be among the early adopters of this change. They are participants in the Centers for Medicare and Medicaid Innovations Pioneer Accountable Care Organization (ACO) project, in the CMS Medicare Shared Saving Program ACOs, and also are working with private payers to develop and test innovative care delivery models. A unifying theme of all of these activities is that they require vigorous monitoring and reward for quality and efficiency.

A consequence of this activity is that parts of the health system are experiencing some necessary consolidation. This represents the reality that it is very difficult, if not impossible, to deliver the best, most efficient care when delivery is fractured. Consolidation can take many forms, including hospital mergers, acquisition of physician practices, and affiliations that allow entities to remain separate but agree on a commitment to work together in a coordinated fashion. Such changes are evidence of a health care market that is finding positive ways to respond to numerous, often conflicting pressures. The Department of Justice and the Federal Trade Commission acknowledged the value of these collaborations when they jointly issued a *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*. The movement in the health care market is undergirded by an underlying assumption that the current system is unsustainable, and that teaching hospitals and health systems, and others that are the first to respond also will be the ones to guide the system to a better way of care.

For more information, please contact Leonard Marquez, Director, Government Relations, AAMC, at lmarquez@aamc.org or 202-862-6281.

American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

Statement of the American Hospital Association
before the
Subcommittee on Intellectual Property, Competition and the Internet
of the
Committee on the Judiciary
of the
U.S. House of Representatives

"Health Care Consolidation and Competition after PPACA"

May 18, 2012

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record as the Subcommittee on Intellectual Property, Competition and the Internet of the Committee on the Judiciary examines health care consolidation and competition after enactment of the *Patient Protection and Affordable Care Act* (PPACA).

The health care landscape is changing. The reasons for such change are varied; but chief among them are expectations by employers, insurers and government at all levels for higher quality, more efficient health care – in other words, greater value. Meeting those expectations requires building a continuum of care to replace the current fragmented system of health care.

Some pundits decry the changing landscape and hospitals' need to seek partners to ensure their stability and access to essential capital, as well as to buttress their expertise in quality improvement and efficiency enhancement. These critics, it seems, would have it both ways. On the one hand, they blame the current health care system for high costs and inefficient and uncoordinated care, among other ills. On the other hand, they express alarm over the prospect of *hospitals* trying to replace the current silos with a better-coordinated continuum of care that delivers higher quality care at a lower cost.

These criticisms are often at odds with the assessments of professional observers, such as Moody's and Standard & Poor's, for example, and are too often based on flawed data and out-of-date biases. Moreover, they rarely pause to examine the impact that a concentrated health insurance market currently has on health care prices and quality, or to note that the health insurance industry is engaged in a round of acquisitions of its own (*e.g.*, doctors and hospitals).

CHANGING LANDSCAPE BENEFITS PATIENTS

Building that continuum of care is the future. The forces that make it imperative include the need for hospitals to respond to powerful financial incentives for meeting performance objectives and avoiding penalties for failing to do so.

According to a recent Moody's report, "[t]he ability to demonstrate lower costs while providing higher quality will be the key driver in government and commercial reimbursement going forward."[i] One estimate is that 6 percent of hospital revenue could be at risk from penalties from government and commercial payers for lack of coordination.

The need for capital to build the continuum is also driving hospitals together. Hospitals are faced with unprecedented demands for capital to invest in new technology such as electronic health records – as much as $50 million for a mid-size hospital – implement new modes of delivering care such as telemedicine, and build new and improved facilities. Moody's states that "[a]ccess to capital markets has become more difficult for lower-rated hospitals, driving the need for many to seek a partner."

Mergers and acquisitions are often the preferred way to build the continuum because of numerous regulatory barriers. Antitrust laws, outdated fraud and abuse policies and even tax-exempt rulings favor consolidation over clinical integration. It is notable that all of the federal agencies that administer these laws needed to provide guidance or waivers to make the Medicare Accountable Care Organization (ACO) program feasible. However, their coordination ends outside of that narrow program.

Mergers and acquisitions are vigorously policed by two federal and numerous state antitrust authorities. Deals and integrative arrangements that these authorities deemed to be anticompetitive have been challenged. In fact, there has been much more attention paid to the hospital field than to the health insurance industry. The result is that the health insurance industry is highly concentrated and is now acquiring hospitals and providers in an effort to replicate the care continuum hospitals are building.

Despite this activity, hospitals' price growth is at an historic low and is not the main driver of higher health insurance premiums. The growth in health insurance premiums from 2010 to 2011 was more than double that of underlying health costs, including the cost of hospital services. An important feature of hospital costs is that two-thirds of those costs are attributable to caring for patients, specifically the wages and benefits paid to caregivers and other essential staff. This is unlike any other part of the health care sector.

THE HOSPITAL FIELD IS MOVING TOWARD BUILDING THE CONTINUUM

The hospital field has long recognized the need to build a more coordinated continuum of care and the benefits that could have for patients. More than a decade ago in its 2000 report, *To Err is Human: Building a Safer Health System*, the Institute of Medicine (IOM) called for improvements in the way care is delivered and stressed the importance of creating systems that support caregivers and minimize risk of errors. In its subsequent 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the IOM challenged the adequacy

and appropriateness of the current health care system to address all components of quality and meet the needs of all Americans. According to the report, a 21st century system should provide care that is "evidence-based, patient-centered, and systems-oriented."

As an outgrowth of those reports, a number of commentators, including the IOM, advocated linking provider payment to provider performance on quality measures because such an approach is "one of several mutually reinforcing strategies that collectively could move the health care system toward providing better-quality care and improved outcomes." Numerous pay-for-performance and incentive programs were launched in the private sector and were incorporated into Medicare payment systems for both hospitals and physicians. Those programs were predicated on collaboration through aligning hospital and physician incentives, encouraging them to work toward the same goals of improving quality and patient safety, and providing effective and appropriate care to create better health outcomes.

A 2005 AHA Task Force on Delivery System Fragmentation found that better alignment among providers was the key to improving patient care and enhancing productivity, and that removing impediments to such alignment created by various federal laws and policies was essential. It called upon a variety of federal agencies, including the Federal Trade Commission (FTC) and Department of Justice (DOJ), to:

> Establish a simpler, consistent set of rules for how hospitals and physicians construct their working relationships. The complexity, inconsistency and sometimes conflicting interpretations of federal laws and regulations affecting hospital-physician arrangements are a significant barrier. Few arrangements can be structured without very significant legal expense.

Despite those calls, many of these regulatory barriers remain. As noted, these barriers favor mergers and acquisitions over integration and should be addressed without delay.

Building a new continuum of care will require scrutiny of health plans. The American Medical Association annually reports that an abundance of health insurance markets are concentrated,[ii] with negative impact on providers. In May 2009, the AHA called upon DOJ to re-examine and bolster its enforcement policy as it applies to health plans in *The Case for Reinvigorating Antitrust Enforcement for Health Plan Mergers and Anticompetitive Conduct to Protect Consumers and Providers and Support Meaningful Reform*.[iii]

Among the AHA's requests were that the Antitrust Division:

- Undertake a comprehensive study of consummated health plan mergers; and
- Revisit and revise its analytical framework for reviewing health plan mergers and conduct complaints. The areas of scrutiny should include whether:
    - Proposed mergers by plans with pre-existing market power should be viewed as presumptively unlawful;
    - The ability of merged or dominant health plans to price discriminate against certain hospitals poses particular concerns about likely competitive harm;

- Merged or dominant health plans can wreak competitive harm in ways other than reducing prices below competitive levels, such as adversely affecting the development or adoption of quality protocols or technology tailored to meet the needs of hospitals and the patients they serve; and
- Mergers of health plans with service areas that technically do not overlap because of license or other agreements still pose a risk of competitive harm and, therefore, should be challenged.

While we are pleased that DOJ has increased its enforcement activities against health plans, continued vigilance, commensurate to that applied to hospitals, is essential to ensure continued progress toward building a new health care continuum.

CONCLUSION

Patients receive significant benefits when caregivers work together to provide more coordinated, more efficient and higher-quality care. That is the path we are on and the one that holds the greatest promise for not only improving health but fixing the fragmented health care delivery system.

We look forward to working with this subcommittee to forge ahead toward a shared goal: improving the quality of American health care.

Attachments:

Statement of the American Hospital Association before the Subcommittee on Health of the Committee on Ways and Means of the U.S. House of Representatives, Hearing on Health Care Industry Consolidation, September 9, 2011.

Hospitals: The Changing Landscape is Good for Patients and Health Care. © 2012 American Hospital Association.

---

[i] Moody's Investors Service Inc. (2012.) *New Forces Driving Rise in Not-for-Profit Hospital Consolidation*. Accessed at www.moodys.com.

[ii] American Medical Association. (2011). *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2011 Update.* Accessed at https://catalog.ama-assn.org/Catalog/product/product_detail.jsp?productId=prod1940016.

[iii] American Hospital Association. (2009). *The Case for Reinvigorating Antitrust Enforcement for Health Plan Mergers and Anticompetitive Conduct to Protect Consumers and Providers and Support Meaningful Reform*. Accessed at www.aha.org/aha/content/2009/pdf/09-05-11-antitrust-rep.pdf.

ATTACHMENT

American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
U.S. House of Representatives

Hearing on Health Care Industry Consolidation

September 9, 2011

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) thanks you for the opportunity to provide feedback on the impact of health care industry consolidation.

The need for greater collaboration among health care providers has never been more compelling. Persistent fragmentation contributes to gaps in quality and efficiency that adversely impact providers and their patients. The AHA has long recognized the importance of collaboration in health care, particularly between hospitals and physicians. A 2005 AHA Task Force on Delivery System Fragmentation supported "the integration of clinical care across providers, across settings and over time" as an important strategy to foster collaboration and, consequently, to improve the quality and efficiency of care. A recent AHA *Trendwatch* publication titled "Clinical Integration – The Key to Real Reform"[1] highlighted the crucial role of clinical integration in achieving the kind of systemic change needed in the health care delivery system.

At the same time health care providers are actively looking for strategies to address unhealthy and wasteful fragmentation, they also are seeking to improve efficiency and quality; they are also under internal pressure to reduce costs and achieve higher quality as well as increasing pressure from others – government and private payers in particular. The pressure for efficiency is longstanding. In a 2000 report, *To Err is Human: Building a Safer Health System*, the Institute of

Medicine (IOM) called for improvements in the way care is delivered and particularly stressed the importance of creating systems that support caregivers and minimize risk of errors. In its subsequent 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century,* the IOM challenged the adequacy and appropriateness of the current health care system to address all components of quality and meet the needs of all Americans. According to the report, a 21st Century system should provide care that is "evidence-based, patient-centered, and systems-oriented."

A number of commentators, including the IOM, advocate linking provider payment to provider performance on quality measures because such an approach is "one of several mutually reinforcing strategies that collectively could move the health care system toward providing better-quality care and improved outcomes." Numerous pay-for-performance and incentive programs have been launched in the private sector in recent years, and such efforts also have been incorporated into Medicare payment systems for both hospitals and physicians. To be effective, such programs need to foster collaboration by aligning hospital and physician incentives, encouraging them to work toward the same goals of improving quality and patient safety, and providing effective and appropriate care to create better health outcomes.

The AHA Task Force saw that better alignment among providers was the key to improving patient care and enhancing productivity, and that removing impediments to such alignment created by various federal laws and policies was essential. It called upon a variety of federal agencies, including the Federal Trade Commission (FTC) and Department of Justice (DOJ) to:

> Establish a simpler, consistent set of rules for how hospitals and physicians construct their working relationships. The complexity, inconsistency and sometimes conflicting interpretations of federal laws and regulations affecting hospital-physician arrangements are a significant barrier. Few arrangements can be structured without very significant legal expense.

We support user-friendly guidance from the antitrust agencies on how antitrust laws and policies will be applied to clinical integration arrangements among hospitals and other caregivers, and urge those agencies to act quickly to provide such guidance.

We also urge the DOJ's Antitrust Division to be increasingly vigilant about anticompetitive conduct on the part of entrenched health insurers and commend the division for its recent stepped up enforcement. We disagree with those who contend that hospitals – the object of so much antitrust scrutiny – have somehow acquired the power to dictate terms to health plans. Two well-known and respected antitrust economists from Compass Lexecon (referred to below) conclude that these critics confuse patient preference for providers with highly differentiated services or specialized service, with market power. For all the reasons that collaboration is good and fragmentation is bad, we believe that mergers and consolidations can be helpful. Consolidation among health care providers can address fragmentation and lead to the same benefits as less formal collaboration.

THE NEED FOR VIGILANT ANTITRUST ENFORCEMENT FOR HEALTH PLANS

Criticizing the historic lack of a robust and coherent enforcement policy on health insurance plan mergers and anticompetitive conduct in May 2009, the AHA called upon DOJ to re-examine and bolster its enforcement policy as it applies to health plans in *The Case for Reinvigorating Antitrust Enforcement for Health Plan Mergers and Anticompetitive Conduct to Protect Consumers and Providers and Support Meaningful Reform.*[ii] Among the AHA's requests were that the Antitrust Division:

- Undertake a comprehensive study of consummated health plan mergers.
- Revisit and revise its analytical framework for reviewing health plan mergers and conduct complaints. The areas of scrutiny should include whether:
    - Proposed mergers by plans with pre-existing market power should be viewed as presumptively unlawful;
    - The ability of merged or dominant health plans to price discriminate against certain hospitals poses particular concerns about likely competitive harm;
    - Merged or dominant health plans can wreak competitive harm in ways other than reducing prices below competitive levels, such as adversely affecting the development or adoption of quality protocols or technology tailored to meet the needs of hospitals and the patients they serve; and
    - Mergers of health plans with service areas that technically do not overlap because of license or other agreements still pose a risk of competitive harm and, therefore, should be challenged.

Unlike other sectors of the health care field, such as hospitals and physicians, health plan mergers and other anticompetitive conduct had received comparatively little scrutiny:

> In the past eight years, the Antitrust Division has requested only relatively minor divestitures and other relief in two health plan mergers. In addition, the Antitrust Division has offered no explanation for failing to respond to provider requests for more robust enforcement in the last two major health plan mergers.

While enforcement has been stepped up recently, it is noteworthy that since the AHA's May 2009 letter, DOJ has challenged only one health insurance transaction, involving a small provider-owned HMO, while other larger transactions have been cleared.

Contrasting with that lack of scrutiny was the fact that during the same time period, the FTC launched a major retrospective of the hospital field that was intended to lead to more successful challenges to hospital mergers where anticompetitive ones were identified, apparently in an attempt to overcome losing virtually all of its hospital merger challenges in the federal courts. Following that retrospective, the FTC challenged one long-consummated hospital merger via an internal agency hearing and blocked another outright. The FTC also has aggressively applied antitrust law to arrangements between physicians and between physicians and hospitals, all to "protect" patients from any increase in market power resulting from such arrangements. Moreover, while some of these specific hospital and physician cases have been high profile and touted with frequency, numerous other mergers and acquisitions have occurred, many reviewed,

with few challenges, suggesting the infrequency of "anticompetitive" hospital mergers. Where was the comparable focus on health plan mergers and market power?

Today, some would turn the lack of antitrust enforcement against health plans on its head, contending instead that hospitals – the object of so much antitrust scrutiny – have somehow acquired the power to dictate terms to health plans. To examine these claims, the AHA recently commissioned two well-known and respected antitrust economists from Compass Lexecon to evaluate two publications that have been widely cited as support for this mistaken notion: a 2010 *Health Affairs* article about California health care providers[iii] and the 2010 report by the Massachusetts Attorney General on health care costs.[iv]

In short, the economists from Compass Lexecon concluded, after rigorous analysis, that neither publication contains any credible support for such claims. While the two publications have different but serious flaws, they share one that is particularly glaring: they confuse patient preference for providers with highly differentiated services or specialized service with market power.

> A hospital can become highly desired simply by providing excellent care. Indeed strong consumer preferences for specific hospitals and their services provide an incentive for hospitals to improve services, enhance quality or expand output of services in greater demand, and to expect an appropriate return on the investment required to provide these services.[v]

Hospitals, in particular, are held accountable for the care they provide to their communities; for example, quality and patient satisfaction are routinely measured and publicly reported.[vi] Hospitals also have been subject to intense scrutiny by the federal antitrust agencies. Conversely, insurers, which wield enormous – largely unchecked – market power in most markets, have not faced nearly as much public antitrust scrutiny and oversight.

Most importantly, however, patients get real benefits when caregivers work together to provide more coordinated, more efficient and higher quality care. That is the path we are on and the one that holds the greatest promise for fixing a fragmented delivery system. The antitrust laws can make a real contribution to progress if the agencies enforcing them are willing to exercise the same type of leadership and foresight that led to the issuance of the *Statements on Antitrust Enforcement in Health Care*. User-friendly guidance for clinical integration and more vigilance in the health insurer sector are important steps, not just for hospitals, but for the future health and vitality of the nation's health care delivery system and the patients it serves.

CONCLUSION

The AHA appreciates the opportunity to discuss these issues. America's hospitals look forward to working with the Committee on Ways and Means and the Administration to improve the quality and efficiency of care for all patients in every community.

[i] American Hospital Association, February 2010; *Trendwatch: Clinical Integration – The Key to Real Reform. http://www.aha.org/research/reports/tw/2010/10feb-clinicinteg.pdf*

[ii] American Hospital Association. (2009). *The Case for Reinvigorating Antitrust Enforcement for Health Plan Mergers and Anticompetitive Conduct to Protect Consumers and Providers and Support Meaningful Reform.* Accessed at www.aha.org/aha/content/2009/pdf/09-05-11-antitrust-rep.pdf .

[iii] Berenson, R., Ginsburg, P., and Kemper, N. "Unchecked Provider Clout in California Foreshadows Challenges to Health Reform," *Health Affairs*, Vol. 29, No. 4, April 2010.

[iv] Office of Attorney General Martha Coakley, "Examination of Health Care Cost Trends and Cost Drivers," March 2010 and Letter to Partners HealthCare, June 2010.

[v] Guerin-Calvert, M., Israilevich, G. (2010). *A Critique of Recent Publications on Provider Market Power*. Compass Lexecon for the American Hospital Association. Accessed at http://www.aha.org/aha/content/2010/pdf/100410-critique-report.pdf.

[vi] Guerin-Calvert, M., Israilevich, G. (2011). Assessment of Cost Trends and Price Differences for U.S. Hospitals. Compass Lexecon for the American Hospital Association. Accessed at http://www.aha.org/advocacy-issues/letter/2011/110308-let-hatton-dojftc.pdf)

Hospitals: The Changing Landscape is Good for Patients & Health Care

American Hospital Association.

Hospitals: Care Integration for the Right Reasons

Coming on the heels of the recession, hospital merger/acquisition activity began to accelerate. Hospitals began acquiring other hospitals and hiring medical staff in an effort to provide the leadership needed to reform a siloed health care system that nearly everyone from Institute of Medicine to the Medicare Payment Advisory Commission (MedPAC) singled out as one of the main culprits in higher cost lower quality health care.

Both government and the private sector are creating incentives that are driving hospitals toward one another and toward their medical staffs with new global and fixed payments schemes, new incentives for meeting quality, efficiency, and patient satisfaction goals (and penalties for failing to do so), and rescinding payments for certain readmissions.

> Both Moody's and Standard & Poor's report a negative financial outlook for hospitals, attributable in large part, to the fact that "[t]he healthcare industry is undergoing a period of fundamental transformation in which the very model of healthcare delivery is being questioned and changed."
>
> —*Moody's Outlook 2012*

> "[H]ospitals that successfully improve operating efficiencies, engage in growth strategies, and align more closely with physicians will be better poised to adapt to ongoing challenges."
>
> —*Moody's Special Comment 2012*

Meeting these myriad challenges requires building a continuum of care that includes healthier, leaner hospitals and closely aligned medical staff.

> "The ability to demonstrate lower costs while providing higher quality care will be the key driver in governmental and commercial reimbursement going forward."
>
> —*Moody's New Forces 2012*

To achieve these worthy goals, mergers may be the only recourse as decades old regulatory barriers can keep hospitals and doctors from working closely together to improve care and reduce costs unless they are under the same ownership umbrella. Gainsharing demonstration projects in New Jersey, for example, show care and cost improvements from closer collaboration, yet the barriers remain.

> "We believe physician employment ... will continue to grow because of the expected incentives ... call for tighter care coordination to manage services that are bundled together ... or simply to better manage patients with chronic conditions."
>
> —*Standard & Poor's 2012*

Hospitals: Antitrust Watchdogs Prevent Anticompetitive Mergers

Hospitals have been under the watchful eyes of the federal antitrust authorities for decades. When the Federal Trade Commission (FTC) believes a hospital merger threatens competition, the agency has not hesitated to step up.

The FTC alone investigated a dozen completed hospital mergers and challenged or threatened to challenge at least that many proposed mergers in recent years.

New care models, like accountable care organizations, will continue to get the FTC's closest scrutiny. In response to a question about ACOs, the FTC's chairman said:

> *"We're not going to roll over and play dead and allow a lot of health-care consolidation."*

Not so for insurance companies. Over the past decade, no merger between major insurance companies has been completely rejected by the federal antitrust authorities. Indeed, as well documented annually by the American Medical Association and observed by others:

> "[T]he vast majority of health insurance markets in the United States are highly concentrated ....this strongly suggests that health insurers are exercising market power in many parts of the country and in turn causing competitive harm to consumers and providers of care."
>
> —*Competition in Health Insurance 2011*

> "Payers have consolidated over the past several years ... providing greater negotiating leverage for the payer."
>
> "In most markets dominated by large payers, hospital commercial reimbursement rates are lower than average."
>
> —*Moody's 2012*

Some payers tend to blame hospital mergers for high insurance premiums. *Two* economic consulting firms examined charges that hospital mergers in the 1990s drove up prices. They said:

"There is no valid empirical basis for [that] conclusion."
—*Competition Policy Associates and Economists Incorporated 2003.*

That is still true today.

—Continued

Hospitals: Consumer Preference Matters

Like firms in every other sector of our economy, hospitals are not all the same. Some hospitals with high-level or more costly services, like burn or high-level trauma units or other highly specialized care, have higher costs and may charge higher prices. These may also be the very hospitals that consumers most want to go to when they are seriously ill or badly injured.

Pundits often confuse such consumer preferences with market power – they are wrong to do so.

> "Even the FTC acknowledges that for hospitals, different prices are "neither necessary nor sufficient to demonstrate ... market power."
>
> —*FTC Working Paper 2009*

Hospitals compete to be the best and invest the resources needed to maintain consumer trust and loyalty.

—*Compass Lexecon 2010*

In a radio interview, small business owners in California said they were willing to pay more for the hospitals their employees believed were the best.

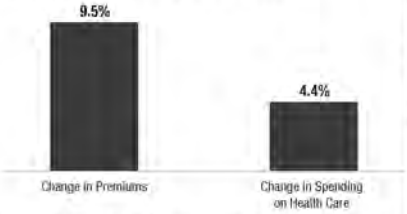
—*KQED, November 20, 2010*

Hospitals: Price Growth is at Historic Lows

> **Despite renewed merger activity, the growth in spending on hospital care is at historic lows.**
>
> —*Altarum 2012*

It is *not* hospital prices that are driving the rise in insurance premiums. The growth in insurance costs from 2010 to 2011 was more than double that of the underlying health care costs, including hospitals.

Percent Change in Premium Levels vs. National Spending on Health Care, 2010 to 2011



Source: The Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits Survey.* Data released 2011. Link: http://ehbs.kff.org/pdf/2011/8225.pdf. Altarum Institute, Insights from Monthly National Health Expenditure Estimates through December 2011. Link: http://www.altarum.org/research-initiatives-health-systems-health-care/altarum-center-for-studying-health-spending/health-indicator-reports.

Insurance companies are expected to drive hospital rate increases even lower, according to Moody's, "continuing a multi-year trend."

> "[T]he opportunities to gain leverage and higher rates from commercial payors are quickly dissipating ..."
>
> —*Moody's New Forces 2012*

> "We expect commercial payers to remain highly aggressive in negotiating lower reimbursement rates with hospitals in 2012."
>
> —*Moody's 2012*

Unlike other health care sectors, study after study has shown that hospital prices are directly related to the cost of caring for patients. Funds needed to hire and retain doctors, nurses and other medical and support staff with the right qualifications and training are the single largest cost for hospitals – they account for two-thirds of total expenses.

About two-thirds of hospital costs go to the wages and benefits of caregivers and other staff.

Percent of Hospital Costs[1] by Type of Expense, 4Q09

Source: IHS Global Insight, Quarterly Index Levels in the CMS Prospective Payment System (IPPS) Hospital Input Price Index, 2009 Q3.

—Continued

Hospitals: Investing in Technology and Upgraded Facilities

Other significant outlays for hospitals involve IT. Every hospital is expected to meet new standards for having and using electronic medical records for its patients or face penalties in 2015.

Meeting that requirement safely will cost as much as $50 million for a midsize hospital.

—National Journal 2012

> Moody's lists "[i]ncreased need for capital relating to plant modernization and IT systems" as one of the top reasons for its negative outlook for hospitals in 2012.
>
> *—Moody's 2012*

Getting and making this new technology work for patients and meet new and far-reaching government and private-sector requirements (coming from employers and payers) is a major investment for all hospitals. For cash strapped hospitals it may be beyond their reach without merging with another hospital that can provide those funds.

These same hospitals may not be able to borrow to do so because of depreciation rules.

> "Independent hospitals tend to have narrower margins, meaning they can't simply fork over the cash . . . to digitize their records."
>
> *—National Journal 2012*

Doctors must meet similar requirements, yet regulatory barriers make that difficult or impossible to do so in collaboration with a hospital without being in its employ.

Hospitals: Essential Capital is in Short Supply

There is no doubt that limited access to capital for IT and other investments essential to providing high quality care at lower costs is driving mergers.

Capital markets for not-for-profit hospitals have still not fully recovered from the recent financial meltdown. Three temporary federal financing options that helped ease the credit crunch expired in 2010. For many hospitals, particularly those with lower bond ratings, the best and perhaps only strategy to remaining viable in their community is merging with another hospital that has the financial resources it lacks.

> "Access to the capital markets has become more difficult for smaller and lower-rated hospitals, driving the need for many to seek a partner."
>
> *—Moody's New Forces 2012*

The Michigan Attorney General recently approved a hospital deal citing access to capital as its primary benefit. The AG said that lack of capital made it impossible for the hospital to "perform necessary renovations, improvements, and expansion of its aging structures and equipment . . . ." The deal, the AG said, "offers hope that the [community] will continue to be well served . . . for a long time to come."

Hospitals: Need to be Healthy to Provide the Most Value

> "Of all the transformations reshaping American healthcare, none is more profound than the shift toward value."
>
> *—Value through Partnership 2012*

Quality outcomes, affordability, and patient satisfaction are rapidly becoming the touchstones employers, payers, government and, most importantly, patients expect and demand. Meeting these challenges requires reshaping the hospital field, sometimes through mergers, alliances, partnerships or other innovative relationships.

This transformation will require time, patience and capital investment to build a continuum of care that accommodates 21st century technology and standards of medical care. When mergers are needed to help financially, geographically or otherwise challenged hospitals avoid "closure, bankruptcy, or payment default," or to become stronger and more efficient to meet current challenges and fulfill community needs, that should be a welcome development.

References available at *www.aha.org*

© 2012 American Hospital Association