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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"[i] 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)