PREPARED STATEMENT OF THE
FEDERAL TRADE COMMISSION

Before the

SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION, AND INTERNATIONAL SECURITY

of the

COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS

U.S. SENATE

on

NEW ENTRY INTO HOSPITAL COMPETITION

MAY 24, 2005

I. INTRODUCTION

Mr. Chairman, I am John Graubert, Principal Deputy General Counsel of the Federal Trade Commission.[1] I appreciate the opportunity to appear before you today to discuss new entry into hospital competition and related issues.

The Federal Trade Commission has familiarity with these issues through Hearings held together with the Department of Justice, Antitrust Division, and the resulting Report, *Improving Health Care: A Dose of Competition,* issued jointly by the Commission and the Department of Justice, Antitrust Division, in July 2004, as well as through the Commission's substantial experience in enforcing the antitrust laws in health care markets. The Joint Hearings and Joint Report broadly examined the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying the preferences of Americans for high-quality, cost-effective health care. The Joint Hearings took place over 27 days from February through October 2003, following a Commission-sponsored Workshop on health care issues in September 2002. The Commission, along with the Department of Justice, heard testimony from about 240 panelists, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from antitrust and economics to health care quality and informed consent. Together, the Hearings and Workshop elicited 62 written submissions from interested parties. Almost 6,000 pages of transcripts of the Hearings and Workshop and all written submissions are available on the Commission website,

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[1] This written statement reflects the views of the Federal Trade Commission. My oral statements and responses to any questions you may have represent my own views, and do not necessarily reflect the views of the Commission or any individual Commissioner.

Antitrust Division, undertook independent research for the Report.

Today, the Commission focuses specifically on a few of the issues addressed in the Report that relate to new entry into competition among hospitals and other entities. Three main points require attention. First, vigorous competition can have important benefits in the hospital

[2] Federal Trade Commission & the Department of Justice, *Improving Health Care: A Dose of Competition,* Exec. Summ., at 15-16, ch.1, at 31-33, ch.3, at 22-27 (July, 2004) [hereinafter "*Improving Health Care*"].

system has substantially driven the emergence of single-specialty hospitals and ambulatory surgery centers. Medicare's administered pricing system, albeit inadvertently, can make some services extraordinarily lucrative, and others unprofitable.

Several panelists at the FTC/DOJ Hearings expressed concern that single-specialty hospitals and ambulatory surgery centers would siphon off the most profitable patients and procedures under Medicare reimbursement policies, leaving general hospitals with less money to cross subsidize other socially valuable, but less profitable, care.[7] The FTC/DOJ Report pointed out that "[c]ompetitive markets compete away the higher prices and supra-competitive profits necessary to sustain such subsidies,"[8] and concluded that "[i]n general, it is more efficient to provide subsidies directly to those who should receive them, rather than to obscure cross subsidies and indirect subsidies in transactions that are not transparent."[9] The FTC/DOJ Report recommended that "[g]overnments should reexamine the role of subsidies in health care markets in light of their inefficiencies and potential to distort competition."[10]

In testimony before the House Committee on Energy and Commerce on May 12, 2005, Mark McClellan, Administrator of the Centers for Medicare and Medicaid Services (CMS), reported that CMS, following its own study of specialty hospitals pursuant to congressional direction,[11] will analyze and reform its payment rates "to help reduce the possibility that

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[7] *Id.,* ch.3, at 21 & n.106, and 27 & n.138.

[8] *Id.,* Exec. Summ., at 23.

[9] *Id.*

[10] *Id.*

[11] Section 507(b)(2) and (b)(3) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Department for Health and Human Services, of which CMS is a part, to study a set of quality and cost issues related to specialty hospitals and to report to Congress on their findings. Pub. L. No. 108-

specialty hospitals may take advantage of imprecise payment rates in the inpatient hospital prospective payment system" and "to diminish the divergences in payment levels [for ambulatory surgical centers] that create artificial incentives for the creation of small orthopedic or surgical hospitals."[12]

II. NEW TYPES OF FIRMS TO COMPETE WITH HOSPITALS.

One topic of great interest at the FTC/DOJ hearings involved entry by single-specialty hospitals and ambulatory surgery centers to compete with general hospitals in the provision of certain types of services. Although the types of services offered by such firms differ, they raise similar competitive issues. We discuss each in turn.

173, § 507, 117 Stat. 2066 (2003). Dr. McClellan's testimony presented the results and recommendations from the CMS report.

[12] Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, Before the House Committee on Energy and Commerce Hearing, "Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care," May 12, 2005, *available at* http://www.cms.hhs.gov/media/press/testimony.asp?Counter=1459 [hereinafter McClellan Testimony].

[13] George Lynn, Remarks at the Federal Trade Commission and Department of Justice Hearings on Health Care and Competition Law and Policy (Mar. 27, 2003) at page 27 ("Historically, they were children's hospitals or psych. hospitals; now they include heart hospitals, cancer hospitals, ambulatory surgery centers, dialysis clinics, pain centers, imaging centers, mammography centers and a host of other narrowly focused providers generally owned, at least in part, by the physicians who refer patients to them.") [hereinafter, citations to transcripts of these Hearings state the speaker's last name, the date of testimony, and relevant page(s).] Transcripts of the Hearings are *available at* http://www.ftc.gov/ogc/healthcarehearings/index.htm#Materials.

[14] Lesser 3/27 at 10-11.

[15] *Id*.

[16] Alexander 3/27 at 34. *See also* Nat'l Surgical Hospitals, *Single Specialty Hospitals* (Mar. 27, 2003) (Public Comment) [hereinafter links to FTC/DOJ Health Care Hearings Public Comments are *available at*

basis"); Alexander 3/27 at 35 (stating that operating rooms in some markets "are at capacity" and it is very difficult for physicians to schedule elective surgeries at general hospitals).

[21] Lesser 3/27 at 14. *See also* Alexander 3/27 at 33 ("Specialized facilities are a natural progression and are a recognition that the system needs to be tweaked, perhaps overhauled, to achieve lower costs, higher patient satisfaction, and improved outcomes.").

[22] Lesser 3/27 at 14-15 (noting that specialty hospitals across the country have stated that by "concentrating more cases in a particular facility, specialty hospitals may help to lower per-case costs and boost quality").

[25] Beeler 3/26 at 59.

[26] Lawrence P. Casalino et al., *Focused Factories? Physician-Owned Specialty Facilities*, 22 HEALTH AFFAIRS 56, 59 (Nov./Dec. 2003).

[27] Beeler 3/26 at 60.

[28] Rex-Waller 3/27 at 50 (stating that the growth of ASCs "has been driven by technology, technological

[31] Technological changes include the development of flexible fiberoptic scopes used for colon cancer screening and upper GI procedures as well as advancements in microsurgery and ultrasound techniques used in cataract lens replacement. *See* MEDICARE PAYMENT ADVISORY COMM'N (MEDPAC), REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY § 2F, at 140 (2003), *at* http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf [hereinafter MEDPAC] .

[32] *See, e.g.*, *id.*, § 2F, at 140 (noting that the specialized settings may have allowed physicians to perform procedures more efficiently than in an outpatient setting and allowed physicians to reserve surgical time).

[33] Rex-Waller 3/27 at 50. *See also* Beeler 3/26 at 62 (noting the "development of new technology and techniques for both the surgery itself and anesthesia" have allowed providers to discharge patients more quickly after surgery).

[34] MEDPAC, *supra* note 31, § 2F, at 140 (assessing coinsurance is 20 percent lower in an ASC).

[35] According to the testimony of the Administrator of CMS on May 12, 2005, the CMS congressionally
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control appear to be more effective and pose less significant competitive concerns. We analyze each point in turn.

A. Background on the History and Purpose of State CON Programs.

State CON programs generally prevent firms from entering certain areas of the health care market unless they can demonstrate to state authorities an unmet need for their services. Upon making such a showing, prospective entrants receive from the state a CON allowing them to proceed.[40]

Many CON programs trace their origin to a repealed federal mandate. The National Health Planning and Resources Development Act of 1974[41] offered states powerful incentives to enact state laws implementing CON programs.[42] By 1980, all states except Louisiana had enacted CON programs.[43] Congress repealed the federal law in 1986, but a substantial number of states continue to maintain CON programs,[44] "although often in a loosened form compared to

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[40] *See* JOHN MILES, 2 HEALTH CARE & ANTITRUST LAWS: PRINCIPLES AND PRACTICE § 16:1, at 16-2, 16-5 to 16-6 (2003) (noting that CONs under the federal Health Planning Act required providers to "obtain state approval – a 'certificate of need' – before spending set amounts on capital investments or adding new health care services"); James F. Blumstein & Frank A. Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 UTAH L. REV. 3; Randall Bovbjerg, *The Importance of Incentives, Standards, and Procedures in Certificate of Need*, 1978 UTAH L. REV. 83; Clark C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 VA. L. REV. 1143 (1973).

[41] Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k-300n-5), *repealed*, Pub. L. No. 99-660, § 701, 100 Stat. 3799 (1986).

[42] MILES, *supra* note 40, § 16:1, at 16-2.

[43] *See, e.g.*, Morrisey 6/10 at 146; *On Certificate of Need Regulation: Hearing on H.B. 332 Before the Senate Comm. On Health and Human Services* (Ohio 1989) (Statement of Mark D. Kindt, FTC Regional Director) [hereinafter Kindt].

[44] *See* Davenport-Ennis 5/29 at 113-14; Morrisey 6/10 at 146 (noting that by 2002, about 36 states and the District of Columbia retained CON programs in some form); MILES, *supra* note 40, § 16:2, at 16-9 (stating that "CON laws remain in many states and the District of Columbia"). Quite recently, Florida exempted from CON new adult open-heart surgery and angioplasty programs at general hospitals and the addition of beds to existing hospital structures. Fla. Bill SJ 01740 (effective July 1, 2004), *amending* FLA STAT. ch. 408.036, .0361 (2003).

their predecessors."[45]

CON programs had the major goal of controlling costs by restricting provider capital expenditures.[46] The forces of competition ordinarily limit excess supply, but, according to a panelist representing the American Health Planning Association, "[c]ompetition in health care is … very different" than in other markets.[47] Congress appears to have shared this view in 1974; the passage of the Health Planning Act reflected a congressional belief that market failure plagued the health care market, resulting in "excess supply and needless duplication of some services."[48]

The system of cost-based reimbursement may have driven the problem that Congress sought to solve.[49]

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[45] MILES, *supra* note 40, § 16:1, at 16-2 to 16-3. *See also* Len M. Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning*, 23 HEALTH AFFAIRS 1, 11 (Mar./Apr. 2004) (noting that CON programs "eroded through the 1990s").

[46] *See* Piper 6/10 at 53; Morrisey 6/10 at 146 (noting that CON programs "were established in the '70s to help control health care costs"). *See also* MILES, *supra* note 40, § 16:1, at 16-4 ("[The primary role of the Health Planning Act was to regulate the supply of health care resources, particularly institutional services, by requiring a CON from the state before certain levels of capital expenditures could be made or new services introduced."); Kindt, *supra* note 43, at 2-3 (noting that a "key justification" for CON programs has been "the belief that health care providers, particularly hospitals, would undertake excessive investment in unregulated health care markets," driving up health care costs); PUBLIC HEALTH RESOURCE GROUP, CERTIFICATE OF NEED PROJECT REPORT 17-18 (2001).

[47] Piper 6/10 at 53-54 (observing that the main aim of CON programs is to limit "excess supply generating excess demand"). *See also* PUBLIC HEALTH RESOURCE GROUP, *supra* note 46, at 18.

[48] MILES, *supra* note 40, § 16:1, at 16-4.

[49] *See id.*

[50] Keith B. Anderson, Certificate of Need Regulation of Health Care Facilities, FTC Staff Prepared Statement Before North Carolina State Goals and Policy Board 6 (Mar. 6, 1989). *See also* Davenport-Ennis 5/29 at 114 (noting that at the time, the federal government reimbursed health care expenses on a "cost-plus basis, which did not provide the cost control capability of today's prospective payment system").

would demand the perceived highest quality services, led to the fear that health care providers would expand their services to the point of offering unnecessarily duplicative services, because they competed largely on non-price grounds.[51]

Cost-based reimbursement is much less common today, but some contend that CON programs still have a role to play. Indeed, one panelist argued that in health care markets, "providers control the supply of services. Medical practitioners direct the flow of patients and therefore the demand for services."[52]

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[51] Morrisey 6/10 at 147; *see also* Davenport-Ennis 5/29 at 114 (noting that government officials intended CON to "retain rising health care costs, to prevent unnecessary duplication of resources and services, and [to] expand consumer access to quality health care services").

[52] Piper 6/10 at 55.

[53] *Id*. at 55 (noting, however, that consumers do "suffer under the ultimate increased costs in premiums and their taxes"). The same panelist also cited empirical studies suggesting that CON programs reduce health care costs, studies that another panelist questioned. *Compare* Piper 6/10 at 57-61, *and* Thomas R. Piper, *Comments Regarding Hearings on Health Care and Competition Law and Policy* 5-13 (Public Comment) (discussing these and other studies) [hereinafter Piper (public cmt)], *with* Loeffler 6/10 at 127 (questioning those studies), *and with* Piper 6/10 at 127-28 (responding to such questions).

[54] *See, e.g.*, MILES, *supra* note 40, § 16:1, at 16-4 (describing Congress' concerns); Piper 6/10 at 62 (asserting that "[a]reas with more hospitals and doctors spend more on health care services per person"); PUBLIC HEALTH RESOURCE GROUP, *supra* note 46, at 11 ("Adding providers usually mean increases in costs."); *see also* Piper 6/10 at 126 (noting that the fact that the public fisc is at stake adds importance to the concern).

[55] PUBLIC HEALTH RESOURCE GROUP, *supra* note 46, at 5.

[56] Piper (public cmt), *supra* note 53, at 12 (noting, for example, that in CON-free states, "the percentage of patients that had surgery in low volume programs was three times higher than in states with CON regulation").

regulation also can address cherry picking, preventing firms from, for example, converting "[cancer] medical practices to medical care facilities [that] divert well-insured patients [from] local hospital cancer programs" and "undermine[] the ability of essential community hospitals to provide a full array of oncology services to the entire community."[57]

However, as one commentator noted, "[t]he regulation of supply through mechanisms such as CON may have made sense when most reimbursement was cost-based and thus there was incentive to expand regardless of demand[,] but they make much less sense today when hospitals are paid a fixed amount for services and managed care forces them to compete both to participate in managed-care networks and then for the plans' patients."[58] This policy justification of CON programs is particularly questionable given the new strategies that have evolved to control costs.[59]

Moreover, it appears that CON programs generally fail to control costs.[60] One panelist

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[57] *Id.*, at 13-14; *see also* Piper 6/10 at 54 (noting that CON programs aim to overcome "market gaps and excesses like the avoidance of low-income populations and concentration of services in … affluent areas"); Nichols et al., *supra* note 45, at 11 (stating that today "some states are considering reinstituting or reinvigorating [CON programs] in response to construction of physician-owned specialty facilities, which has posed a competitive threat to community hospitals"). *But see* Price 6/10 at 108 (would-be entrant denying allegation of "cherry picking"); Davenport-Ennis 5/29 at 115-16 (stating that CON programs restrict the supply of cancer treatment services such that "low-income, seriously ill, and rural patients" who do not live near a hospital or major medical center lose access to care).

[58] MILES, *supra* note 40, § 16:1, at 16-3.

[59] *See, e.g.*, Kindt, *supra* note 43, at 8-11; Anderson, *supra* note 50, at 9-13 (same); Davenport-Ennis 5/29 at 121 (citing means other than CON programs "to regulate over-usage and over-referral"). *But see* PUBLIC HEALTH RESOURCE GROUP, *supra* note 46, at 11 (stating that "[m]anaged care companies have not created the competition and lower cost solutions originally expected of them").

[60] *See* Hennessy 6/10 at 93-94 (stating that "CON is a failure as a cost containment tool" and that the premiums in Kansas and Missouri are generally the same, in spite of the fact that one state has a CON program and the other does not); Anderson, *supra* note 50, at 2-6 (summarizing empirical evidence and finding that CON fails to regulate costs); Kindt, *supra* note 43, at 3-5 (summarizing empirical studies on the economic effects of CON programs and concluding that "[t]here is near universal agreement among the authors [of studies on the economic effects of CON programs] and other health economists that CON has been unsuccessful in containing health care costs"); DANIEL SHERMAN, FEDERAL TRADE COMM'N, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON

surveyed the empirical literature on the economic effects of CON programs and reported that the "literature tends to conclude … that CON has been ineffective in controlling hospital costs," and that, to the contrary, "[i]t may have raised costs and restricted entry."[61] Commentators stated the reason that CON has been ineffective in controlling costs is that CON programs do not put a stop to "supposedly unnecessary expenditures[,]" but "merely redirect[] any such expenditures into other areas."[62] Thus, a CON rule that restricts capital investment in new beds does nothing to prevent hospitals from "add[ing] other kinds of fancy equipment" and using that to compete for consumers.[63]

B. Competitive Concerns that CON Programs Raise

Many have criticized CON programs for creating barriers to entry in the health care market.[64] As noted previously, CON regimes prevent new health care entrants from competing

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HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data, that strong CON programs do not lead to lower costs but may actually increase costs); MONICA NOETHER, FEDERAL TRADE COMM'N, COMPETITION AMONG HOSPITALS 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); KEITH B. ANDERSON & DAVID I. KASS, FEDERAL TRADE COMM'N, CERTIFICATE OF NEED REGULATION OF ENTRY INTO HOME HEALTH CARE: A MULTI-PRODUCT COST FUNCTION ANALYSIS (1986) (economic study finding that CON regulation led to higher costs, and that CON regulation did little to further economies of scale); *cf.* PUBLIC HEALTH RESOURCE GROUP, *supra* note 46, at 4 (noting that the "track record of the cost effectiveness of state CON programs is decidedly mixed," and that "[i]n some states, the effectiveness is at least partially attributable to deficiencies in program operations and to political environments in which legislative or high-level executive branch intervention alters or affects CON decision-making"). *See also* David S. Salkever, *Regulation of Prices and Investment in Hospitals in the United States*, *in* 1B HANDBOOK OF HEALTH ECONOMICS, 1489-90 (A.J. Culyer & J.P. Newhouse eds., 2000) (concluding that "there is little evidence that [1970s-era] investment controls reduced the rate of cost growth," even though "inconsistent reports of constraining effects on numbers of beds and diffusion of some specialized services did appear").

[61] Morrisey 6/10 at 148-49, 152-53.

[62] Kindt, *supra* note 43, at 5.

[63] *Id.*

[64] *See* Anderson, *supra* note 50, at 7; Hennessy 6/10 at 95, 99-100 ("CON protects incumbent providers . . . from competition" and is an "impediment to innovation [and] quality improvement" in health care); Blumstein & Sloan, *supra* note 40; Bovbjerg, *supra* note 40; Havighurst, *supra* note 40. The Commission has also noted the impact of CON programs on entry and firm behavior. *See In re Hosp. Corp. of Am.*, 106 F.T.C. 361, 489-501

without a state-issued certificate of need, which is often difficult to obtain. This process has the effect of shielding incumbent health care providers from new entrants. As a result, CON programs actually can increase health care costs, as supply is depressed below competitive levels.[65]

CON programs also can retard the entry of firms that could provide higher quality services than the incumbents.[66] By protecting incumbents, CON programs can "delay[] the introduction and acceptance of innovative alternatives to costly treatment methods."[67] Similarly, CON programs' "[c]urtailing [of] services or facilities may force some consumers to resort to more expensive or less-desirable substitutes, thus increasing costs for patients or third-party payers. For example, if nursing home beds are not available, the discharge of patients from more expensive hospital beds may be delayed or patients may be forced to use nursing homes far from home."[68]

The experience of SSHs is revealing. There are relatively few SSHs. In October 2003, the General Accounting Office identified 100 existing SSHs, with an additional 26 under development. SSHs are located in 28 states, but two-thirds are located in only seven states.[69]

(1985).

[65] *See* Anderson, *supra* note 50, at 7-8; Kindt, *supra* note 43, at 6-7.

[66] *See, e.g.*, Anderson, *supra* note 50, at 7-9; Kindt, *supra* note 43, at 6; *Hosp. Corp. of Am.*, 106 F.T.C. at 495 (opinion of the Commission) (stating that "CON laws pose a very substantial obstacle to both new entry and expansion of bed capacity in the Chattanooga market" and that "the very purpose of the CON laws is to restrict entry").

[67] Anderson, *supra* note 50, at 9; Kindt, *supra* note 43, at 6.

[68] Kindt, *supra* note 43, at 7.

[69] U. S. GENERAL ACCOUNTING OFFICE, GAO-04-167, SPECIALTY HOSPITALS: GEOGRAPHIC LOCATIONS, SERVICES PROVIDED AND FINANCIAL PERFORMANCE 3-4 (2003) (Report to Congressional Requesters) [hereinafter GAO, SPECIALTY HOSPITALS], *at* http://www.gao.gov/new.items /d04167.pdf. The seven states are Arizona,

California, Texas, Oklahoma, South Dakota, Louisiana, and Kansas. Of those seven states, only three (Texas, Oklahoma and Arizona) require all hospita

Medicare's administered pricing system has substantially driven the emergence of SSHs and ASCs. Medicare's administered pricing system, generally inadvertently, can make some services extraordinarily lucrative, and others unprofitable. This problem is by no means unique to Medicare; it is virtually impossible for any administered pricing system to specify prices identical to those that a fully competitive marketplace would have produced.

The result of such pricing distortions is that some services are more or less available than they would be based on the demand for the services – which in turn triggers adaptive responses by providers.[72] New entrants formed to profit from distortions in Medicare's administered pricing can take such profits away from general hospitals. General hospitals, however, report that they have used, and continue to need, those profits to cross subsidize unprofitable services, such as the care they must provide to indigent and other patients.

Cross subsidization and competition are at odds with one another. Competition competes away cross subsidies. Thus, policymakers may wish to replace indirect cross subsidies with direct subsidies for services that are socially desirable.

A. Medicare's Administered Pricing Program Has Encouraged the Entry of SSHs and ASCs.

Some SSHs have entered in response to government reimbursement for cardiac care that makes cardiac care generally more profitable than many other types of inpatient care. Commentators and panelists suggested that CMS never made a deliberate decision to provide for

[72] *See, e.g.*, Hammer 2/27 at 52 (noting that when CMS "has a misalignment of the regulatory pricing system, . . . it creates competition gaming the regulatory system); Scully 2/26 at 28, 46 ("So, when the government, either Federal or State, is fixing prices, the rest of the market's flexibility to respond to that is kind of muted . . . I can tell you when I drive around the country and see where ASCs are popping up, I can tell who we're overpaying.").

greater profits for such services relative to the amounts paid for other inpatient services, but that the administered pricing schedule does so.[73] This pricing distortion creates a direct economic incentive for SSHs to enter the market. Absent the distortions created by the excess profits for cardiac services in Medicare's administered pricing system, the incentive for SSH entry would be less.

Medicare reimbursement also has had a profound impact on the number of ASCs and the amount of surgery performed in them.[74] Congress first approved coverage of ASCs by Medicare in 1980, as part of an effort to control health care spending by providing low-risk surgeries in a less-expensive ambulatory setting.[75] Between 1982 and 1988, Medicare paid 100 percent of the reasonable charges for approved ambulatory procedures, and waived the deductible and copayment that would apply if the procedure were provided in an inpatient setting.[76] From 1988 to 2003, the fee schedule has been based on an inflation-adjusted 1986 cost survey for ambulatory surgery. The ASC payment schedule has not been adjusted for advances in technology and productivity over the last 16 years; some procedures that were once labor-and-

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[73] *See, e.g.*, Ginsburg 2/26 at 65 ("Medicare sets the DRG rates, … but their productivity gains are much faster in cardiovascular services so that, in a sense, the rates become obsolete fairly quickly …."); KELLY DEVERS ET AL., SPECIALTY HOSPITALS: FOCUSED FACTORIES OR CREAM SKIMMERS? (Ctr. for Studying Health Sys. Change, Issue Brief No. 62, 2003), *available at* http://www.hschange.com/CONTENT/552/ (reporting statements of hospital executives that certain surgical procedures (*e.g.*, cardiovascular and orthopedic) are among the most profitable surgeries, and that it is unlikely that payors intended to create these distortions in payment rates).

[74] The anti-kickback statute, described in detail in *Improving Health Care*, *supra* note 2, Chapter 1, has also had an effect on the rise of ASCs. The anti-kickback statute generally discourages physicians from investing in facilities to which they refer patients, but a regulatory safe harbor explicitly excludes ASCs from this prohibition. Office of the Inspector General, *Programs: Fraud and Abuse; Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute; Final Rule*, 64 Fed. Reg. 63,517 (Nov. 19, 1999).

[75] Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 934, 94 Stat. 2599 (1980). *See also* Shelah Leader & Marilyn Moon, *Medicare Trends in Ambulatory Surgery*, 8 HEALTH AFFAIRS 158, 158-59 (Spring 1989).

[76] *Id.*, at 158-59.

resource intensive are now much less costly for ASCs to perform. In recognition of this, among the other things, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003[77] (MMA) freezes Medicare payment rates for ASCs from 2005 through 2009 and directs the Department of Health and Human Services to implement a new payment system by 2008.[78]

In addition, although ASCs and hospital outpatient departments perform some of the

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[77] Pub. L. No. 108-173, 117 Stat. 2066 (2003).

[78] MMA § 626(d).

[79] Andrew 3/26 at 118.

[80] The MMA also directs the GAO to conduct a study comparing the costs of procedures in ASCs to the cost of procedures furnished in hospital outpatient departments, and make recommendations about the appropriateness of using the outpatient prospective payment system as a basis for paying ASCs. MMA § 626(d).

[81] Scully 2/26 at 46.

[82] Lesser 3/27 at 14-21; Cara Lesser, *Specialty Hospitals: Market Impact and Policy Implications* 14-15 (3/27) (slides) (considerable variation in scope of emergency services provided) at http://www.ftc.gov/ogc/healthcarehearings/docs/lesser.pdf; Ginsburg 2/26 at 66 (stating the "threat for specialized services does have the potential to erode some of the traditional cross subsidies that the health system is run on"); Lesser 9/9/02 at 92. *See also* G. Lynn 3/27 at 31 (arguing that the Agencies must take into account the effect specialty hospitals have on "the medical safety net" of the community hospital).

[83] Morehead 3/27 at 42. *See also* Harrington 4/11 at 76-77 ("We can't afford to continue to lose a percentage of our volume and thus our revenue, and be able to provide the same quality level of service that we provide … if we continue to be niched away."); G. Lynn 3/27 at 28 (specialty hospitals "threaten[] community access to basic health services and jeopardizes patient safety and quality of care"); Dan Mulholland, *Competition Between Single-Specialty Hospitals and Full-Service Hospitals: Level Playing Field or Unfair Competition?* 7 (3/27) (slides) at http://www.ftc.gov/ogc/healthcarehearings/docs/mulholland.pdf (community hospitals may be victims of

Hospital panelists see cross subsidies not as a theory, but as a fact of life:

> [If we] take away those profitable services and leave the hospital, the community hospital, with just the unprofitable services, one of two things is going to happen. Either services will be diminished to the community in a way that is not transparent, in a way that they cannot see that happening, or costs will be shifted back to other payors, and business and labor and consumers end up absorbing them, once again, not in a transparent way where they can see what's happening.[87]

C. Cross Subsidization and Competition Are At Odds.

Cross subsidizing is the practice of charging supracompetitive prices to some payors for some services and using the surpluses to subsidize other payors or other clinical services.

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[87] G. Lynn 3/27 at 86. *See also* Opelka 2/27 at 180 ("Cost shifting was once the remedy to ensure a stable practice, but this [is] no longer a solution for surgeons."); Mansfield 4/25 at 88-89 ("[A]cute care hospitals, … [are] very dependent upon being able to cross subsidize the losses we have for patients who have medical DRGs by treating those who are surgically or procedurally oriented."); Joyce Mann et al., *Uncompensated Care: Hospitals' Responses To Fiscal Pressures*, 14 HEALTH AFFAIRS 263, 263 (Spring 1995) ("Hospitals historically have taken it upon themselves to fill some of the gaps in the U.S. health insurance system by treating uninsured patients and then charging more to those who can pay to offset the costs. This practice, known as cost shifting, distinguishes the hospital sector from nearly all other sectors of the economy.").

[88] Cross subsidies may also occur if a non-profit-maximizing firm has market power and exercises that power to obtain supra-competitive profits on certain services, but not on other services.

[89] Commentators state that for-profit hospitals are less likely to offer non-remunerative services. *See* Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-for-Profit Hospitals*, 50 UCLA L. REV. 1345, 1367-76 (2003) (finding increased probability of non-remunerative services offered by nonprofit hospitals); Linda B. Miller, *The Conversion Game: High Stakes, Few Rules*, 16 HEALTH AFFAIRS 112, 116 (Mar./Apr. 1997) ("These services – such as burn units, perinatal intensive care units, transplantations, and other sophisticated medical interventions – exist overwhelmingly in the nonprofit sector and represent an investment in a social good, not potential financial returns.").

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