



Hospitals Face a Challenging Operating Environment

**Statement of the American Hospital Association
before the Federal Trade Commission
Health Care Competition Law and Policy Workshop
September 9-10, 2002**

The American Hospital Association (AHA) and its nearly 5,000-member hospitals, health systems, networks, and other providers are committed to providing patients with the highest possible quality of care and improving the health of their communities through an efficient and effective health system. We are pleased to provide the Federal Trade Commission with a brief overview of the health care marketplace as it relates to hospitals. Specifically, we will examine trends in health care spending and identify the reasons for growth in spending on hospital services.

INTRODUCTION

Recently health care spending has risen substantially after relatively low rates of increase during the mid-1990s. As described below the increases in hospital spending can be explained by the growth in demand for hospital services, coupled with numerous factors that have increased hospital input costs. The rate of hospital mergers has slowed substantially in recent years, and hospitals in many areas are now facing increased competition from non-hospital providers, as well as hospitals in other geographic areas. In addition, employer, consumer and health plan customers are becoming increasingly sophisticated and demanding in their approach to choosing and contracting for hospital services.

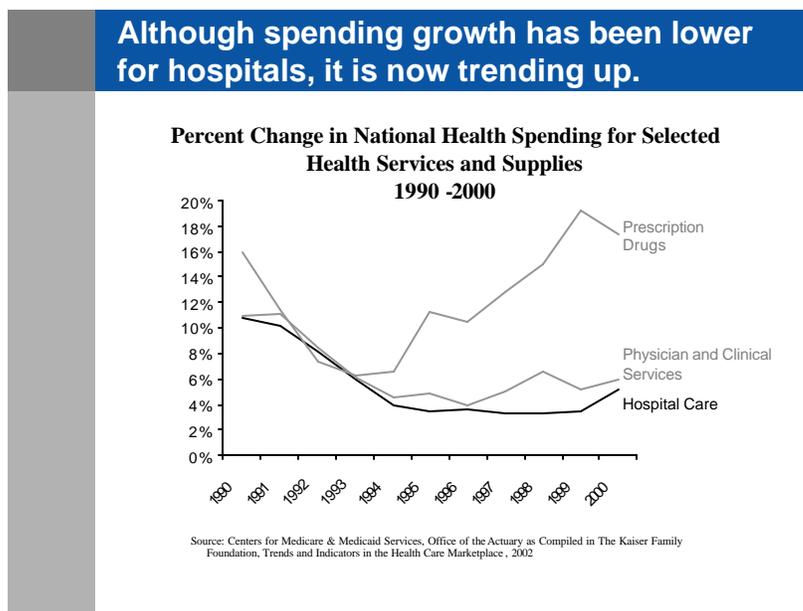
RECENT TRENDS IN HOSPITAL SPENDING

Over the past twenty years, the percentage of the nation's health care spending related to hospital care has declined markedly – from 43.5 percent in 1980 to 32.8 percent in 2000. This reduction can be attributed to many factors, including declining lengths of stay, the shift of the site of care for many procedures from the inpatient to the less expensive outpatient setting, and relentless initiatives to improve hospital efficiency. Thus, as Figure 1 shows, throughout the 1990s the annual percent change in health care spending for hospitals was consistently below that of changes in spending for prescription drugs or physician and clinical services. Also, according to

the Centers for Medicare & Medicaid Services (CMS) between 1999 and 2000 (the last full year for which national health accounts data is available), spending on hospital care rose by 5.1 percent, compared to the overall growth in health care spending of 6.9 percent.

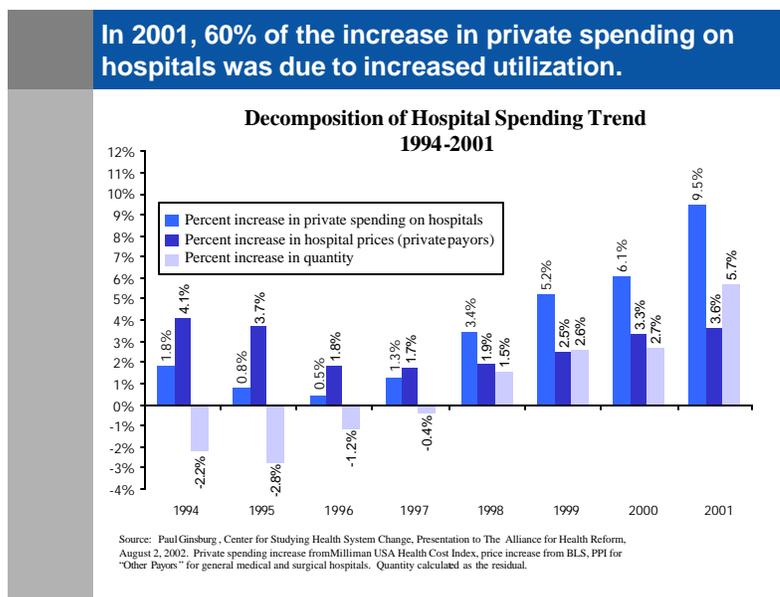
While hospital spending makes up 33 percent of total health care spending, growth in hospital spending is only responsible for about a quarter of the overall growth in health care spending. In contrast, prescription drugs account for only 9.7 percent of health care spending but account for 21 percent of the overall growth in health care spending.

Figure 1



Recently, however, hospital care spending has been growing at a faster rate. In part, this is simply due to an increase in demand for hospital services. Hospital admissions nationwide declined throughout the 1980s (from 36 million in 1980 to 31 million in 1990), but began to rise in the 1990s to more than 33 million in 2000. After two decades of decline, the number of hospital days rose in both 1999 and 2000 to 191 million and 192 million, respectively. To a large extent, these increases are attributable to population growth and an aging U.S. population. It also reflects a shift away from tightly managed HMO products that included very stringent controls over hospital utilization and length of stay. As Figure 2 illustrates, utilization of hospital services by privately insured patients actually declined in the mid-1990s. By 2001, their use of hospital services was increasing at a 5.7 percent annual rate, and accounted for roughly 60 percent of the increase in hospital care spending.

Figure 2

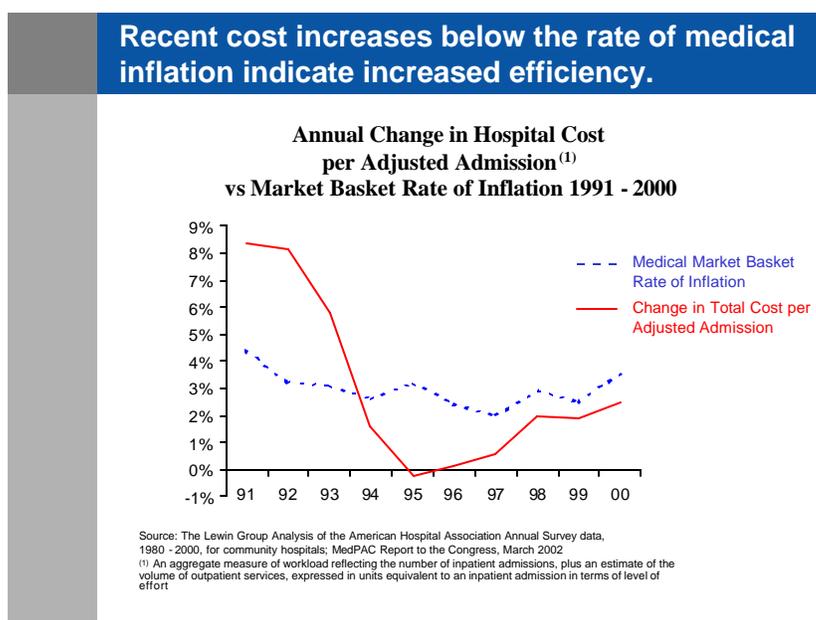


As described in the next section, however, 40 percent of the increased spending on hospital care can be attributed to rising hospital costs.

HOSPITAL COSTS HAVE BEEN RISING IN RECENT YEARS

Throughout the 1980s and 1990s, the nation's hospitals undertook a wide range of efficiency-enhancing steps to reduce their costs. These steps bore fruit in the late 1990s as the annual change in hospital costs were consistently below the market basket rate of inflation. See Figure 3.

Figure 3

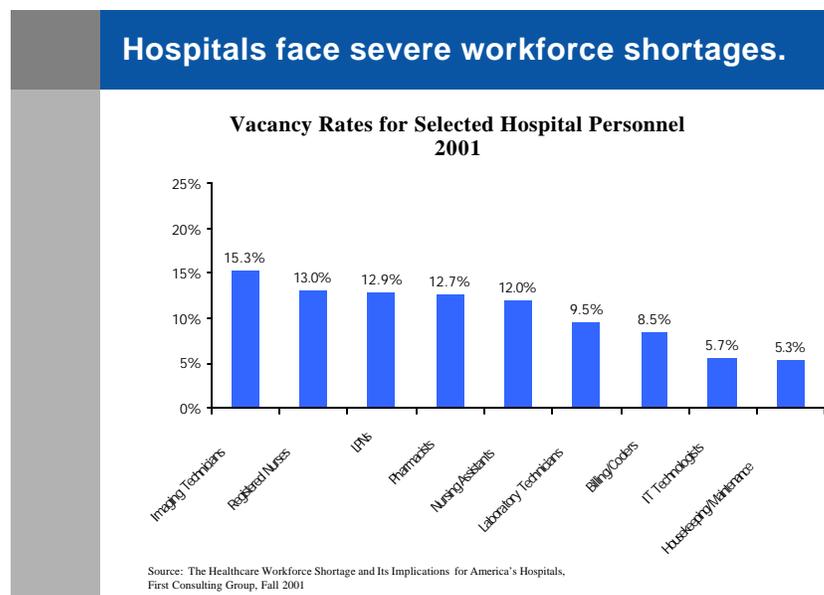


The more easily achieved efficiency-enhancing opportunities have largely already been implemented, and hospitals now face a number of cost increases that are beyond their control.

Workforce shortages and increased labor costs.

As Figure 4 illustrates, the 2001 vacancy rates for selected hospital personnel ranged as high as 13 percent for registered nurses and more than 15 percent for imaging technicians. This health care workforce shortage means that hospitals must pay higher wages, contract with expensive temporary employees, pay regular employees costly overtime, and offer costly financial incentives to attract and retain workers. Thus, for the 12 months ending in March 2002, the employment cost index for hospitals was 6.1 percent, a rate of increase more than 50 percent higher than that of all service industries.

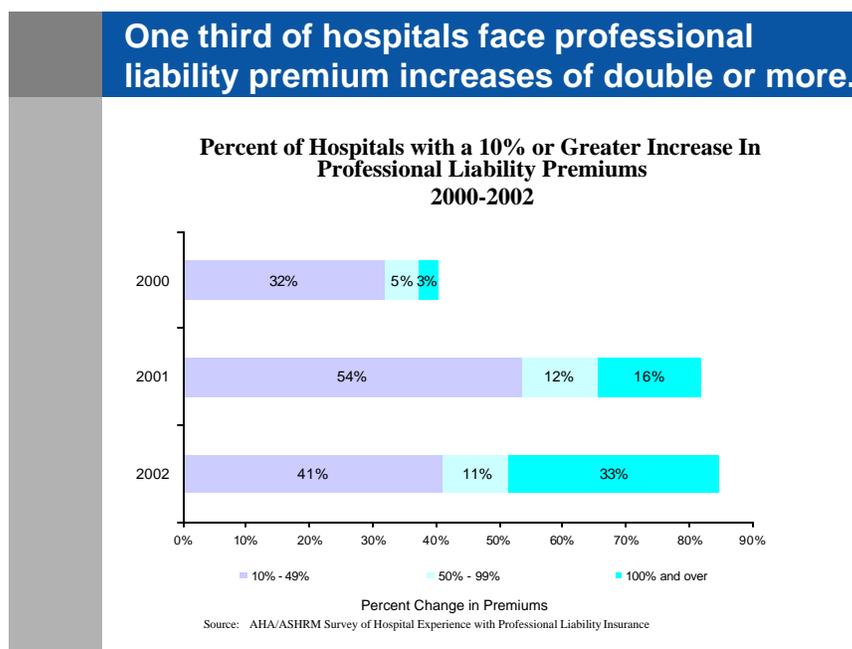
Figure 4



Rapid increases in professional liability premiums.

In the past two years, there has been a dramatic increase in professional liability premiums. This year, one-third of responding hospitals reported that these premiums had at least doubled, and an additional 11 percent reported increases of 50 percent or more. See Figure 5. These huge premium increases are severely affecting access to services. In an AHA survey, 20 percent reported cutbacks in services in their communities and 6 percent had eliminated some units.

Figure 5



Medical advances and new technologies increase supply costs.

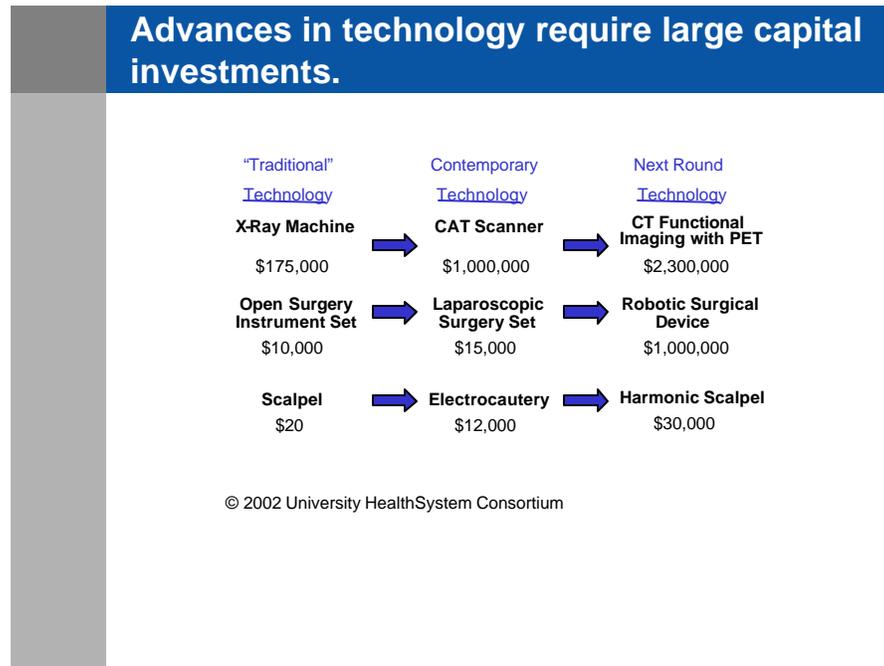
New medical technologies have enabled hospitals to provide life-saving diagnostic and therapeutic alternatives that were unavailable only a few years ago, but these advances come at a considerable cost. For example, a few years ago the major supply cost for patients undergoing angioplasty was the approximate \$500 expense of a cardiac balloon catheter. In the late 1990s, the use of a stent that cost \$2,300 was added to the balloon cost. It is now predicted that drug-coated stents, which significantly improve outcomes for patients with heart disease and which cost \$5,000 each, are expected to fully replace uncoated stents as the recommended medical protocol. Similarly, hospital patients are receiving drug therapies that can improve mortality and morbidity, but are extremely costly. For example, a new drug designed to treat sepsis, a major cause of death of patients in hospitals, costs \$6,800 for a 96-hour course of therapy. Patients may receive several courses of therapy.

Supply cost increases are not confined to drugs and devices. For example, in 2001 the average cost of a pint of blood increased 31 percent, according to a survey of blood suppliers. Because hospitals use more than 23 million units of blood each year, this jump translates into increased hospital costs of \$920 million. Pathogen inactivated blood, when approved, will push blood costs even higher.

Need for additional investment.

Advances in medical technology also increase capital technology investment costs, as shown in Figure 6.

Figure 6



Hospitals are also incurring or facing the immediate need to modernize and expand their physical facilities, but often lack the funding to do so. The median age of hospital facilities has increased from 7.9 years in 1990 to 9.3 years in 1999. Many hospitals, particularly those in urban settings, are at or above capacity in their emergency departments and need to expand their critical care bed capacity, which includes raising wages to attract nurses to staff those beds

Regulatory burden.

Hospitals are one of the most highly regulated sectors of the economy. These burdens have increased in recent years due to additional government mandates. These include complying with the Health Insurance Portability and Accountability Act's privacy requirements – just three of the rule's provisions are estimated to cost hospitals between \$4 billion and \$22 billion, according to study conducted on behalf of the AHA. Another recent study shows that every hour of patient care provided in a hospital generates 30 minutes of paperwork. In the emergency department every hour of care results in an extra hour of paperwork.

Disaster readiness.

While hospitals always have had disaster plans in place, the events of 9/11 and last year's anthrax attacks have changed the "definition" of disaster, requiring hospitals to be prepared for terrorist attacks that may include chemical, biological and radiological components. Responding to requests from congressional leaders, the AHA estimates that approximately \$11.3 billion will be needed to augment hospitals' existing disaster infrastructure. Key areas of investment in such readiness include communication systems; surveillance and detection; medical and pharmaceutical supplies; personal protection; facility changes; decontamination facilities; training and drills; and expanded mental health resources.

Similarly, hospitals are incurring huge costs to ensure that they are prepared to address natural disaster situations. For example, in California, new seismic standards will cost hospitals an estimated \$24 billion.

Efforts to improve quality and patient safety.

Hospitals are also undertaking a number of initiatives to improve patient safety and quality. These include implementing electronic medical record and decision support systems, investing in bar coding technology, and creating systems to report and analyze medical errors. Such initiatives are expensive. For example, a computerized physician order entry system costs more than \$5 million for a single hospital to fully implement. This translates into \$25 billion if adopted industry-wide.

OTHER CHALLENGES FACING HOSPITALS

Hospitals are facing a number of very difficult and complex challenges in addition to increases in input costs. On the one hand, they are facing reduced reimbursement from public payers (Medicare and Medicaid) that account for roughly 51 percent of their revenues. At the same time hospitals are providing more care to the uninsured for which they receive no payment. Private payers are becoming increasingly demanding and sophisticated in how they choose and contract for hospital services. Hospitals are also facing growing competition, especially from providers that often do not play the same role as community hospitals in providing access to unprofitable services, such as emergency departments and burn units. The overall result has been a decline in hospital total margins.

Reduced government reimbursement.

Medicare accounts for approximately 38 percent of hospital revenues, and thus the growing gap between Medicare reimbursement rates and hospital costs has a tremendous impact. Hospitals have received Medicare payment updates that are below the rate of inflation in 13 of the last 15 years. Even more challenging, hospitals in the late 1990s faced the largest cuts in Medicare payments in the history of the program as a result of the Balanced Budget Act of 1997. Even after Congressional efforts to mitigate these cuts, Medicare payments remained 12 percent lower. As a result, the number of hospitals with a negative total Medicare margin – hospitals losing money on the Medicare patients they treat – continues to rise, reaching 58.1 percent in 2000 and projected to increase to almost 65 percent in 2005.

Medicaid hospital reimbursement rates are generally even lower than Medicare rates, and as a result 73 percent of hospitals reported negative Medicaid margins in 2000. Hospitals received 82 cents for every dollar spent for Medicaid and charity care patients in 2000.

The Emergency Medical Treatment and Labor Act requires hospitals to provide health care to the nation's uninsured who need emergency care. In 2000, hospitals provided \$21.6 billion in uncompensated care. These costs are expanding as the ranks of the uninsured grow.

Increasing demands from private payers, employers and consumers.

On the private side, health plans, employers and consumers are becoming more sophisticated and demanding in how they choose and contract with hospitals. Numerous efforts have been undertaken to compare hospitals on the basis of outcomes and provide such information to hospital customers. Initiatives by employers and other health care purchasers have begun to

provide information to the public about the extent to which hospitals have undertaken certain quality-improvement initiatives in an effort to shift business to those entities. In 2004, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will begin to require a core set of quality measures from every accredited hospital. In addition, the Internet also has facilitated the ability of consumers to obtain comparative cost and quality information about hospitals.

Health plans are also using more sophisticated benefit designs to enable them to be responsive to consumer demands for broader provider networks, while at the same time incentivizing patients to utilize hospitals that have lower costs or that they believe offer higher quality. Such “tiered” network approaches enable health plans to exert significant pressure in their negotiations with hospitals to reduce their rates.

Increased competition from other providers.

In many areas hospitals are facing increased competition. This growth in competition stems from several sources.

First, it must be recognized that hospital merger activity has significantly slowed over the last five years. According to Irvin Levin Associates, which publishes an annual report on health care acquisitions, in 2001 there were 83 announced mergers and acquisitions involving 118 hospitals, down 3 percent from 86 transactions in 2000, and 58 percent fewer than the 197 deals in 1997. This trend appears to be continuing in 2002 as noted in the July 1 Modern Healthcare article “Hospital mergers, acquisitions projected to stay sluggish.”

Second, a significant regulatory barrier to entry – state Certificate of Need laws – have been relaxed in many jurisdictions, thus making it easier for providers to expand or enter new markets.

Third, for some procedures, particularly “tertiary” or “quaternary” services, patients are often willing to travel substantial distances to obtain care at facilities that perform a high volume of the procedures. A number of health plans have encouraged such efforts by providing financial incentives to patients to do so.

Fourth, there has been a growth in specialty hospitals that focus on treating a single major disease category, such as heart disease, but which can account for a very large share of the services that are provided in a typical community hospital. Often these specialty providers team with physician specialists in the local area and can quickly become a potent competitive force.

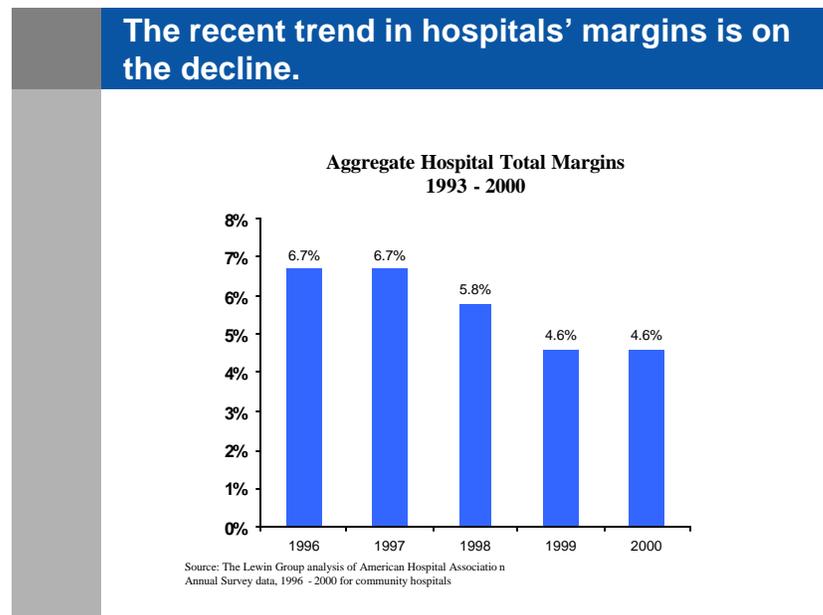
Finally, hospitals are facing increasing competition from non-hospital entities, such as freestanding ambulatory care centers, imaging centers, lithotripsy providers and even physician offices, to provide services that have traditionally been furnished by hospital outpatient departments. Some of these centers are owned and operated by local physicians who are able to control a substantial volume of referrals.

The above factors combine to subject hospitals to increased competition for “high end” cases from specialty providers and more distant tertiary care centers, at the same time as they have increased competition for less complex cases from freestanding entities and doctors’ offices.

Hospital margins have declined and remain low.

In light of all of the above, it is not surprising that hospital margins declined in the late 1990s, and remain low. As Figure 7 shows, aggregate hospital total margins declined from 6.7 percent in 1996 to 4.6 percent in 1999 and 2000.

Figure 7



Hospital operating margins are even lower. Moody's Investors Services survey of over 500 not-for-profit hospitals found median operating profit margins in 2001 of 1.4 percent, up slightly from 0.7 percent in 2000, but still substantially below the 3.6 percent rate in 1997.

CONCLUSION

During the last two decades hospitals have undertaken massive efforts to become more efficient. Some of these have involved horizontal mergers to reduce excess capacity and redundant services. Others have involved vertical integration with other providers such as physician practices or home health agencies. For the most part, these efforts have enabled the nation's hospitals to reduce their costs, while retaining a high level of quality and providing a range of services of increasing complexity and sophistication.

As the above discussion has described, however, hospitals are now facing unprecedented challenges. The more easily achieved efficiency-enhancing opportunities have largely already been implemented, and hospitals now face a number of cost increases that are beyond their control. At the same time, government payment rates are failing to keep up with hospital cost increases, and private sector customers are becoming more sophisticated and demanding. Meanwhile, competition is increasing at both the high and low ends of the spectrum of hospital services.

To meet these challenges, hospitals are redoubling their efforts to improve efficiency and be responsive to the needs of their patients and local communities.