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Statement
of the
American Hospital Association
before the
Subcommittee on Regulatory Reform, Commercial and Antitrust Law
of the
Committee on the Judiciary
of the
U.S. House of Representatives

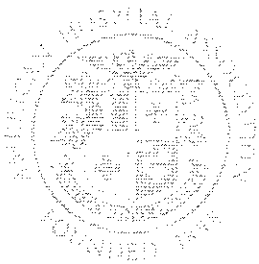
"The Patient Protection and Affordable Care Act, Consolidation, and the Consequent Impact on Competition in Healthcare"

September 19, 2013

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit this statement to the Subcommittee on Regulatory Reform, Commercial and Antitrust Law of the Committee on the Judiciary as it examines "The Patient Protection and Affordable Care Act, Consolidation, and the Consequent Impact on Competition in Healthcare."

The health care field is undergoing a period of fundamental transformation in which the very model of health care delivery is being changed in order to improve quality and lower costs. The reasons for such change are varied; but chief among them are expectations by patients, employers, insurers and government at all levels for higher quality, more efficient health care – in other words, greater value. Meeting these expectations requires building a continuum of care to replace the current fragmented system of health care. In addition, hospitals are facing enormous pressure to raise capital to invest in new technologies and facility upgrades.

Mergers or acquisitions are often essential to make these goals a reality. That is also why doctors and other caregivers are being added to the hospital family – they are linchpins of better, more coordinated care. One reason: Outdated regulatory barriers can keep hospitals and doctors from working closely together unless they are under the same ownership umbrella.



Some pundits decry the changing landscape. 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).

They are also at odds with the data. A recent study conducted for the AHA by the Center for Healthcare Economics and Policy found that only 10 percent of the nation's nearly 5,000 hospitals were involved in a merger or acquisition between 2007 and 2012. The average number of hospitals acquired in a given transaction was small – just one or two. And far from being anti-competitive, these activities had real benefits for the affected patients and communities.

THE FORCES DRIVING REALIGNMENT

From Volume to Value. The hospital field has long recognized the need to build a more coordinated continuum of care, and the benefits that the continuum 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.

According to a 2012 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.

Investment Needed to Drive Improvement. At the same time, 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."

BARRIERS IMPEDING PROGRESS

Regulatory Hurdles. Mergers and acquisitions are often the preferred way to build the care continuum because of numerous regulatory barriers that prevent providers from working together to deliver care more efficiently. 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.

As long ago as 2005, an 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, and calls from many others, including members of Congress, most of these regulatory barriers remain. As noted, these barriers favor mergers and acquisitions over integration and should be addressed without delay.

CHANGING LANDSCAPE PROVIDING BENEFITS TO PATIENTS AND COMMUNITIES

Much has been written and said about hospital mergers and acquisitions – primarily, that they are anticompetitive and driving up health care costs. But what the facts show is that the overwhelming majority of transactions over the past six years are procompetitive and fully support the twin goals of higher quality and more affordable health care.

The AHA and the Center for Healthcare Economics and Policy (Center) recently released the results of a comprehensive study the Center undertook to determine just how many hospital transactions there have been since 2007 and how many hospitals remained in a local area following those transactions to provide options for patients in need of hospital care.[ii]

Hospital markets are local. Determining the potential competitive impact of any transaction begins by looking for other hospitals in the area. The Center measured the impact of these transactions by Metropolitan Statistical Area, which is a geographical region with a relatively high population density at its core and close economic ties throughout the area. Between 2007 and 2012 only a fraction of the hospital field, 551 hospitals or about 10 percent of community hospitals, have even been involved in a transaction (merger or acquisition).

The transactions themselves have been modest: the average number of hospitals acquired in a transaction was between 1 and 2. Of those hospitals that have been involved in a transaction, *all but 20 have occurred in areas where there were more than five independent hospitals*. That means there were plenty of hospitals left following the transaction to maintain a competitive marketplace.

Looking more closely at hospitals included within this group of 20, the stories about how the transaction benefitted the community are compelling. Nine of the transactions involved small hospitals with 50 or fewer beds; the type of hospitals that often struggle without a larger partner to supply essential capital or specialized expertise.

- One hospital (25 beds) was in bankruptcy when it was acquired.
- Another hospital (34 beds), received a commitment of $10 million in new investment over 10 years.
- One hospital (50 beds) was struggling with excess capacity when it was acquired.
- For two hospitals (25 beds), the acquisitions included promises of new services (*e.g.*, a birthing center, a new information system).
- For another hospital (12 beds), recently altered federal regulations made it difficult to grow or expand and the hospital likely would not have been able to stay open; the transaction was reviewed by the state attorney general.
- For a slightly larger rural hospital (85 beds), the city approved the transaction to "ensure the long-term viability of the community's acute care hospital, long-term care facility and independent living apartments for seniors." Officials specifically noted the challenging regulatory environment facing rural hospitals.
- Another larger hospital (181 beds) was losing money and had laid off 91 employees the year before it was acquired.
- In a transaction that involved two different hospitals being acquired at the same time (and that was cleared by Federal Trade Commission(FTC)), one of those hospitals was owned by a corporation that went out of business shortly after the acquisition and the other was suffering from a deteriorating facility, decreased patient volumes and various financial challenges.

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 numbers of transactions and the stories behind them demonstrate that mergers and acquisitions are supporting the changing landscape of health care delivery in a positive way for patients and communities.

Lack of Health Plan Scrutiny. While these hospital transactions have been scrutinized, less oversight has been applied to the health insurance market. The American Medical Association annually reports that an abundance of health insurance markets are concentrated,[iii] 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.*[iv]

Among the AHA's requests was 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.

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[i] Moody's Investors Service Inc. (2012.) *New Forces Driving Rise in Not-for-Profit Hospital Consolidation.* Accessed at: www.moodys.com.

[ii] Center for Healthcare Economics and Policy (2013). *How Hospital Mergers and Acquisitions Benefit Communities*. Accessed at: http://www.aha.org/content/13/13mergebenefitcommty.pdf.

[iii] American Medical Association. (2012). *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2012 Update.* Accessed at: https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod1170048&navAction=push.

[iv] 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.