
**AN EMERGING CONCERN:
The State's Role in Hospital Consolidations**

Senate No. 1830

*A Report of the
Senate Committee on Post Audit and Oversight
November 1994*

MASSACHUSETTS SENATE
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President of the Senate*

*Senate Committee on Post Audit and Oversight
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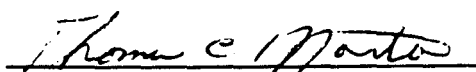
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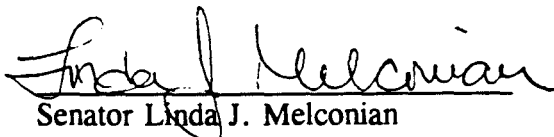
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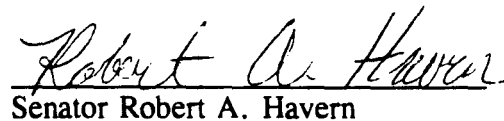
Pursuant to M.G.L. Chapter 3, Section 63 as most recently amended by Chapter 557 of the Acts of 1986, the Senate Committee on Post Audit and Oversight respectfully submits to the full Senate the following report: **AN EMERGING CONCERN: The State's Role in Hospital Consolidations (S. 1830)**. This report is based on research by the Senate Post Audit and Oversight Bureau. It focusses on the impact of consolidation in the hospital industry on health care delivery.

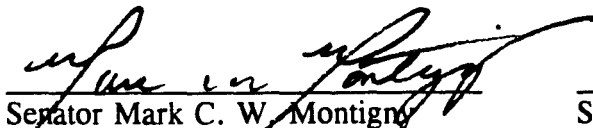
Respectfully filed by the Senate Committee on Post Audit and Oversight:



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TABLE OF CONTENTS

EXECUTIVE SUMMARY	i
INTRODUCTION	1
THE HOSPITAL SYSTEM IN MASSACHUSETTS	4
PRESSURES FACING THE HOSPITAL INDUSTRY	9
RESPONSES OF THE HOSPITAL INDUSTRY	15
HOSPITAL CLOSURES, CONSOLIDATIONS AND MERGERS	18
IMPLICATIONS OF HOSPITAL MERGERS AND CONSOLIDATIONS	21
CURRENT REGULATORS OF HOSPITAL CONSOLIDATION	26
LIMITATIONS OF ANTITRUST AND CAPITAL EXPENDITURE ANALYSIS ...	37
CONCLUSIONS, FINDINGS AND RECOMMENDATIONS	39
APPENDIX I: Senate Committee on Post Audit and Oversight Hearings on Health Care Reform – January 1994	46
ENDNOTES	49
Reports of the Senate Committee on Post Audit and Oversight	54
LIST OF FIGURES AND TABLES:	
Figure 1: Hospital Care Expenditures Per Capita	5
Figure 2: Hospital Inpatient Days and Outpatient Visits	12
Table 1: Hospital Care Expenditures Per Capita	6
Table 2: Massachusetts Hospital Activity	19

EXECUTIVE SUMMARY

In January 1994, the Senate Post Audit and Oversight Committee held a series of hearings to determine how recent and proposed changes in the Massachusetts health care system affect providers of health care services and access to quality affordable care. This report, **An Emerging Concern: The State's Role in Hospital Consolidations**, focusses on the issue of consolidation in the hospital industry, and examines possible impacts of hospital mergers and closings on the delivery and cost of health care in Massachusetts.

One of the reasons that recent hospital activity has drawn the scrutiny of the public and the media is that hospitals play a major role in the economy of the Commonwealth. According to data from the Health Care Financing Administration (HCFA), hospital care expenditures in Massachusetts in 1991 totalled over \$9 billion, up from over \$4.1 billion in 1981.

Hospitals are also significant employers in Massachusetts, and much of the money spent by hospitals is spent on employee wages. In fiscal year 1992, payroll accounted for over \$4.28 billion in Massachusetts hospitals -- almost 60% of hospital expenses statewide. Hospitals are also the largest employer in the state's private health care sector, accounting for approximately 46% of all private health care related employment. Changes in the hospital industry are therefore significant for the impact they would have on employment in Massachusetts. Over the next three to five years, the hospital industry could lose up to 30,000 jobs, mostly nurses and low-skilled service workers. While all of these jobs may not disappear entirely, they are likely to be replaced by jobs in clinics or in home health care -- segments of the industry that typically do not pay as well as hospitals do.

Hospitals are facing stiff competition for patients and enormous pressures to reduce their costs. Other trends are also placing a strain on the hospital industry: the increase in aggressive care management policies, reduced hospital utilization, the increase in excess hospital capacity, caring for the uninsured, changes in the Medicare payment structure, price competition, and changing health care needs.

In response to these pressures, hospitals have attempted to improve their management systems, restructure, and become more competitive. They have also diversified, and have sought to maintain or expand their patient base by affiliating, merging, or acquiring other hospitals or health care organizations or physician practices. Some hospitals have been unable to adapt to the changing environment and have simply closed down. In Massachusetts, there has been a net loss of nearly one-third of the state's acute care hospitals, from 141 in 1967 to 91 in early 1994. Since 1985, eighteen acute care hospitals have closed, twelve acute care facilities have merged, six have been acquired outright by other institutions, twenty acute care hospitals have developed corporate affiliations with other hospitals, hospital systems, or health maintenance organizations, and twenty acute care hospitals have developed contractual affiliations.

Hospital mergers (or hospital closures subsequent to merger) may reduce the number of excess hospital beds and increase hospital occupancy rates, but this may not always lead to lower costs. A hospital merger does not guarantee that the most inefficient facilities (or hospital beds) will close. Moreover, mergers may leave some areas of the state with limited access to hospital services. The residents of some small communities are concerned that if the local hospital merges with a larger regional hospital, the larger hospital may shut down the smaller facility. This could leave the

residents of that community without certain acute care services (particularly emergency and intensive care services).

All of this hospital activity has not happened without the notice of state governmental regulators. There are a number of state agencies that play a policy role in the hospital system, but there are two state agencies that have primary regulatory authority over hospitals' decisions to consolidate: the Determination of Need program in the Department of Public Health, and the Antitrust and Public Charities Divisions of the Attorney General's Office. The Attorney General's Office also works closely with two federal agencies: the Department of Justice and the Federal Trade Commission.

The Determination of Need program has the authority to evaluate only a very narrow aspect of the consolidation transaction. Their evaluation involves a departmental approval process rather than a public approval process, and the evaluation is usually fairly routine.

The Public Charities Division of the Attorney General's Office has recently sharpened its focus on the charitable nature of non-profit hospitals. The Attorney General's Office has asserted that because of their tax-exempt status, non-profit hospitals should provide for the needs of the medically underserved. This recommendation is very controversial; at the center of the issue is the question of how to calculate the "proper" amount of community benefit a hospital should provide.

The Antitrust Division of the Attorney General's Office has been very involved in the oversight of hospital consolidation activity in Massachusetts. The Attorney General's antitrust analysis defines and identifies product and geographic markets, and then applies a mathematical algorithm to determine the level of market concentration before and after a proposed merger.

Within the federal Department of Justice and the Federal Trade Commission, there has been an internal debate on how best to approach the issue of hospital consolidation. The agencies treat hospitals as businesses, and they therefore are subject to the constraints of antitrust law as are other businesses. Yet there has also been a recognition that the "business" provided by hospitals holds a special place in society, and that hospitals may require special treatment in order to meet larger social goals.

Each of the regulators involved in antitrust analysis is limited to a very specific arena of analysis. Unfortunately, none of these regulators has the jurisdictional authority to effectively assess the larger societal or public health impacts of hospital consolidation activity.

The appropriate state agencies and the legislature need to take an active role in the oversight of the changing hospital care system, and must be convinced that participants in this system are meeting the needs of the communities they serve. Although business antitrust law is an indispensable element of the review process, it cannot be relied upon in and of itself. If institutions want to merge or affiliate, they need to be able to demonstrate how that decision will benefit the health status of the community, independent of cost savings or business advantages.

FINDING: There is no comprehensive state government oversight of the consolidation of the health care and hospital systems to ensure that marketplace consolidation works toward improving the health status of the residents of the Commonwealth.

RECOMMENDATION: The Committee recommends that the Public Health Council be given full responsibility to survey, monitor and oversee the consolidation of the Massachusetts hospital system. To assure the independence of the Council, the Committee recommends that the Council be made up of the following members: the Commissioner of Public Health (Chairman); eight persons appointed by the Governor as required by Chapter 17, Section 3 of the Massachusetts General Laws; the Attorney General of the Commonwealth or his designee; and the Auditor of the Commonwealth or his designee. The Committee further recommends that the Public Health Council assume certain of the responsibilities of the Acute Hospital Conversion Board as defined in Chapter 6B, Section 16 in order to monitor how acute hospital closures or conversions affect the health status of the surrounding communities. The Committee also recommends that the Commissioner of Public Health dedicate to the Public Health Council personnel as are necessary for the proper discharge of its duties. These personnel shall have technical expertise in such areas as planning, assessment and evaluation in order to support the efforts of the Council. The Public Health Council shall also have an Advisory Council consisting of the members of the Acute Hospital Conversion Board.

FINDING: The process for approving most hospital mergers, acquisitions, and affiliations consists solely of an internal review by the Department of Public Health, and does not include a public hearing.

RECOMMENDATION: The Committee recommends that the Department of Public Health amend 105 CMR 100.601 to allow for a public hearing as part of the public comment process which would be mandatory for all hospital mergers, acquisitions and affiliations.

FINDING: Changes in the hospital industry will have significant employment impacts in Massachusetts, possibly resulting in unemployment for thousands of hospital workers, especially nurses and low level service workers.

RECOMMENDATION: The Committee recommends that the Massachusetts Industrial Services Program and the Department of Employment and Training plan for the employment impact of changes in the hospital industry, and develop retraining and placement programs for displaced hospital workers.

FINDING: Hospital policy making at the state government level is fragmented; there is little formal inter-agency or intra-agency coordination.

RECOMMENDATION: The Committee recommends that the Governor and the Legislature designate a lead agency to eliminate overlapping state agency roles and to coordinate and plan state health care policy making.

INTRODUCTION

In January 1994, the Senate Post Audit and Oversight Committee held a series of hearings to determine how recent and proposed changes in the Massachusetts health care system affect providers of health care services. One of the specific issues addressed at the hearings was how consolidation in the hospital industry affects competition and access to quality affordable care. This report, **An Emerging Concern: The State's Role in Hospital Consolidations**, is the second in a series of reports issued by the Senate Committee on Post Audit and Oversight analyzing the hospital industry in Massachusetts.¹ This report focusses on the issue of consolidation in the hospital industry, and examines possible impacts of hospital mergers and closings on the delivery and cost of health care in Massachusetts.

No one could argue that the health care system in general and the hospital system in specific are in the midst of a very significant set of changes. The national debate on health care reform has called into question some of the basic tenets on which our current system is founded. The rising costs of care have caused patients, providers, and payers to reassess their health care priorities.

Hospitals, as one of the most significant players in the health care system, have had an important role both in effecting some of these changes and in being affected by these changes. Although hospitals (or more precisely, the people who work in hospitals) are important providers of health care, they are not the only providers of health care. Therefore, any assessment of hospital activity must consider how hospitals fit into a larger health care system. Whereas over \$11-12 billion will be spent to pay for care in Massachusetts hospitals in 1994 (the highest amount per capita in the country), as much as \$30 billion will be spent in 1994 on all aspects of health care in Massachusetts (hospitals, physicians,

prescriptions, equipment, research, teaching, etc.)² The debate about state policy toward regulating the hospital industry and controlling costs must take into account the government's involvement in the entire health care system.

There has been a lot of public discussion recently about the introduction of competition into the hospital system, and the deregulation of hospital pricing. Unfortunately, much of that discussion has simplified what is an inherently very complex mix of issues into a specious debate about whether competition is "bad" or "good" for hospitals or for the people of Massachusetts. The underlying assumption for proponents of competition is that the health care marketplace and the hospital marketplace can be thought about in terms of the simple economic laws of supply and demand and the workings of buyers and sellers. This is not the case.

It is in the health care marketplace where most theory and actual practice diverge. In the workings of a typical marketplace for a typical commodity, there are two principal actors: a buyer and a seller. The buyer purchases a commodity from the seller at a price determined by the competitive marketplace. The lower the price for the commodity, the more of the product the buyer will purchase. Buyers are usually aware of the quantity and quality of the product they are buying. In this theoretical environment, the workings of competition do a pretty good job of keeping the supply of the commodity regulated to the demand for the commodity. In the theoretical model of perfect competition, sellers have free entrance into and exit from the market, buyers have full access to information about product price and quality, individual buyers and sellers cannot influence the price of a commodity, and there are no artificial restraints on supply, demand or product price.

In health care, however, there is a much more complex dynamic operating which stymies traditional

economic analysis. Is the sick person a "buyer" purchasing the "commodity" of health care services from the "seller" at a price set by the supply and demand for health care services in a freely competitive market? Not quite.

Typically, a sick person receives services from the hospital, without questioning the medical necessity of those services prescribed by professionals. But in order for the hospital staff to provide the services, a physician with admitting privileges to that hospital must arrange for and authorize the provision of the services. The physician, in turn, does not get paid by the sick person directly. The physician usually gets paid by the sick person's insurance company. The insurance company is paid by the sick person's employer. The employer then passes on the cost of the insurance to his or her employees (by limiting wages or benefits), and to the purchasers of the employer's product or service (through increased prices). In some instances, these relationships are further complicated when the sick person has no insurance. Some of the services for the uninsured sick person are paid through governmental subsidy and surcharges on other peoples' insurance.

In the health care marketplace, the economic relationships among the buyer, the seller, and the commodity purchased are very indirect, and "unique among industries."³ As pointed out in a recent health policy study, "Individuals are rarely direct payers of care, and few are bargain hunters when it comes to health."⁴ Accordingly, the standard assumptions about competition and supply and demand do not operate.

Nevertheless, there are substantial economic inefficiencies in the hospital marketplace that competition can help eliminate. The debate about governmental intervention in the hospital marketplace centers around the nature of these inefficiencies, and whether regulated competition or unregulated

competition is the more effective means of rationalizing the health care system. Yet the complex nature of health care, the critical role that hospitals play in the structure of health care, and the government's particular commitment to ensuring that people have access to quality care, all make the relationship between the health care marketplace and governmental regulation quite complex and controversial.

THE HOSPITAL SYSTEM IN MASSACHUSETTS

One of the reasons that recent hospital activity has drawn the scrutiny of the public and the media is that hospitals play a major role in the economy of the Commonwealth. Hospitals are major landowners, they are major political powers, they are major employers, and they are thought to be major economic engines throughout the cities and towns of Massachusetts.

Hospitals are big businesses, and large quantities of public and private funds flow through them annually. According to data from the Health Care Financing Administration (HCFA), hospital care expenditures in Massachusetts in 1991 totalled over \$9 billion, up from over \$4.1 billion in 1981, an increase in nominal terms of 118 percent. Between 1981 and 1991, national hospital care expenditures rose from over \$118 billion to \$286 billion. Estimates for 1993 exceed \$363 billion. During this same period, Massachusetts per capita expenditures increased from \$723 in 1981 to \$1,517 in 1991 (see Figure 1). The national average of per capita hospital expenditures was \$516 in 1981, and \$1,134 in 1991.⁵

Moreover, as Table 1 (below) indicates, costs in Massachusetts consistently exceed costs for the New England region and for the rest of the U.S. There are numerous reasons for these variations.

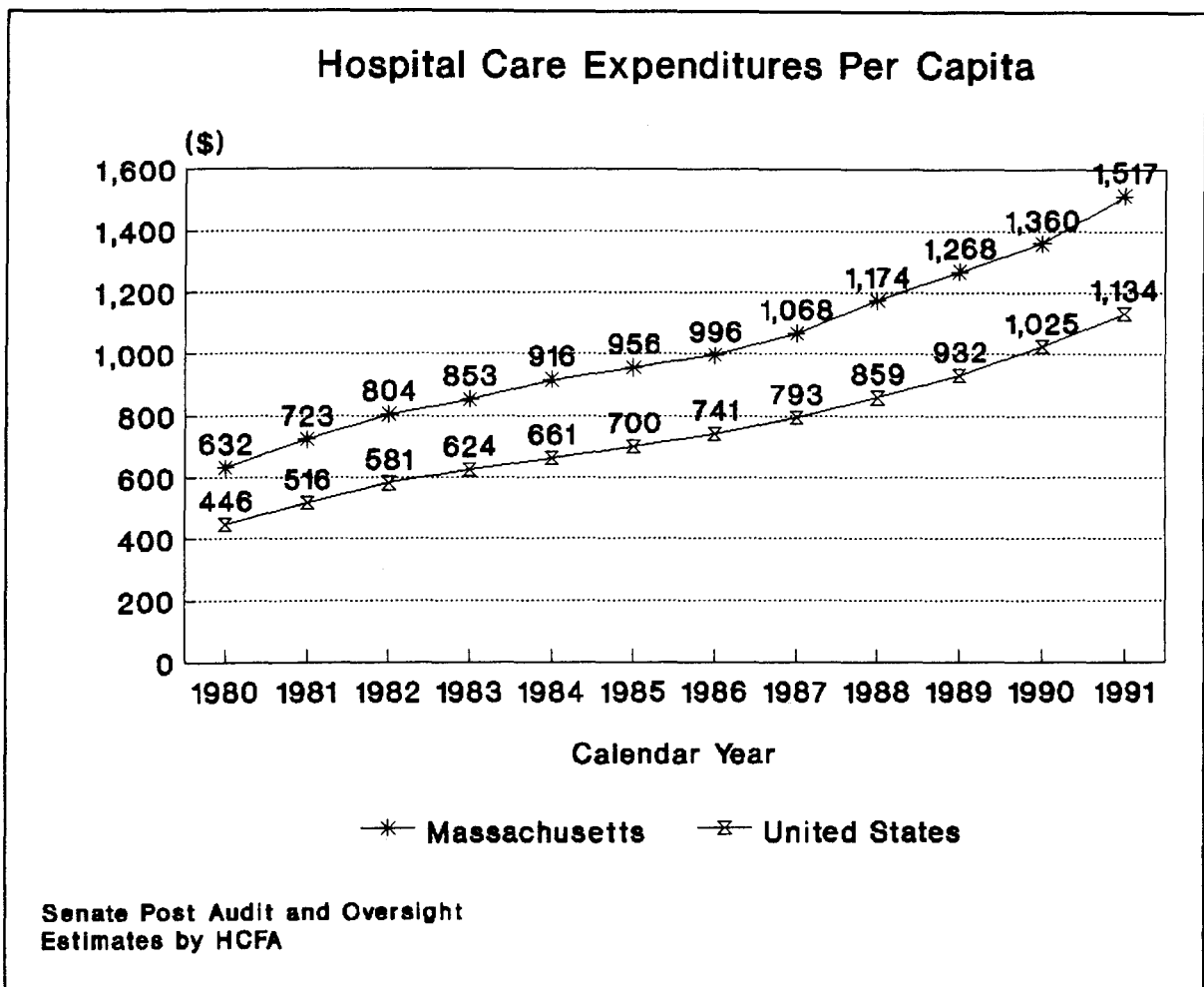


Figure 1

Massachusetts has a relatively high level of personal income (which tends to be correlated to health care usage), there are high levels of hospital utilization by an older population, there is a high incidence of non-Massachusetts residents crossing the border to receive care in the Commonwealth, there are relatively high costs associated with research and the training of new physicians, there are costs incurred by the lack of primary care received by the uninsured, and there is a tendency for high health care usage to follow from large numbers of available health care facilities.⁶

Table 1
HOSPITAL CARE EXPENDITURES PER CAPITA
U.S. and Region

	1981	1991
United States	\$516	\$1,134
New England	597	1,310
Connecticut	513	1,242
Maine	468	1,018
Massachusetts	723	1,517
New Hampshire	404	1,022
Rhode Island	562	1,210
Vermont	398	886

Source: Health Care Financing Administration

Possibly one of the most significant contributors to the high cost of health care in Massachusetts is the unique nature of the health care delivery system in the Commonwealth. The predominance of large urban teaching hospitals in Massachusetts has a substantial impact on the costs of health care.

According to the Governor's Task Force on the Health Care Industry, nineteen hospitals are academic medical centers, and 46 hospitals have residency programs approved by the American Council on Graduate Medical Education. In 1993, Massachusetts hospitals trained over 3,000 medical residents (3.5% of the national total), at a cost of over \$800 million financed by public and private payers.

By their very nature, these teaching-oriented hospitals provide an expensive type of health care. In order to function in their teaching role, teaching hospitals must absorb the costs of teaching into their rate structure. These costs include direct costs such as medical residents' salaries and benefits, faculty salaries, and overhead. There are also indirect costs associated with medical education that include compensation for the decrease in physicians' productivity because of their teaching responsibilities, the costs associated with increased laboratory usage and testing procedures associated with teaching, and the costs associated with providing care to severely ill patients who come to teaching hospitals for their care.⁷ Also because of their instructional role, teaching hospitals tend to

use highly specialized and technical methods for the care they provide. These hospitals use these methods ostensibly for the pedagogic purposes of their medical residents, and they are typically very costly.

The non-teaching hospital, on the other hand, tends to provide relatively low cost primary, secondary and acute care services. Advances in medical technology now allow sophisticated care to be delivered in community hospitals, rather than just in tertiary teaching facilities. However, because of the reputations of the large teaching hospitals in Massachusetts, many people opt for "going downtown" to receive care in the more expensive facilities rather than receiving the same services more economically and closer to home. The use of expensive tertiary care facilities for basic primary and secondary care procedures also tends to drive up the costs of health care in Massachusetts.

Health policy analysts continue to struggle with what portion of the state's hospital costs are really medically necessary. Does Massachusetts have elaborate hospital practice patterns? Is there a net economic gain from patients crossing the border to receive health care in Massachusetts? Many hospitals argue that all current costs are necessary, whereas other health policy experts argue that a sizeable portion of costs are unnecessary.

The money spent in hospitals -- both teaching and non-teaching hospitals -- comes from a variety of sources. According to data from the Congressional Budget Office, nationwide in 1981, 37% of spending for hospital services came from private health insurers such as Blue Cross, HMOs and other commercial insurance companies, 41% came from the federal government, 13% came from state and local governments, 5% was out-of-pocket expenses, and 5% came from other sources. In 1991, 35% came from private health insurance, 41% from the federal government, 15% from state and local

governments, 3% out-of-pocket, and 5% from other sources.⁸

Hospitals are significant employers in Massachusetts, and much of the money spent by hospitals is spent on employee wages. For example, 60% of the expenses of Boston's Beth Israel Hospital -- a large teaching hospital -- are for salaries,⁹ and 60-65% of the expenses at the Massachusetts General Hospital -- another teaching hospital -- are for wages and salaries.¹⁰ In fiscal year 1992, payroll accounted for over \$4.28 billion in Massachusetts hospitals -- almost 60% of hospital expenses statewide.¹¹ Data from 1991 and fiscal year 1992 show that well over 100,000 full-time equivalent employees were employed by Massachusetts hospitals.¹² According to the Massachusetts Department of Employment and Training, hospitals are the largest employer in the state's private health care sector, accounting for approximately 46% of all private health care related employment.¹³

Changes in the hospital industry are therefore significant for the impact they have on employment in Massachusetts. Between 1980 and 1991, the number of registered nurse positions in Massachusetts dropped from 23,039 to 21,096.¹⁴ A recent report by the Task Force on the Health Care Industry of the Governor's Council on Economic Growth and Technology estimated that over the next three to five years, the hospital industry could lose up to 30,000 jobs, mostly nurses and low-skilled service workers.¹⁵ While all of these jobs may not disappear entirely, they are likely to be replaced by jobs in clinics or in home health care -- segments of the industry that typically do not pay as well as hospitals do.¹⁶

PRESSURES FACING THE HOSPITAL INDUSTRY

The role of the hospital has been questioned and redefined, primarily -- but not exclusively -- because of money. The hospital marketplace is now a "buyer's marketplace." Reduced hospital stays have created excess capacity and stiff competition for patients. Massachusetts hospitals receive billions of dollars each year for the care they provide, and they are facing enormous pressures to lower their prices and reduce their costs.

Where does that pressure come from? Pressure comes from the hospital administrators themselves who are forced to cut costs to compete with other hospitals for survival. Pressure to reduce costs comes from purchasers of care who are demanding lower and lower prices. Pressure to reduce costs comes from employers who are faced with rising health care premiums from their insurance companies. Pressure to reduce costs comes from employees when employers pass on the costs of rising health insurance. Pressure to reduce costs also comes from the patients themselves who are being asked to pay for larger and larger shares of the costs of health care directly from their own pockets. There is also pressure on hospitals to provide more and more services and free care. Of course, along with these pressures to reduce costs is an expectation that health care providers will not compromise the quality of care provided.

Managed Care

Over the last decade, much of the effort to contain health care costs has focused on managed care techniques that limit the actual amounts and types of services provided. A managed care plan integrates the financing and delivery of care. Although there are different types of managed care

organizations such as point-of-service plans, managed indemnity plans, and preferred provider organizations, the health maintenance organization (HMO) is the predominant and fastest growing form of managed care. An HMO receives a prepaid, fixed amount of money to pay for the health care costs of each enrollee. This creates an incentive for HMOs to find cost-effective ways to administer and purchase health care services, and it leads to bargaining for better prices for services from hospitals and other providers of care.

HMOs control the number of units of service provided by employing "gatekeepers" to determine the need for services. They control the price of services provided by channelling large numbers of members to a limited number of providers. In Massachusetts, almost 40% of the population (over 2.3 million people) are enrolled in some form of HMO. Nationally, in 1993 there were 549 HMO plans with approximately 46.7 million enrollees,¹⁷ although the distribution of participation is varied. Over 20% of the population is enrolled in HMOs in nine states, but less than 8% of the population is enrolled in 23 states.¹⁸ In fact, low population densities in rural states or in rural parts of states may inhibit the successful use of HMOs, although some speculate that by the year 2000 most Americans will be members of an HMO or some other managed health care network. In spite of the fact that Massachusetts leads the nation in the percent of the population enrolled in HMOs, its health care costs continue to be the highest in the country.

As financial pressures to control health care costs continue, it is likely that the process of negotiating payment between managed care organizations and providers will get more aggressive. HMOs will be expecting hospitals, primary care physicians, specialists, and other providers to "share more of the financial risk" by accepting "capitation," a payment system in which providers receive a fixed amount of money per month to treat a group of patients. If the actual cost of treatment exceeds the capitation

rate, the provider loses money. If the cost does not exceed the capitation rate, the provider profits. Capitation payment is fast becoming the new paradigm for payment, and is expected to accelerate the reduction of hospital occupancy rates.

Utilization

There are other ways to manage care besides utilizing health maintenance organizations. These methods include limiting the insured person's choice of health care provider to a select "circle" or group of preferred or exclusive providers, requiring "second opinions" and "pre-admission certifications" for many types of medical procedures, and arranging for concurrent and retrospective review by a health care utilization review organization to ensure that the care provided is appropriate, necessary, and economical.

The increase in managed care and the use of new technologies that allow sophisticated outpatient treatment have changed the utilization of Massachusetts hospitals for routine care. Many insurers are operating under the philosophy that health care should be provided in the least expensive setting possible. This, in many instances, does not mean an overnight stay in a hospital.

Data from the Health Care Financing Administration clearly demonstrate this trend. In 1981, Massachusetts hospitals registered 1,335 inpatient days per 1,000 population (one measure of hospital utilization). By 1991, however, this number dropped to 963 inpatient days per 1,000 population (see Figure 2). During the same period the average length of stay dropped from 8.9 days to 7.0 days. Recent data suggest that between the first quarter of 1993 and the first quarter of 1994, the average length of stay in a hospital in Massachusetts dropped more than 7%. Inpatient admissions during this

Average hospital occupancy dropped from 82.4% in 1981 to 73.1% in 1991.²¹ As occupancy drops, hospitals become burdened with excess capacity -- unused or under-used hospital beds. In Massachusetts the cost for carrying an empty bed is over \$70 dollars per day,²² and only some types of excess space can be appropriately converted to outpatient use.

In spite of a reduction in hospital occupancy, admissions, and length of stay, medical care inflation (which includes hospital prices) continues to increase. Individual payers and insurers may be saving money using strict utilization review programs, but little evidence suggests that costs are dropping for the entire health care system. Between March 1992 and March 1994, the medical care consumer price index increased approximately 14% in the Boston area as compared to just over 11% nationally.²³

Uncompensated Care

There are other significant cost pressures affecting the hospital industry in Massachusetts. Most hospitals in Massachusetts will provide care for anyone, regardless of ability to pay. In order to reimburse hospitals for this care, Massachusetts administers an "uncompensated care pool" to provide the funds to hospitals for free care provided to people not covered by health insurance. This fund, capped at \$315 million in fiscal year 1993, is financed by a 7% surcharge on insured hospital bills. Estimates are that in 1993 there were over 700,000 individuals requiring free care, up from 633,000 in 1991.²⁴ As more and more uninsured people require access to a "capped" pool, the value of the pool per uninsured person decreases.

Both advocates of universal health care and hospital representatives in Massachusetts have said that

actual hospital claims for free care far exceed present funding for free care. National estimates are that hospitals in 1991 provided \$10.8 billion worth of care for which they were not reimbursed (either by insurance or by public subsidy).²⁵ In other words, although providing a certain amount of unreimbursed free care is a community service, hospitals are losing money on providing care to people without health insurance. As price competition dominates the hospital market, hospitals trim their profit margins, giving them less and less financial "flexibility" to provide care for which they are not reimbursed.*

Medicare Payment Policies

There is another financial pressure affecting many hospitals that is worth mentioning. Hospitals are a major beneficiary of the federal government's Medicare program, since over 60% of federal Medicare expenditures go toward hospital care. Medicare reimbursement policy also fueled the hospital building boom of the 1980s. Major capital expansion during that time left many hospitals with over-expanded capital capacity, and high levels of debt. As the federal government has become more cost conscious, the tightening up of Medicare reimbursement policies has led to a reduction in hospital profits, having a direct effect on hospital behavior.²⁶ In other words, the federal government can no longer afford to pay for a system whose expansion it helped finance. According to a representative from the Massachusetts insurance industry, "A high Medicare patient population, with its accompanying low reimbursement, strains a hospital's finances. As evidence, most of the hospitals that have closed or been forced to merge have had significant Medicare penetration of up to 70-

*The ability of a hospital to absorb the financial costs associated with free care depends upon that hospital's individual financial situation. The question of how to correctly quantify the financial health of a hospital, however, has been a matter of controversy. A recent study, "Report on the Financial Resources of Major Hospitals in Boston" by Nancy M. Kane, D.B.A. of the Harvard School of Public Health (May 1993) suggests that by using simple and legitimate accounting techniques, a hospital can present a widely varied financial picture about itself to the public, to state regulators, or to its board of trustees. Accordingly, a hospital could "hide" its "true" ability to support uncompensated care for the uninsured.

80%. "27

Health Care Needs

As the public has become more sophisticated about health care, there has also been an increasing awareness of the importance of preventive care and education. In many instances, insurers and health care providers have found that information, education and non-medical preventive measures have been invaluable in keeping people out of the hospital.

In addition to a shift toward outpatient care, the demographics of the Commonwealth have effected a change in the health care needs and status of the population. With the aging of the population, for example, there is more of a need for chronic, long-term care. Along with a shift in Medicare reimbursement policies that discouraged inpatient hospital care in favor of community-based care came a move for older people to "age in place." Continuing care communities, home-based health care and community-based social services -- all of which are becoming increasingly popular -- have helped keep elders out of hospitals in the first place, and have provided for them out of the hospital upon discharge. As more and more of the elderly are discharged "sicker and quicker" from hospitals, however, it will become increasingly more difficult and expensive for families to provide community-based care that is largely uncovered by insurance.

RESPONSES OF THE HOSPITAL INDUSTRY

The increase in managed care organizations, reduced hospital utilization, the increase in excess hospital capacity, changes in the Medicare payment structure, price competition, and changing health

care needs have prompted hospitals to streamline, diversify and consolidate.

In general, hospitals have attempted to improve their management systems, restructure, and become more competitive. Hospitals realize that although acute care remains the nucleus of their business, providing only this type of care in an inpatient facility is not the best way either to meet the health care needs of the patients they serve or their own internal financial needs.

Some hospitals have diversified in order to provide a full range of comprehensive health services. These institutions have attempted to make up for diminishing revenues in inpatient care with revenues from outpatient and ancillary health services. They have offered programs such as home care services, worksite injury prevention programs, or substance abuse treatment. Some hospitals have offered hairstyling services for the elderly or have sold special food items to the public prepared in the hospital kitchen.

Other hospitals have expanded their patient base through vertical integration. In a vertically integrated system, hospitals affiliate with or purchase allied health care organizations such as home care agencies, free-standing outpatient centers, or physician group practices to provide primary care services not available at the hospital. According to a 1993 survey of 507 hospital chief executive officers, one out of five acute care hospitals in the U.S. has at least one type of integrated hospital/physician structure.²⁸ Vertically integrated systems provide revenue for the system anchor, the hospital, by keeping patients in their network. Moreover, physicians participating in the vertically integrated system have access to more services for their patients, thereby providing a broader continuum of care. Vertical systems of care will continue to grow rapidly because of the pressure to find alternatives to inpatient hospitalization.

Some hospitals have expanded their service base through horizontal integration. In a horizontally integrated hospital system, hospitals merge or affiliate to enjoy the benefits of a larger hospital system. Hospital affiliations allow hospitals to consolidate certain duplicative services, and they allow for a wider patient referral base. As stated by two hospitals interested in winning regulatory approval for a planned horizontal affiliation, "[t]he affiliation will create an integrated health care system that will include primary, inpatient, outpatient, psychiatric, rehabilitation and care"29

Hospital mergers and consolidations also allow for hospitals to benefit from certain economies of scale and purchasing discounts in operational costs, although much of this benefit may be hard to quantify. Moreover, it is not clear that consolidations are the only way to achieve these savings, since some of these economies of scale can be gained through out-sourcing of work or various forms of contract management.

Nevertheless, these considerations have driven affiliations, even among financially healthy institutions. For example, the Notice of Determination of Need for the Transfer of Ownership and Original Licensure of Brigham and Women's, The General, McLean, and Spaulding Rehabilitation Hospitals ("MGH/Brigham") illustrates these alleged motivations directly. According to the Massachusetts Department of Public Health staff summary of this transaction, "[The applicants (MGH/Brigham) state that the affiliation will] reduce operational costs by consolidating administrative services, sharing operational efficiencies, combining and consolidating departments and programs and eliminating unnecessary duplication of services."³⁰

Some analysts, however, are skeptical of the economies or efficiencies that could be gained by the consolidation of large hospital facilities. According to one analysis, "a hospital of about 300 beds

[already] exhausts most of the available economies."³¹

The number of horizontal systems of care is likely to increase in the near future, often in conjunction with vertically integrated systems of care. According to the general director of a Boston teaching hospital that recently announced its own affiliation with another institution, "[The hospital industry faces] difficult challenges, and we are convinced they can only be achieved [met] through the creation of horizontally and vertically integrated health care systems. . . . My major concern is to see these major institutions play a major leadership role in the creation of a model integrated health care delivery system" ³²

HOSPITAL CLOSURES, CONSOLIDATIONS AND MERGERS

Some hospitals have been unable to adapt to the changing environment and have simply closed down. In many instances, once these hospitals lost their licensure, they converted their physical facilities to other -- often related -- uses that reflect the changing health care environment. For example, some hospitals converted their facilities to outpatient or chronic care usages. According to data from the American Hospital Association, during the 1980s more than a dozen hospitals in Massachusetts closed.³³

Table 2 (below) charts hospital activity in Massachusetts over the last decade.

Table 2
MASSACHUSETTS HOSPITAL ACTIVITY
Acute Care Hospitals -- 1985 through Present**

Closures

Doctor's Hospital of Worcester (converted to alcohol/drug)	1985
HCHP (Parker Hill) (converted to rehabilitation)	1986
Fairlawn (converted to rehabilitation)	1987
Mary Alley (converted to outpatient/other)	1987
Brookline	1988
Farren Memorial (converted to long term care)	1988
Parkwood (converted to rehabilitation/chronic care)	1988
Choate (converted to outpatient/assisted living)	1989
Sancta Maria (converted to nursing home)	1989
Holden (converted outpatient/chronic care)	1990
Hunt (converted to outpatient)	1990
Massachusetts Osteopathic	1990
St. Luke's (Middleborough) (converted outpatient/chronic care)	1990
Worcester City (converted to outpatient/substance abuse)	1991
Amesbury (converted to outpatient)	1993
J.B. Thomas (converted outpatient/long term care)	1993
St. Margaret's (converted to outpatient/other)	1993
Winthrop Hospital	1994

Mergers

Lynn/Union of Lynn became Atlanticare Medical Center	1986
Worcester Hahnemann/Worcester Memorial became Medical Center of Central Massachusetts	1990
Framingham Union/Leonard Morse became MetroWest Medical Center	1992
St. John's/St. Joseph's became Saints Memorial Medical Center	1993
Burbank/Leominster became Health Alliance	1993
Cardinal Cushing/Goddard Memorial became Good Samaritan Medical Center	1993

Acquisitions

Parkwood by St. Luke's of New Bedford	1987
Hunt by Beverly	1990
J.B. Thomas by Lahey Clinic	1992
J.B. Thomas by Transitional Hospitals from Lahey Clinic	1993
Amesbury by Anna Jaques	1993

****DEFINITIONS:**

Closures. No longer licensed as hospitals; some facilities converted to non-health care related uses.

Mergers. Combined Boards of Trustees.

Corporate Affiliations. Involves transferring control of one organization to parent company of another, through by-law amendment changes; allows both to operate as affiliates or subsidiaries of parent.

Contractual Affiliations. Usually involves written agreement, but no change in ownership or control.

Some hospitals appear on more than one list.

Source: Massachusetts Hospital Association

St. Margaret's by St. Elizabeth's Medical Center	1993
Hahnemann by Mediplex Rehab of Mass., Inc.	1993
Hahnemann by Vencor	1994

Corporate Affiliations

Cardinal Cushing, St. Elizabeth's, St. John of God, St. Margaret's formed Caritas Christi	1985
Franklin Medical Center with Baystate Health Systems, parent of Baystate Medical Center	1985
Bon Secours, now Holy Family Hospital and Medical Center with Caritas Christi	1986
Fairview with Berkshire Health Systems, parent of Berkshire Medical Center	1986
North Shore Children's with Charter Health Services Corp., parent of Salem Hospital	1990
Saint Vincent with Fallon Community Health Plan	1990
Mary Lane with Baystate Health Systems	1991
St. Anne's with Caritas Christi	1991
Nashoba Community with New England Deaconess Hospital Corp., parent of Deaconess Hospital	1993
Massachusetts General, McLean, Spaulding Rehabilitation with Brigham and Women's	1994
Holyoke/Sisters of Providence Health Systems with Mercy and Providence Hospitals	1994

Contractual Affiliations

Massachusetts General/Salem	1992
UMASS Medical Center/Milford Whitinsville Regional	1992
Beverly/Addison Gilbert	1993
Cooley Dickinson/Mary Hitchcock Memorial (Lebanon, N.H.)	1993
Deaconess/Glover Memorial	1993
Lahey Clinic/Atlanticare Medical Center	1993
Medical Center of Central Massachusetts/Marlborough	1993
St. Elizabeth's/Somerville	1993
UMASS Medical Center/Athol Memorial	1993
UMASS Medical Center/Health Alliance	1993
Lahey Clinic/Wing Memorial Hospital and Medical Centers	1994
UMASS Medical Center/Harrington Memorial	1994
UMASS Medical Center/Clinton	1994

The hospital industry in the United States, as well as in Massachusetts, has been consolidating since the 1960s. According to the American Hospital Association, in 1960 there were 6,876 registered hospitals in the United States; by 1991, that number had declined 3.5% to 6,634, in spite of a general population growth of almost 40%.³⁴

Nationally, according to the American Hospital Association, between 1980 and 1992 there have been 210 hospital mergers or acquisitions involving approximately 420 hospitals, averaging almost 16 per year.³⁵ Of the 195 mergers and acquisitions which occurred through 1991, all except twelve

involved not-for-profit hospitals, and in most cases involved two hospitals in the same community.³⁶ According to a spokesperson for the American Hospital Association, "Now, consolidation is an industry-wide strategy to deal with reform."³⁷

In Massachusetts, there has been a net loss of nearly one-third of the state's acute care hospitals, from 141 in 1967 to 91 in early 1994.³⁸ Although the hospital system has been contracting gradually since the 1960s, much of the activity has occurred since the mid-1980s. Table 2 indicates that since 1985, eighteen acute care hospitals have closed, twelve acute care facilities have merged, six have been acquired outright by other institutions, twenty acute care hospitals have developed corporate affiliations with other hospitals, hospital systems, or an HMO, and twenty acute care hospitals have developed contractual affiliations.

This rapidly increasing pace of hospital closures, mergers and affiliations and other forms of bed reductions illustrates well that hospitals feel the pressure to respond to present market conditions. Hospitals are finding that consolidation has been a way to attract contracts with managed care providers, and to achieve financial stability. As viewed by two institutions seeking approval for their affiliation, "the affiliation will enable [us] to meet anticipated changes by health care reform and the demand for managed health care. . . . [It] creates a regional health care network that will be attractive to managed care organizations."³⁹

IMPLICATIONS OF HOSPITAL MERGERS AND CONSOLIDATIONS

Hospital consolidation is a market response to declining hospital occupancy and the subsequent hospital excess bed capacity. According to a representative from the Massachusetts Attorney

General's Office, "Industry analysts agree that very significant consolidation is absolutely necessary to eliminate excess capacity and create integrated delivery systems."⁴⁰ It may be more efficient for the health care system to support fewer fully-utilized hospital facilities than more partially-empty facilities, assuming that the hospitals that survive the market contraction are the most efficient hospitals -- hospitals which have the best outcomes using the least amount of resources.

Mergers are also often the only way to save financially troubled or under-utilized facilities that may, in fact, be the only providers of hospital care in a given geographic area. As noted by a representative of the Massachusetts Hospital Association, "The evolution of broader health forces is . . . driving hospital consolidations. The growth in HMOs and managed care plans coupled with changing clinical procedures will cause a drop in hospital inpatient use by 30-40% in the next 3-4 years. Often, a merger is the only alternative to complete closure of a hospital."⁴¹

There are also larger financial implications associated with hospital consolidation. Many hospitals carry large quantities of debt, much of it spurred by the hospital expansion and construction boom of the 1980s, and financed through the Massachusetts Health and Educational Facilities Authority (HEFA). There are billions of dollars in current bond issues outstanding.⁴² A hospital merger can be complicated in the face of significant institutional indebtedness. One of the questions to be negotiated among the affected parties is how the debt would be handled, and the impact of the transaction on the bondholders since HEFA bonds are not technically guaranteed by the state. Mergers which result in bond defaults or concessions from bondholders could have a significant impact on Massachusetts' reputation in the financial markets.

Recently, Lowell General Hospital decided not to merge with another local hospital because it was

hesitant to assume millions of dollars in new debt. According to a portfolio manager of a health care mutual fund in Boston, "High debt will make needed mergers more difficult to carry out."⁴³

Hospital consolidations can benefit the health care system. An advantage of a hospital merger is that it may allow a hospital to concentrate on what it does best, and not try to diversify beyond its true capabilities. For example, in order to compete in the current marketplace and gain managed care contracts, a hospital may determine that it needs to be able to provide obstetric services, a specialty way beyond the scope of what they currently provide. The hospital could choose to expand its services to include obstetrics independently, thereby duplicating the obstetric services of a nearby facility, or it could merge or affiliate with the nearby facility to provide the services jointly. The more efficient response for the entire system may be the consolidation of services, rather than the duplication, assuming, of course, that the consolidating facility operates efficiently.

Unfortunately, to this point there is no indication that the hospitals that have merged or closed have been high-cost and inefficient hospitals. In fact, a recent study comparing the relative efficiency of eighteen hospitals that have stopped providing acute care services and 87 hospitals that have remained open between 1984 and 1994 showed that the hospitals that closed had a 1984 case-mix adjusted inpatient cost per discharge of \$2997, and the hospitals that remained open had an inpatient cost per discharge of \$3041. This analysis suggested that efficient hospitals were more likely to close than inefficient hospitals.⁴⁴

Instead of making the hospital market more efficient, mergers or affiliations could have the opposite market effect, and create greater market inefficiencies. Some mergers may push nearby competing institutions out of business, even though these institutions may be needed by their communities.

Moreover, for a competitive market to exist, there must be a sufficient number of competitors. For instance, one less competing hospital in a particular hospital submarket could cause undue market concentration. This a particular risk in the hospital submarket for specialty services.

In fact, the theory of the competitive marketplace is that the competition created by the existence of a sufficient number of participants in the market works to keep prices down. Moreover, undue concentration in the hospital marketplace could lead to oligopolistic market conditions (or possibly monopolistic submarkets) which would limit the choices of consumers, raise prices, or have adverse effects on access to services. This is particularly a concern since a free market requires easy market entry and exit, and as a practical matter, market access is limited by regulation, and new hospitals cannot enter the market freely and compete in Massachusetts.

Hospital mergers (or hospital closures subsequent to merger) may reduce the number of excess hospital beds and increase hospital occupancy rates, but this may not always lead to lower costs. A hospital merger does not guarantee that the most inefficient facilities (or hospital beds) will close. Area hospital costs may rise if the hospital that closed subsequent to a merger was a relatively low-cost hospital, and if the remaining hospitals' costs per day do not fall with their increased patient volume. Even if area hospitals' costs do not rise, patients who live near the hospital that closed may experience increased costs associated with obtaining access to the remaining hospitals (such as increased transportation costs).⁴⁵ It may be better for consumers if two hospitals providing similar services in similar geographic locations remain in competition with each other rather than merge.

Mergers may leave some areas of the state with limited access to hospital services. The residents of some small communities are concerned that if the local hospital merges with a larger regional

hospital, the larger hospital may shut down the smaller facility. This could leave the residents of that community without certain acute care services (particularly emergency and intensive care services).

Recently, in fact, the small central Massachusetts town of Holden negotiated a \$2.5 million settlement from the Medical Center of Central Massachusetts. The Medical Center had been created from the merger of Holden Hospital, Worcester Memorial Hospital, and Worcester Hahnemann Hospital. Six months after the merger, the Medical Center closed down the Holden Hospital. Concerned about the loss of their emergency medical facility, the town of Holden appealed to the Public Charities Division of the Attorney General's Office. The Attorney General encouraged the monetary settlement for the town, in order to support the town's increased emergency medical transportation costs.⁴⁶

In addition to impacts on access to care, hospital consolidation activity can have an impact on the quality of care received by hospital patients. It is generally believed that the more a facility performs a particular procedure, the more likely there will be positive outcomes. Consolidation could therefore lead to better medical outcomes in certain types of services. Conversely, there is some evidence that hospital inefficiency is sometimes related to poor outcomes. A recent analysis of 42 Pennsylvania hospitals suggested that hospitals with relatively poor outcomes tended to be inefficient resource users.⁴⁷

On the other hand, the financial pressures often associated with a hospital merger or consolidation can lead a facility to cut back on medical support services, or cut back on staffing, either of which could have a negative impact on health care outcomes. A recent study by E.C. Murphy Ltd. reported that 81% of facilities that downsized by 7.5% across the board during 1990 experienced higher mortality rates for Medicare patients than predicted.⁴⁸

Another implication of hospital merger activity is that physicians in the merging institutions may have conflicting care philosophies and personalities. Mergers may also disrupt patient referral patterns which would lead to (temporary) reductions in physician income until new referral patterns are established. Even though these physician issues may have no direct relationship to quality of care provided for patients, these disruptions are rarely a significant factor in determining whether a hospital would undertake or avoid a merger transaction.

CURRENT REGULATORS OF HOSPITAL CONSOLIDATION

There are a number of state agencies that play a policy role in the hospital system. Chapter 495 of the Massachusetts General Laws of 1991 created the Hospital Payment Advisory Commission (HospPAC) in order to evaluate and make more efficient the implementation of competitive financing for hospital payment. The Department of Medical Security administers the state's uncompensated care pool and a variety of other programs which have improved access to insurance for the unemployed, college students, and children. The Massachusetts Health and Educational Facilities Authority arranges the financing of millions of dollars of hospital debt. The Division of Medical Assistance of the Executive Office of Health and Human Services administers the Medicaid program and its hospital payments. The Acute Hospital Conversion Board was created to offer financial relief to hospitals in danger of closing. The Rate Setting Commission, which collects copious amounts of diagnostic and financial information from hospitals, recently published an analysis that suggests a link between inadequate primary care and hospital utilization for certain diagnoses. The Massachusetts Group Insurance Commission is a major purchaser of hospital and health care, and as a "power buyer" for thousands of state employees can have a significant impact on hospital finances. The Division of Insurance regulates health insurers such as Blue Cross/Blue Shield (but not health

maintenance organizations), and handles consumer complaints about insurers. The Boards of Registration monitor licensure and quality issues for physicians, nurses, and a variety of allied health providers. These linking and overlapping agencies all have an impact on the hospital system, and in turn are affected by changes in the hospital system. None of these agencies, however, monitors the appropriateness of hospital consolidations or how consolidations might affect their constituencies.

There are two state agencies, however, that do have primary regulatory authority over hospitals' decisions to consolidate: the Determination of Need program in the Department of Public Health, and the Antitrust and Public Charities Divisions of the Attorney General's Office. The Attorney General's Office also works closely with two federal agencies: the Department of Justice and the Federal Trade Commission.

The Role of the Determination of Need Program

The Determination of Need Program within the Department of Public Health (DoN) is responsible for reviewing and (when appropriate) granting approval when there is need for "substantial capital expenditures for construction of a health care facility or [substantial changes in] the service of such facility."⁴⁹ DoN program staff review an application, and present their recommendations to the Public Health Council for approval. The Public Health Council consists of the Commissioner of Public Health who acts as chairman, and eight members appointed by the Governor. Three of the members must be providers (two of whom must be physicians), and five are non-providers. Under most circumstances, proposals coming before the DoN require a substantial public review. Each application is open for review by interested parties, and can be discussed at a public hearing.

The Department's Community Health Initiatives program is part of this review process. Under this program, applicants with capital projects subject to DoN review typically contribute an amount equal to about 5% of their proposed capital expenditures to community health services. The program, spelled out in DoN regulations, has thus far directed \$38 million from hospitals to programs that directly affect communities.

The DoN program also has a regulatory role in hospital mergers. When two hospitals choose to merge, however, the DoN process is streamlined since typically there is no capital expenditure associated with a merger. The regulations governing the Determination of Need program explicitly give the Commissioner of Public Health the authority to exempt a merger transaction from an extensive public review process. Technically, as long as there are no changes in services, a merger is simply a "change of ownership" under the regulations, and there is an "alternate [approval] process for change of ownership of hospitals and freestanding ambulatory surgery centers."⁵⁰

This alternate delegated review process eliminates the public review process, makes less stringent the approval criteria, and delegates to the Commissioner the authority to approve the application without the involvement of the Public Health Council. The criteria for approval of such a "change in ownership" are that the majority of people responsible for certain decisions live in the primary service area of the institution; that the institution addresses issues of access to services for recipients of Medicaid; that the institution does not discriminate against recipients of Medicare; that the institution allocates a certain minimum level of gross patient revenue to bad debt or free care; and that the hospital submitting the application is licensed by the Department of Public Health.⁵¹ According to information from the Department of Public Health, between January 1985 and May 1994, thirty-six hospital change of ownership projects have been delegated to the Commissioner of Public Health and

all but one have been approved, approved in part, or approved with conditions.⁵²

The role of the DoN program, therefore, is very specific in its evaluation of hospital consolidation activity. The Determination of Need program has the authority to evaluate only a very narrow aspect of the consolidation transaction. Furthermore, since the evaluation involves a departmental approval process rather than a public approval process, the evaluation is usually fairly routine. Hospitals are not required to address specifically the public health impacts of a proposed merger or affiliation when requesting state approval.

Moreover, according to staff for the Determination of Need program, because the mergers that have come before them typically do not present with a change in services at the time of the merger, there is no need to include a public review process in the approval process.⁵³ The technical merger of two facilities, however, can often precede substantial changes in services after the merger has been approved. These changes, in spite of the potentially significant impacts on surrounding communities, occur without the opportunity for public debate.

The Role of the Attorney General's Office

The Attorney General's Office (AGO) is involved in several different aspects of health care, such as investigating Medicaid fraud, advocating for consumers in Blue Cross/Blue Shield non-group and Medicare supplemental rate setting, protecting consumers from deceptive health care advertising, protecting the rights of the elderly in nursing homes, and assisting consumers who have been denied health insurance coverage.

With regard to hospital consolidations, the AGO has two divisions with specific responsibilities. The Public Charities Division within the Office of the Attorney General is responsible for ensuring that "charitable funds held by trustees and charitable organizations are used properly."⁵⁴ For a hospital established under the provisions of a trust, any consolidation activity that might threaten the integrity of that trust would require approval by the Division of Public Charities.⁵⁵

The Public Charities Division of the Attorney General's Office has recently sharpened its focus on the charitable nature of non-profit hospitals. In draft guidelines published in January 1994, the Attorney General's Office proposed responsibilities for non-profit hospitals to "best fulfill their charitable obligations and tax-exempt purpose."⁵⁶ The intent of these guidelines was to force hospitals to be very specific in how they would implement a plan for improving the health care of medically-underserved populations in the state.

The Attorney General's use of the Public Charities Division to attempt to effect change in hospital behavior is significant. Although the Attorney General does have appropriate authority over the tax-exempt status of non-profit institutions, using that authority to develop expectations for public health planning by hospitals may only be desirable if that role is not being filled by other governmental entities. The Attorney General's Office recognized a need, and used its broad statutory oversight role in the public charities arena to try to supplement initiatives by other parts of the executive branch of government, particularly the Community Health Initiatives linkage program within the Department of Public Health.

Because hospitals gain substantial financial advantage if they are non-profit and exempt from taxes, they have a social responsibility to the communities they serve. Massachusetts hospitals provide

millions and millions of dollars of unreimbursed free care, and certain hospitals have developed laudable community service models. For example, the University of Massachusetts Medical Center has developed a family practice residency program to train primary care physicians. The Deaconess Hospital has an AIDS outreach project which provides financial and program support for community-based organizations. Beth Israel Hospital has a Family Van, in collaboration with the Boston Department of Health and Hospitals and several agencies and health centers, which in 1993 delivered primary health care services to over 2000 individuals.

At the center of this issue, however, is the question of how to calculate the "proper" amount of community benefit a hospital should provide. Which is more "valuable," actual free care delivered, or support for a community health organization, or community services provided by hospitals which are not reimbursable through the financing system? What is the proper method for calculating the value of free care? Should the reimbursement hospitals receive for free care be based on hospital charges or on the average cost of services or on the marginal costs of services?

A more effective mechanism for ensuring that medically under-served communities receive direct benefits from the hospital system would be to view these responsibilities in terms of all payers and providers, rather than "regulate" exactly how much service needs to be provided by each particular hospital. Assuming a hospital is efficient and is needed in a community, it may not be wise to legislate that a specific amount of money be spent on community service, at the risk of the hospital not being able to fulfill its mission of providing acute care services to the community. It is not unfair, however, to expect that hospitals develop community benefit plans. All participants in the health care system should be responsible for the development of community benefit plans, especially as complex health care systems evolve into integrated organizations that provide care and also pay for

care. Health maintenance organizations, commercial and government payers, physicians and other health care providers -- not just hospitals -- have a responsibility to the communities they serve. The compilation of these plans could then be the basis for a comprehensive state health plan.

In spite of the press prominence given to the Public Charities Division initiatives, the key actor in the Attorney General's Office in the area of hospital consolidation activity is the Antitrust Division. This division's primary goal is to enforce "federal and state antitrust laws prohibiting anti-competitive activity. . . . Enforcement of these laws protects consumers from the adverse economic effect of price-fixing, boycotts, monopolization and other similar restraints of trade."⁵⁷

The Antitrust Division of the Attorney General's Office has been very involved in the oversight of hospital consolidation activity in Massachusetts. During the past eighteen months, the Attorney General's Office has reviewed sixteen inter-hospital transactions. Thirteen of these transactions have been proposed mergers or acquisitions, and three have been proposed joint ventures.⁵⁸

In response to the pace of such activity, in August 1993, the Division published Antitrust Guidelines for Mergers and Similar Transactions Among Hospitals (developed as a supplement to the general antitrust guidelines of the National Association of Attorneys General), which sought to clarify the criteria the Attorney General would use in assessing a particular hospital consolidation transaction.

According to the guidelines:

Fundamental changes in medical techniques and in the management of health care are making obsolete much of the installed capacity in hospitals. Consolidation of unneeded or underutilized hospital facilities is in the interest of consumers. In addition, health care providers have recognized the need to reduce fragmentation in the delivery of care through various forms of integration. The Attorney General recognizes these trends and seeks to facilitate their progress while enforcing the antitrust laws and preserving meaningful competition.⁵⁹

The Attorney General's antitrust analysis defines and identifies product and geographic markets, and then applies a mathematical algorithm to determine the level of market concentration before and after a proposed merger.⁶⁰ It is this mathematical formula that defines competition and identifies concentration within the relevant marketplace.

The precise definitions of product or geography are very significant for the analysis. In hospital services, defining the product is an especially slippery problem. Two particular hospitals may be the only ones that provide a very specialized and highly technical procedure. For that product, a merger between those two hospitals may technically create a monopoly, if all health insurers have to contract with those merged hospitals for that particular procedure. For other procedures, such as more commonplace secondary care provided by all the other hospitals within a specified geographic area, the same hospital may hold only a negligible market share. Market concentration analysis is very sensitive to the precise definition of the product.

The Attorney General also evaluates other aspects of the dynamics of a particular marketplace to determine whether a merger would create excessive market power. The Attorney General's Office uses antitrust analysis to review concentrations in various health care submarkets and geographic areas. Moreover, the analysis can address concerns of competitive "efficiency," and examine the impact of market consolidation on competition and access to care as it relates to competitive market share.

The Role of the Federal Government

The federal government also has been actively reviewing hospital merger activity. Horizontal

acquisitions and mergers are subject to section 7 of the Clayton Act (15 U.S.C. sec. 18), section 1 of the Sherman Act (15 U.S.C. sec. 1), and section 5 of the Federal Trade Commission Act (15 U.S.C. sec. 45). While both the Department of Justice and the Federal Trade Commission have broad authority to restrict certain mergers, they typically allocate enforcement responsibilities for antitrust activities between them, usually by industry.

An amendment to the Clayton Act, the Hart-Scott-Rodino Antitrust Improvements Act (15 U.S.C. sec. 18a) clarified the federal government's jurisdiction over merger activity. If the consolidation transaction exceeds a certain size, the businesses in question must submit their plans to the Federal Trade Commission or the Department of Justice in advance for approval. Pre-merger approval would be required if the transaction meets each of the following three jurisdictional tests: at least one party to the acquisition must be "engaged in commerce or in any activity affecting commerce"; at least one party must have annual net sales or total assets of at least \$100 million and the other at least \$10 million; and the acquiring party must hold at least \$15 million worth or 15% of the acquired party's assets or voting securities or \$15 million worth of stock and assets.⁶¹ The federal government may also choose to examine a merger transaction if they receive a complaint or if there is sufficient press coverage of the merger to raise antitrust concerns.

According to a position paper on hospital mergers published by the American Hospital Association, "The antitrust laws, which are intended to promote consumer welfare, are based on the presumption that competition is the best method of allocating resources."⁶² Statements by the federal government seem to corroborate this perception. In 1992, the U.S. Department of Justice and the Federal Trade Commission issued joint guidelines governing horizontal mergers among businesses. Underlying the guidelines is the "recognition that sound merger enforcement is an essential component of our free

enterprise system benefitting the competitiveness of American firms and the welfare of American consumers." According to the guidelines, "mergers should not be permitted to create or enhance market power or to facilitate its exercise."⁶³

In an attempt to achieve the goals of the guidelines, the Department of Justice (D.O.J.) and the Federal Trade Commission (F.T.C.) use a very specific analytical tool for assessing whether or not a particular market activity (such as a merger) would have an anticompetitive effect on the market in question:

First, the Agency [D.O.J. and F.T.C.] assesses whether the merger would significantly increase concentration and result in a concentrated market, properly defined and measured. Second, the Agency assesses whether the merger, in light of market concentration and other factors that characterize the market, raises concern about potential adverse competitive effects. Third, the Agency assesses whether entry would be timely, likely and sufficient either to deter or to counteract the competitive effects of concern. Fourth, the Agency assesses any efficiency gains that reasonably cannot be achieved by the parties through other means. Finally the Agency assesses whether, but for the merger, either party to the transaction would be likely to fail, causing its assets to exit the market.⁶⁴

In fiscal year 1993, the Department of Justice received 53 requests for approval from hospitals planning to merge nationwide. It had received only 21 requests in the previous year.⁶⁵ Since 1987, there have been more than 225 hospital mergers nationwide, and yet the D.O.J. and F.T.C. have required "second-request" investigations of only 22 of them, and only seven of the transactions have been challenged.⁶⁶

In September 1993, the F.T.C. and the D.O.J. issued six "Statements of Antitrust Enforcement Policy in the Health Care Area." The intent of these statements was to clarify the federal government's position and approach to antitrust enforcement in the changing health care environment. One of these statements targeted specifically the question of hospital mergers: "Statement of Department of Justice

and Federal Trade Commission Enforcement Policy on Mergers Among Hospitals."

This statement sets up several "antitrust safety zones" within which the federal government would be unlikely to challenge hospital transactions. Except under "extraordinary circumstances," the D.O.J. and the F.T.C. would not challenge:

any merger between two general acute-care hospitals where one of the hospitals (1) has an average of fewer than 100 licensed beds over the three most recent years, and (2) has an average daily inpatient census of fewer than 40 patients over the three most recent years. . . . This antitrust safety zone will not apply if that hospital is less than 5 years old.⁶⁷

The statement further discusses merger activity that does not fall within the "safety zones," and comments that the assessment of most hospital merger activity is that it does not result in an anticompetitive environment. Specifically:

the Agencies found that: (1) the merger would not increase the likelihood of the exercise of market power either because of the existence post-merger of strong competitors or because the merging hospitals were sufficiently differentiated; (2) the merger would allow the hospitals to realize significant cost savings that could not otherwise be realized; or (3) the merger would eliminate a hospital that likely would fail with its assets exiting the market.⁶⁸

This pronouncement by the D.O.J. and the F.T.C. was not without controversy, however. One of the Commissioners of the Federal Trade Commission published a separate dissenting opinion. Her primary concern was that any sort of antitrust exemption for the hospital industry threatened to pose "a serious question of harm to some consumers in an area where they are gravely concerned about prices, quality, and availability of services." Moreover, she felt that while the health care industry "does exhibit some unique characteristics, these are fully considered in [F.T.C.'s] traditional case analysis, and [she did] not believe that they justify special treatment The obvious inequities stemming from special treatment for one industry [were] achieved primarily on the basis of effective lobbying" The Commissioner then went on to state that she believed that the "creation of any

exemption from the antitrust statutes, no matter how limited should be achieved by the legislature, rather than by unelected prosecutors."⁶⁹

The significance of this internal debate within the agencies of the federal government is that it suggests that there continues to be a lack of consensus on how best to approach the issue of hospital consolidation. Hospitals are indeed businesses, and therefore should be subject to the constraints of antitrust law as are other businesses. Yet a majority of the Commissioners of the F.T.C. tried to develop special exemptions for hospitals from these laws, recognizing that the "business" provided by hospitals holds a special place in our society. The dissenting commissioner disagreed with that particular approach, but did not fully disagree with the premise. In fact, she stated that hospitals may require special treatment in order to meet larger goals, but that this special treatment should result from the public deliberation associated with the legislative process, not through the enforcement process.

LIMITATIONS OF ANTITRUST AND CAPITAL EXPENDITURE ANALYSIS

Although traditional antitrust analysis is sometimes very precise, it is by nature limited.^{***} In most cases, it looks only at one aspect of the impacts of a hospital consolidation: the impact of the consolidation on the mathematical definition of the hospital's market share, and the effect on competition. The analysis, in most cases, cannot look at public health impacts beyond the hospital

^{***}Other states have tried different approaches to hospital regulation. Maryland has recently substituted all-payer rate setting for state antitrust enforcement over hospital activity. Because this strategy has been successful, the likelihood of state or federal intervention is minimized. This regulatory program is similar to public utility regulation, in that specific hospital revenues are set by the state, all payers are required to charge the same price for each service, and cost shifting is not permitted. This regulation appears to have achieved its desired effect; in 1993, the state's average cost per admission was 11% below the national average. The state's certificate of need program controls mergers and joint ventures by requiring regulatory approval, and then makes such ventures exempt from state antitrust laws.

system specifically, such as the effect of a merger on employment or community health status.

A consolidation in the hospital industry could have significant market impacts, but outside the hospital market directly. The merger of two hospitals and the closing of one of the facilities could have a significant impact on the primary care system. This is particularly the case if the community surrounding the closed hospital relied heavily on its hospital emergency room to fill in gaps in the primary care network. Mergers and affiliations among teaching hospitals could also have an impact on the medical education system. These impacts, although extremely relevant to the functioning of the health care system, could not be tracked by traditional antitrust merger analysis outside of their impacts on the competitive marketplace.

Antitrust analysis is not responsible for evaluating the impacts of marketplace consolidation on health care quality. Antitrust analysis must necessarily focus on the "health" of the competitive marketplace, and the health of the competitors in that market -- the hospitals. Antitrust analysis cannot, by itself, analyze the impact of market activity on the health of the hospital consumer. It could not fit into the mathematical formulae, for example, if a hospital merger were to have a significant impact on the quality of hospital care provided to a community. Antitrust law alone is not enough of a safeguard for the health care needs of those served by the Commonwealth's hospitals.

According to a current member of the state's Public Health Council:

. . . Primary Care services will not necessarily be distributed equitably nor can health status be improved significantly by the efficiency of markets alone. There is no direct correlation between the medical services that are most profitable to institutions and the health care needs of a community. Priorities and resource allocation have to be rationally and objectively determined and the tremendous investments involved in our state's medical services enterprise should be to some public purpose and driven by health status indicators.⁷⁰

The Determination of Need system within the Department of Public Health, the Antitrust Division of the Attorney General's Office, and the antitrust divisions of the federal Department of Justice and the Federal Trade Commission can be effective regulators of very specific aspects of hospital consolidation activity. Each of these regulators, however, is limited to a very specific arena of analysis. Unfortunately, none of these regulators has the jurisdictional authority to effectively assess the larger societal impacts of hospital consolidation activity.

As acknowledged by a spokesperson for the Massachusetts Hospital Association in testimony to the Department of Public Health:

The public health needs of a community require long-term planning, coordination, and structure. Funding based on the anticipation of capital projects and innovative technology applications will be sporadic and fall short of that intent. Addressing these needs through DoN applications will lead to a fragmented and patchwork response to the basic health needs of the Commonwealth.⁷¹

And as stated by Senator Howard Metzenbaum (D-Ohio), Chairman of the Antitrust, Monopolies and Business Rights Subcommittee of the Senate Judiciary Committee, "none of the groups seeking antitrust concessions has made a convincing case that American consumers would be better off if the antitrust laws were relaxed."⁷² That, of course, must be the state's highest concern as well: what is in the best interests of the public health of the people of Massachusetts?

CONCLUSIONS, FINDINGS AND RECOMMENDATIONS

Although the state's hospital system has been contracting gradually for over thirty years, the last six years have seen a major reduction in the number of hospitals in Massachusetts. The changing hospital environment is the result of many interacting factors. High hospital costs in Massachusetts

and the efforts to reduce those costs by managing care have brought about changes within the hospitals themselves. Both hospital utilization and hospital reimbursement patterns have changed. As a result, hospitals have been pressured to restructure their organizations and the types of services they provide.

Hospitals are also changing the ways that they organize themselves relative to each other. Hospitals are collaborating and competing with each other in many ways and for many reasons. Some have joined together for protection from financial disaster, others have joined to be better able to adapt to the demands of managed care. Other institutions have joined together to better compete with those institutions that have already joined together. As hospitals respond to HMO and insurer consolidations, more of them are likely to merge as they attempt to protect themselves.

Unfortunately, the decisions about hospital consolidations have not always been made by taking into full consideration the needs and concerns of the people who are paying for or receiving hospital care. It is difficult to assess accurately whether parties to a given individual hospital affiliation or merger have given sufficient weight to the public health needs of the individuals served by those institutions. Further, little evidence suggests that hospital consolidation is improving hospital efficiency, both at the level of the institution and system-wide. Many hospital administrations seem to act as though they were conducting just another commercial venture, accountable for only business concerns. Yet the complex nature of health care, the critical role that hospitals play in the structure of health care, and the government's particular commitment to ensuring that people have access to quality care, all make the relationship between the health care marketplace and governmental policy making quite complex and controversial.

The appropriate state agencies and the legislature need to take an active role in the oversight of the changing hospital care system, and must be convinced that participants in this system are meeting the needs of the communities they serve. Although business antitrust law is an indispensable element of the review process, it cannot be relied upon in and of itself because it does not always look at the broader public health aspects of hospital activity.

As the momentum for reform at the national level continues to ebb and flow, the states will continue to have a pivotal role to play in this area. The Commonwealth needs to have health status information and guidelines that will provide health policy decision makers with the tools they need to meet the health care needs of Massachusetts residents.

FINDING: There is no comprehensive state government oversight of the consolidation of the health care and hospital systems to ensure that marketplace consolidation works toward improving the health status of the residents of the Commonwealth.

RECOMMENDATION: The Committee recommends that the Public Health Council be given full responsibility to survey, monitor and oversee the consolidation of the Massachusetts hospital system. To assure the independence of the Council, the Committee recommends that the Council be made up of the following members: the Commissioner of Public Health (Chairman); eight persons appointed by the Governor as required by Chapter 17, Section 3 of the Massachusetts General Laws; the Attorney General of the Commonwealth or his designee; and the Auditor of the Commonwealth or his designee. The Committee further recommends that the Public Health Council assume certain of the responsibilities of the Acute Hospital Conversion Board as defined in Chapter 6B, Section 16 in order to monitor how acute hospital closures or

conversions affect the health status of the surrounding communities. The Committee also recommends that the Commissioner of Public Health dedicate to the Public Health Council personnel as are necessary for the proper discharge of its duties. These personnel shall have technical expertise in such areas as planning, assessment and evaluation in order to support the efforts of the Council. The Public Health Council shall also have an Advisory Council consisting of the members of the Acute Hospital Conversion Board.

The Public Health Council should monitor, recommend, give testimony, and report on all aspects of the state's health care system. The Public Health Council should also report twice a year to the Legislative Joint Committee on Health Care and to the Secretary of Health and Human Services on the state of health care service delivery in Massachusetts. As part of the development of a long term plan to improve the health status of the Massachusetts population, an independent Public Health Council would be required to conduct continuous studies and perform analyses to assess appropriate distribution of hospital services across the Commonwealth. The Public Health Council would pay particular attention to the impact of hospital consolidation on the health status of certain regions and cities and towns in the state, and the ability of the population to access primary care services.

Public Health Council reviews should take into account all aspects of the health care system, and how hospitals fit into the larger issue of ensuring adequate health care for the residents of the Commonwealth. The Public Health Council would oversee and compile individual community benefit plans developed by all participants in the health care system into a comprehensive statement of statewide public health goals and guidelines. This statement would have specific goals related to health care quality, access to health care, health care employment, and the special role of academic medicine and research in Massachusetts.

The state needs to take an active role in the assessment and oversight of the changing health care system, and must be convinced that the health care needs of the community are foremost. If institutions want to merge, they need to be able to demonstrate how that decision will benefit the health status of the community, independent of cost savings or business advantages. As a member of the Public Health Council said, the state should:

. . . consider reinventing, or to use a more current phrase, reengineering the concept of Health Care Planning -- not as a regulatory process, but as an empowered collaborative effort among providers, consumers, health professionals, and government to transform an ever-expanding stream of health data into rational, coherent health policies responding to the health needs of the Commonwealth.⁷³

FINDING: The process for approving most hospital mergers, acquisitions, and affiliations consists solely of an internal review by the Department of Public Health, and does not include a public hearing.

RECOMMENDATION: The Committee recommends that the Department of Public Health amend 105 CMR 100.601 to allow for a public hearing as part of the public comment process which would be mandatory for all hospital mergers, acquisitions and affiliations.

FINDING: Changes in the hospital industry will have significant employment impacts in Massachusetts, possibly resulting in unemployment for thousands of hospital workers, especially nurses and low level service workers.

RECOMMENDATION: The Committee recommends that the Massachusetts Industrial Services Program and the Department of Employment and Training plan for the employment impact of

changes in the hospital industry, and develop retraining and placement programs for displaced hospital workers.

The Director of the Industrial Services Program and the Commissioner of the Department of Employment and Training should put into place a careful plan to anticipate the employment needs of people in the hospital sector. It would be a significant loss to the Massachusetts economy to allow the relocation out of state of large numbers of highly skilled medical professionals.

FINDING: Hospital policy making at the state government level is fragmented; there is little formal inter-agency or intra-agency coordination.

RECOMMENDATION: The Committee recommends that the Governor and the Legislature designate a lead agency to eliminate overlapping state agency roles and to coordinate and plan state health care policy making.

In order to better assure the public health of the Commonwealth, the Governor and the Legislature should review and reorganize the health policy making responsibilities of the Office of the Attorney General, the Executive of Health and Human Services, and the Executive Office of Consumer Affairs. At present, these three Offices have many overlapping roles which make the process of health care policy making inefficient and redundant.

For hospitals to operate in the best interests of the public health of the Commonwealth, state government should have a clear idea as to what those interests constitute. Defining the public

interest, in this case, requires consistent and coordinated agency goals, active information sharing, and coordinated state government policy making.

APPENDIX I

SENATE COMMITTEE ON POST AUDIT AND OVERSIGHT HEARINGS ON HEALTH CARE REFORM -- January 1994 Summary

The Senate Committee on Post Audit and Oversight conducted a series of public hearings from January 6 through January 27, 1994 to study competition in the health care industry in Massachusetts. The Committee was interested in determining the impact of the implementation of Chapter 495 on the health care system in Massachusetts, and in determining how the state should prepare for the implementation of nationwide reform of the health care delivery system.

The Committee solicited and received written and oral testimony from many segments of the health care industry, including the hospital industry, the physician community, home health care agencies, and representatives of business and government.

During the course of these hearings, the Committee explored several key issues in the health care debate, including:

- How competition has affected the delivery of health care in Massachusetts, and has affected access to quality care;
- Whether there is a relationship between hospital deregulation and the trend towards increased merger activities among Massachusetts hospitals;
- Whether recent hospital mergers and consolidations adversely affect industry competition and possibly violate antitrust rules;
- What the potential impact of contraction in the hospital industry on the Massachusetts economy might be;
- How increased competition in the health care industry has affected the work of medical providers;
- Whether the state has, or should have, effective planning mechanisms in place, particularly to prepare for national health reform.

The following people provided oral testimony at the hearings:

On Thursday, January 6, 1994 in Gardner Auditorium:

Robert Restuccia, Executive Director, Health Care for All

H. Richard Nesson, M.D., President, Brigham and Women's Hospital

J. Robert Buchanan, M.D., General Director, Massachusetts General Hospital

William Brownsberger, Esq., Assistant Attorney General in the Consumer
Protection/Antitrust Division

Alan Sager, Ph.D., Associate Professor, Boston University School of Public Health

On Monday, January 10, 1994 in Gardner Auditorium:

Judith Shindul-Rothschild, Ph.D., R.N., C.S., Assistant Professor, Boston College
School of Nursing

Charles Lyons, Selectman, Town of Arlington

Nancy Kane, D.B.A., Harvard School of Public Health

Patricia Page, Executive Director, Home and Health Care Association of
Massachusetts

Asher Kramer, Chief Financial Officer, Quincy Hospital

Richard Stanton, Deputy Chancellor for Finance and Administration, Univ. of Mass.
Medical Center

On Wednesday, January 12, 1994 in Hearing Room A-1:

Bruce Bullen, Commissioner, Division of Medical Assistance

Stephen Tringale, Senior Vice President for External Affairs, Blue Cross/Blue Shield
of Massachusetts

Linda Ruthardt, Commissioner, Division of Insurance

Christy Bell, Executive Director, Fallon Health Plan

George Moran, Vice President of Operations, Tufts Associated Health Plans

Delores Mitchell, Executive Director, Group Insurance Commission

On Tuesday, January 18, 1994 in Hearing Room B-1:

William McDermott, Jr., M.D., Executive Vice President, Massachusetts Medical
Society

Elizabeth Campbell, Chair, State Legislative Committee, American Association of
Retired Persons

Marva Serotkin, M.P.H., Massachusetts Public Health Association

Stephen Hegarty, President, Massachusetts Hospital Association

On Wednesday, January 19, 1994 in Gardner Auditorium:

Nils Nordberg, Commissioner, Department of Employment and Training

Enid Eckstein, Staff Director, SEIU Local 285

Jeffrey Ritter, Commissioner, Department of Medical Security

Lawrence Dwyer, Commissioner, Boston Department of Health and Hospitals

Gloria Aubut Craven, R.N., M.S., C.R.R.N., Director of Legislation and
Government Affairs, Massachusetts Nurses Association

On Thursday, January 27, 1994 in Hearing Room A-1:

Charles Baker, Secretary, Executive Office of Health and Human Services

Paula Griswold, Chairman, Rate Setting Commission

David Mulligan, Commissioner, Department of Public Health

Philip Magnusson, Executive Director, Hospital Payment System Advisory
Commission

Stephen Lemire, Executive Director, Massachusetts Business Group on Health.

Written testimony was also received from Bertram A. Yaffe of the Public Health Council and Charles
J. Goudreau, M.D.

At the start of each of the hearings, Senator Thomas C. Norton (D-Fall River), Chairman of the Senate Committee on Post Audit and Oversight read the following statement:

Good morning. This hearing of the Senate Committee on Post Audit and Oversight is now called to order.

The Senate Committee on Post Audit and Oversight has scheduled a series of hearings to examine certain aspects of the health care delivery system in the Commonwealth. The Committee is interested in determining:

- The impact of the implementation of Chapter 495 on the health care system in Massachusetts;
- How the implementation of Chapter 495 in Massachusetts will affect how we prepare for the implementation of national health care reform;
- How recent changes and proposed changes in the health care system affect direct participants in the health care delivery system -- patients, physicians, nurses, and other medical providers, as well as insurers and hospital administrators.

These oversight hearings have been authorized by the Committee as defined by chapter three, sections sixty-three and sixty-four of Massachusetts General Law. The Committee has not requested, nor shall it accept, testimony on any specific bill currently pending before the state legislature.

The Committee has solicited a wide range of witnesses from within all sectors of the health care industry. Inclusion or exclusion of any party should not be inferred as a Committee endorsement or condemnation of the viewpoints represented by that party.

A stenographer will be recording these hearings, and the Committee will maintain a verbatim written record of testimony. Unsolicited written testimony will be accepted by the Senate Committee on Post Audit and Oversight, State House, Room 312, Boston, Mass. until 5:00 p.m. on January 31, 1994.

ENDNOTES

- 1.1. The first report, Paying for Hospital Care in Massachusetts: The Competition Experiment was released in May of 1992 and reviewed hospital payment legislation in Massachusetts over the last twenty-five years. The report discussed the importance of the hospital industry to the Massachusetts economy, and reviewed some reasons why health care costs have increased.
2. State estimate based on data from U.S. Department of Commerce; calculated by Prof. Alan Sager, Ph.D., Deborah Socolar, M.P.H., Peter Hiam, J.D., Access and Affordability Monitoring Project, Boston University School of Public Health.
3. U.S. Department of Commerce, "U.S. Industrial Outlook 1994--Health and Medical Services," p. 42-2.
4. Mitchell T. Rabkin, M.D. and John S. Cook, D.Phil., "What Medicine Must Learn from Business: Basic Considerations for Health Care Reform," December 31, 1992, p.2.
5. These hospital care expenditures include all services that appear on a hospital bill, and are total net revenues. This reduces gross patient revenues (billed charges) by revenues of contractual adjustments with insurers, bad debt and charity care. Estimates prepared by the Office of National Health Statistics, Health Care Financing Administration. Estimates for 1993 from the U.S. Department of Commerce, "U.S. Industrial Outlook 1994--Health and Medical Services," p.42-1.
6. See Task Force on the Health Care Industry, Governor's Council on Economic Growth and Technology, The Massachusetts Health Care Industry: Pathways to the Future, April 1994, pp.1-17.
7. Ibid., p.57-58.
8. Congressional Budget Office calculations based on data from the Health Care Financing Administration. Congressional Budget Office, Trends in Health Spending: An Update, June 1993, Table A-8.
9. Laura Walbert, "Reality is at the Bedside," CFO, December 1993, p.24.
10. From testimony of J. Robert Buchanan, General Director, Massachusetts General Hospital, before the Senate Committee on Post Audit and Oversight, January 6, 1994.
11. Correspondence from the Public and Community Relations Department, Massachusetts Hospital Association, May 17, 1994.
12. Data for 1991 community hospitals from the American Hospital Association, compiled by the Office of National Health Statistics, Health Care Financing Administration. HCFA defines community hospitals to include all non-federal short-term general and special hospitals. These include rehabilitation hospitals, obstetric hospitals, and other specialty short-term hospitals. Data from 1992 from correspondence from the Massachusetts Hospital Association, op. cit.

13. From "Recent Trends in Health Services Employment in Massachusetts, City of Boston, Southern Worcester SDA," Field Research Service, Massachusetts Department of Employment and Training, January 10, 1994. Submitted as testimony by Nils Nordberg, Commissioner, to the Senate Committee on Post Audit and Oversight.
14. From testimony submitted by Judith Shindul-Rothschild, Ph.D., R.N., C.S., to the Senate Committee on Post Audit and Oversight, January 10, 1994., p.3.
15. Task Force on the Health Care Industry, Governor's Council on Economic Growth and Technology, The Massachusetts Health Care Industry: Pathways to the Future, April 1994, p.46.
16. See testimony submitted by Enid Eckstein, Staff Director, Service Employees International Union, Local 285, to the Senate Committee on Post Audit and Oversight, January 19, 1994.
17. "HMO Cost Analysis and Midyear Enrollment Update," Medical Benefits, Vol.11, Number 3, p.2. Data from Table 1: "HMO penetration and enrollment growth, by state, June 30, 1993."
18. Shelda Harden, What Legislators Need to Know About Managed Care, National Council of State Legislatures, April 1994, p.15.
19. Hospital data from the American Hospital Association; population data from the Bureau of the Census; calculated in the Office of National Health Statistics, Health Care Financing Administration.
20. From testimony submitted by Alan Sager, Ph.D., Deborah Socolar, M.P.H., and Peter Hiam, J.D., Hospital Access and Affordability Monitoring Project, Boston University School of Public Health, to the Senate Committee on Post Audit and Oversight, January 6, 1994, p.4.
21. Hospital data through 1991 from the American Hospital Association; population data from the Bureau of the Census; calculated in the Office of National Health Statistics, Health Care Financing Administration. Current year data cited in Charles Stein, "Mass. hospitals face job losses," Boston Globe, May 8, 1994, p.18.
22. James Borghesani, "Excess space worries hospital brass," The Boston Business Journal, June 3-9, 1994, p.31.
23. Federal Reserve Bank of Boston, New England Economic Indicators, June 1994, p.18.
24. Richard Knox, "Health system dumps more poor, uninsured," Boston Globe, May 2, 1993, p.1.
25. Congressional Budget Office calculations based on data from the American Hospital Association. Congressional Budget Office, Trends in Health Spending: An Update, June 1993, Table A-10.
26. For a full discussion of the relationship between Medicare reimbursement and hospital behavior, see: Marc J. Roberts with Alexandra T. Clyde, Your Money or Your Life: The Health Care Crisis Explained, Doubleday, New York, 1993, especially pp.49-60.
27. From testimony by Blue Cross and Blue Shield of Massachusetts, Inc., to the Senate Committee on Post Audit and Oversight, January 20, 1994, p.1.

28. Cited in The State of Health Care in America: 1994, Business & Health Magazine, Montvale, N.J., 1994, p.21.
29. "Staff Summary for Determination of Need by the Commissioner of Public Health (Delegated Review Process), February 1994," (Project No. 4-3891) p.3.
30. Ibid.
31. Erwin A. Blackstone and Joseph P. Fuhr, Jr., "Hospital Mergers and Antitrust: An Economic Analysis," Journal of Health Politics, Policy and Law, Vol. 14, No. 2, Summer 1989, p.399.
32. From testimony of J. Robert Buchanan, M.D., General Director, Massachusetts General Hospital, before the Senate Committee on Post Audit and Oversight, January 6, 1994.
33. Data from the American Hospital Association, compiled by the Office of National Health Statistics, Health Care Financing Administration.
34. Congressional Budget Office, Trends in Health Spending: An Update, June 1993, p.4.
35. David Burda, "Number of hospital mergers slips in '92, expected to rise for '93," Modern Healthcare, December 20-27, 1993, p.3.
36. Howard J. Anderson, "AHA lists hospital merger activity for 12-year period," Hospitals, June 20, 1992, p.62.
37. Burda, op. cit.
38. From testimony submitted by Philip R. Magnusson, Executive Director, Hospital Payment Advisory Commission, to the Senate Committee on Post Audit and Oversight, January 27, 1994, p.2.
39. "Staff Summary for Determination of Need by the Commissioner of Public Health (Delegated Review Process), February 1994," (Project No. 4-3891) p.3.
40. From testimony of Assistant Attorney General William Brownsberger, before the Senate Committee on Post Audit and Oversight, January 6, 1994.
41. From testimony by Stephen Hegarty, President of the Massachusetts Hospital Association, before the Senate Committee on Post Audit and Oversight, January 18, 1994.
42. Correspondence from Massachusetts Health and Educational Facilities Authority, May 11, 1994.
43. Charles Stein, "Lowell hospitals terminate merger talks; debt blamed," Boston Globe, June 16, 1994, p.77.
44. Analysis based on data from the Rate Setting Commission, form 403; calculated by Alan Sager, Ph.D., Deborah Socolar, M.P.H., Peter Hiam, J.D., Hospital Access and Affordability Monitoring Project, Boston University School of Public Health., Summer 1994.

45. Don Shepard, "Estimating the Effects of Hospital Closures on Areawide Inpatient Hospitals," Health Services Research, Vol. 18, No.4, 1983, pp.514-549.
46. Karen Levine, "Emerging Mergers," The Massachusetts Lawyer, December 27, 1993, p.33, p.41.
47. R. Bradbury, J. Golec, P. Stern, "Relating Hospital Health Outcomes and Resource Expenditures," Inquiry, Spring 1994, vol.31, pp.56-65.
48. "Cost-Driven Downsizing in Hospitals: Implications for Mortality," Medical Benefits, Vol. 10, Number 23, p.7.
49. M.G.L. c. 111, s.25C.
50. See 105 CMR 100.600 et seq.
51. 105 CMR 100.602.
52. Memorandum from Paul Dreyer, Department of Public Health, June 27, 1994.
53. Conversation with staff from the Department of Public Health, April 21, 1994.
54. Report of the Attorney General for the Year Ending June 30, 1992, p. 90. See also M.G.L. c.12, s.8 and Frederick J. Marx ed., Massachusetts Nonprofit Organizations (1992), "Chapter 9: Regulation of Public Charities & Fundraising."
55. See also Richard Allen, Esq., Charities Laws Issues For Health Care Provider Transactions, March 14, 1994.
56. L. Scott Harshbarger, Attorney General of the Commonwealth of Massachusetts, "The Attorney General's Community Benefits Guidelines for Nonprofit Acute Care Hospitals," (Draft), January 24, 1994, p.3.
57. Ibid., p. 36.
58. Telephone conversation with Assistant Attorney General William Brownsberger, June 2, 1994.
59. L. Scott Harshbarger, Attorney General of the Commonwealth of Massachusetts, Antitrust Guidelines for Mergers and Similar Transactions Among Hospitals, August 1993, p.1.
60. The algorithm used is the Herfindahl-Hirschman Index ("HHI") which is calculated by summing the squares of the individual market shares of the participants in the defined product and geographic market. The Attorney General follows the procedures set out in federal guidelines for merger analysis. If the post-merger HHI falls within a certain range, the merger is said to be concentrated. If the difference between the pre-merger HHI and the post-merger HHI also exceeds a certain threshold, the Attorney General's Office raises concerns about market concentration. Using the HHI, the Attorney General's Office also measures the increase in market concentration resulting from the merger.

61. Described in The American Hospital Association, "Hospital Collaboration: The Need for an Appropriate Antitrust Policy," 1992, Appendix C: "Existing Federal Procedures Governing Antitrust Review of Proposed Transactions and/or Arrangements," p.1 (footnote).
62. The American Hospital Association, "Hospital Collaboration: The Need for an Appropriate Antitrust Policy," 1992, p.4.
63. Trade Regulation Reports, Merger Guidelines -- 1992 [paragraph 13,104], statement, section 0.1.
64. Merger Guidelines, section 0.2.
65. The State of Health Care in America: 1994, Business & Health Magazine, Montvale, N.J., 1994, p.19.
66. Howard M. Metzenbaum, "Antitrust Enforcement: Putting the Consumer First," Health Affairs, Fall 1993, p.138.
67. "Statements of Antitrust Enforcement Policy in the Health Care Area," Issued by the U.S. Department of Justice and the Federal Trade Commission, September 15, 1993, pp.4-5.
68. Ibid., p.6.
69. "Dissenting Statement of Commissioner Deborah K. Owen on DOJ/FTC Antitrust Enforcement Policy Statements in the Health Care Area" in Trade Regulation Reports, 9-21-93, paragraph 13,235.
70. From testimony submitted by Bertram Yaffe, Member of the Public Health Council, to the Senate Committee on Post Audit and Oversight, January 13, 1994, p.1.
71. Letter from Kenneth E. Leary, Director, Special Program Development, Massachusetts Hospital Association to David Mulligan, Commissioner, Department of Public Health submitted as testimony on proposed amendments to Determination of Need Regulations 105 CMR 100.000 to initiate a Community Health (Linkage) Program., dated March 25, 1992.
72. Metzenbaum, op. cit., p. 142.
73. Yaffe, op. cit.

**REPORTS OF THE
SENATE COMMITTEE ON POST AUDIT AND OVERSIGHT
Sen. Thomas C. Norton, Chairman**

- 11/94 An Emerging Concern: The State's Role in Hospital Consolidations (S. 1830)
- 6/94 The Clean Air Act and Electric Generation Competition: A Win-Win Situation (S. 1716)
- 3/94 Toward Gaming Regulation, Part II: Problem Gambling, and Regulatory Matters S. 1590)
- 2/94 Policy Review of the Commonwealth's Economic Development Efforts
- 1/94 Toward Gaming Regulation, Part I: Crime (S. 100)
- 12/93 A Performance Review of the Massachusetts Office of Business Development (S. 1872)
- 11/93 The Cost of Innovation: The D.P.U.'s Purchased Power Regulations of 1986 (S. 1820)
- 11/93 A Review of Transitional Bilingual Education in Massachusetts (S. 1810)
- 9/93 Toward Expanded Gaming: A Review of Gaming in Massachusetts (S. 1743)
- 8/93 A Program and Performance Audit of the Massachusetts Office of International Trade and Investment (S. 1717)
- 5/93 Workers' Compensation in Massachusetts: Is it Temporarily or Totally Disabled? (S. 1500)
- 1/93 A Review of DMH Policy Planning and Implementation During the Closing of Northampton State Hospital (S. 1485)
- 12/92 A Review of Faculty Workload Policies and Faculty Workloads at the University of Massachusetts at Amherst (S. 1785)
- 10/92 Policy Brief: The Massachusetts Division of Insurance
- 9/92 Social Worker Caseload and Resource Availability at the Department of Social Services (S. 1700)
- 6/92 Massachusetts Public Libraries in Crisis: The Burden of Non-Resident Lending and Borrowing (S. 1635)
- 5/92 Paying for Hospital Care In Massachusetts: The Competition Experiment (S. 1500)
- 4/92 The Decision of the Massachusetts State Lottery to Offer 'Lottery-By-Phone' (S. 1480)
- 11/91 Lottery Revenue Growth: Prospects for the Future (S. 1720)

6/91 Controlling State Employee Health Care Costs (S. 1610)

4/91 An Analysis of the Massachusetts Executive Branch Workforce (S. 1490)

2/91 Early Retirement: Designing and Implementing an Incentive Program in Massachusetts (S. 1361)