United States General Accounting Office

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Report to the Honorable
Fortney H. (Pete) Stark,
House of Representatives

April 1994

HEALTH CARE

Antitrust Enforcement Under Maryland's Hospital All-Payer System

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Health, Education, and
Human Services Division

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April 27, 1994

The Honorable Fortney H. (Pete) Stark
House of Representatives

Dear Mr. Stark:

One of the issues involved in the debate surrounding health care reform is how antitrust law should be applied to health care providers. Federal and state antitrust law seeks to prevent price fixing and predatory pricing and to ensure access to and quality of goods and services for consumers.

The American Hospital Association claims that the threat of antitrust enforcement has had a "chilling effect" on the behavior of hospital executives, preventing them from seeking joint ventures or mergers. The association says that additional joint ventures and mergers could promote greater efficiency in the delivery of health care services and help to reduce the current oversupply of facilities. To facilitate joint ventures and mergers, the association has suggested that certain hospital cooperative actions should be excluded from antitrust enforcement. On the other hand, proponents of antitrust enforcement claim that the antitrust laws promote competition, which will protect consumers.

Maryland has taken a different approach to address the concerns surrounding antitrust enforcement, and you asked us to review the state's experience under this approach. Since 1974, Maryland has operated a rate-setting program that establishes how much hospitals can charge for their services. Also, as is done in most other states, health care facilities operating in Maryland must obtain a certificate of need (CON) if they wish to change the type of services they provide or to make major capital expenditures. You asked us to study the effect Maryland's all-payer rate-setting and CON programs have had on antitrust enforcement in the state and whether these programs have rendered antitrust enforcement in the state completely or partially unnecessary for hospitals.

In doing our work, we did not attempt to determine the effectiveness of Maryland's rate-setting and CON programs. Our scope and methodology are presented on page 12.

Results in Brief

Maryland has supplanted state antitrust enforcement actions concerning prices, mergers, and joint ventures with regulation of hospitals through its

rate-setting and CON programs. Maryland's regulation reduces the likelihood of federal antitrust enforcement in these areas. Other potentially anticompetitive conduct not covered by state regulatory oversight could be subject to federal and state antitrust enforcement actions.

Concerning pricing, Maryland's regulatory approach, which is similar in operation to public utility regulation, enables the state to set the level of each hospital's prices. Under Maryland's system, the state establishes through budget review the amount of revenues each hospital can receive and requires that all payers be charged the same rates for services. Based on a waiver, Medicare and Medicaid also pay on the basis of the state-approved rates. Thus, hospital pricing is not a state antitrust concern for Maryland. This regulatory scheme appears to have had the desired effect of controlling hospital prices. In 1976, for example, Maryland's average cost per admission was 25 percent above the national average, but in 1993 it was 11 percent below the national average.

Concerning access to services, Maryland uses its CON program to regulate mergers and joint ventures, rather than relying on antitrust enforcement. The program's overall goals are to prevent the costly proliferation and unnecessary duplication of facilities, while assuring sufficient services to meet the public's needs. With approval of the state CON agency, hospital mergers or joint ventures to own and operate major medical equipment are exempt from the state's antitrust laws.

A third objective of antitrust policy is to assure quality of services, but the federal and state governments have not used antitrust law specifically to address this area of concern. Rather, the chief protection mechanisms to assure quality services are state licensing and inspection programs and quality assurance programs.

Whether hospital pricing in Maryland and the mergers and joint ventures the state approves are subject to federal antitrust laws depends on whether the courts would judge Maryland's regulatory program to meet the requirements of the Supreme Court's state action immunity doctrine. (See p. 11.)

Background

Monopolies and Markets

In a competitive market, the price and supply of goods and services are set by market forces. In theory, such markets will reach equilibrium at a price where suppliers' marginal costs equal their marginal revenues; that is, the cost of producing one more unit of output equals the additional revenue the supplier will receive from selling that unit of output. When a competitive market is in equilibrium, suppliers earn what economists call "normal profits."

Under noncompetitive conditions, a single supplier or small group of suppliers may gain unfair advantage. If suppliers obtain monopolistic power, they can set prices at levels higher than what would prevail under competitive conditions. Under monopolistic conditions, suppliers tend to set output at the point where marginal revenue equals marginal costs, as under competitive market conditions, but are able to set prices at higher levels than would exist in a competitive market. Thus, monopolists can gain excess profits.

A related concern is unfair control over supply and quality of the goods and services available. If a single supplier or a small group of suppliers collude to restrict output, they can limit supply, forcing prices higher than the market would otherwise bear. Alternatively, a single supplier or small group of suppliers could reduce quality while maintaining prices, thereby lowering the value of their goods or services.

Limiting Monopoly Power

There are two general ways that the government attempts to control or mitigate the undesirable effects of monopolies in the private sector. The first is through the application of the public utility regulation approach. In some industries, such as electricity and natural gas, natural monopolies exist. Because of the high capital costs associated with setting up these industries and inefficiencies that would arise from duplication of capital goods necessary for competition, the government grants a monopoly to one firm and regulates the prices that it can charge. The goal of this form of regulation is to assure adequate supplies at reasonable prices while permitting the firm to earn a reasonable return on investment. This approach has been criticized for not necessarily assuring the lowest possible prices for consumers.

The second approach is through the application of antitrust law, whose goal is to ensure a marketplace where suppliers compete fairly. The country's antitrust laws seek to prevent any supplier from obtaining substantial market power, unless that power is obtained through fair competition. The primary federal antitrust laws most pertinent to hospitals are the Sherman Antitrust Act and the Clayton Act.

Federal Antitrust Laws

Section 1 of the Sherman Act[1] prohibits all conspiracies or agreements that restrain trade. As interpreted by the courts, this prohibition applies to unreasonable restraints on trade, which have included agreements or conspiracies to fix prices, divide market territories or groups of customers, boycott other firms, or use coercive tactics with the intent and effect of injuring competition. Section 7 of the Clayton Act[2] prohibits all mergers and acquisitions of stock or assets that may substantially lessen competition or that tend to create a monopoly.

A merger or joint venture between two or more hospitals may be investigated by either the Federal Trade Commission (FTC) or the Department of Justice (DOJ), the agencies with primary responsibility for enforcing the federal antitrust laws. These agencies have established a procedure for deciding which agency will investigate a particular merger or joint venture based on staff expertise, prior dealings with the parties involved, and case load. While either agency may investigate a merger or joint venture for civil violations, once criminal conduct is suspected, the case is referred to DOJ. Private parties and state attorneys general may also sue to block mergers or joint ventures under either the Sherman or the Clayton Act.

State Antitrust Laws

Historically, states took the lead in passing antitrust legislation more than a century ago.[3] By 1890, when Congress passed the Sherman Act, 27 states had either a constitutional or statutory provision banning monopolies and other restraints of trade. Today, all states, with the exception of

[1]July 2, 1890, c.647,1,26 Stat. 209, classified to 15 U.S.C. 1 (Supp. IV 1992).

[2]Oct. 15, 1914, c.323,7,38 Stat. 731, classified to 15 U.S.C. 18 (1988).

[3]This summary of state antitrust laws is condensed from "State Antitrust Law and Its Application to Health Care: An Overview" (a presentation by Michael F. Brockmeyer and Ellen S. Cooper before The National Health Lawyers Association, Washington, D.C., Feb. 15, 1991).

Pennsylvania and Vermont,[4] have an antitrust law generally applicable to activity within the state. Each of these state antitrust laws contains a provision that is analogous to section 1 of the Sherman Act. Twelve states' laws have provisions relating to mergers but only half of those are analogous to section 7 of the Clayton Act.

Most states have adopted exemptions from the antitrust laws for various activities or industries. These exemptions vary among the states, and several states have enacted specific exemptions for health care activities. For example, Maryland's antitrust law exempts hospital mergers, consolidations, or joint ownership and operation of major medical equipment to the extent that the activity is approved by the state Health Resources Planning Commission.

Maryland's All-Payer Rate-Setting System and Certificate of Need Program

The Rate-Setting System

A major concern of antitrust policy is to prevent monopolistic pricing, and, in effect, Maryland has substituted a hospital rate-setting system for antitrust enforcement in this area. Maryland's payment system, enacted in 1971, was developed by the state's Health Services Cost Review Commission—the first all-payer hospital rate-setting agency in the country. After a 3-year phase-in of a uniform reporting system, the Commission began reviewing and approving hospital rates in 1974. At the same time, the Commission began negotiating with the Department of Health and Human Services (HHS) for a demonstration project that would include a waiver of Medicare and Medicaid reimbursement principles in favor of the Commission's rate-setting methodology. This waiver was granted effective July 1, 1977. In 1983, the Congress made the waiver permanent provided that certain conditions are maintained, including (1) Maryland's system remains all payer and (2) the rate of increase in Medicare payments per admission in Maryland remains below the national rate of increase in Medicare payments per admission.

[4]While they do not have a state antitrust law of general applicability, Pennsylvania and Vermont incorporated the provisions of section 1 of the Sherman Act into statutes applying to bid rigging on governmental contracts.

Maryland's all-payer system covers all acute care inpatient, emergency, and outpatient services provided at hospitals. Although hospital services are not exactly analogous to the natural monopoly model, such as public utilities, Maryland's all-payer system follows a quasi-public-utility approach. The Commission sets unit rates for each hospital department and adjusts them annually for inflation, volume changes, and productivity gains. Hospitals are required to charge those rates, and all payers pay on the basis of those rates. The system is a "macromanagement" approach, which places overall constraints on a hospital's revenue but allows the institution flexibility to operate within the overall limit approved by the Commission. Proponents of Maryland's system claim it benefits hospitals because it provides financial predictability and allows hospital managers to concentrate on controlling costs.

Maryland's hospital rate-setting system includes four processes: full rate review, inflation adjustments, guaranteed inpatient revenue, and screening. The full rate review, required of all hospitals when the all-payer system was implemented and of all new hospitals, involves submitting detailed cost information on a prescribed form for all departmental cost centers. Under full rate review (1) bad debts and uncompensated care expenses are included in the base rate; (2) cross-subsidization among hospital services is prohibited; (3) most non-patient revenue (such as income from parking lots and vending machines) is used to reduce patient care rates; (4) a uniform markup for working capital is included in rates; (5) discounts are provided for prompt payment; and (6) discounts are allowed for Medicare, Medicaid, and other third-party payers who adhere to practices designed to mitigate hospital uncompensated care (for example, by providing open enrollment periods for people to sign up for health insurance). During the rate review process, each hospital's departmental costs are compared with costs of similar hospitals. Hospitals are grouped into one of six comparison groups based on such items as size of institution, case mix, and geographic location (inner city/suburban/rural).

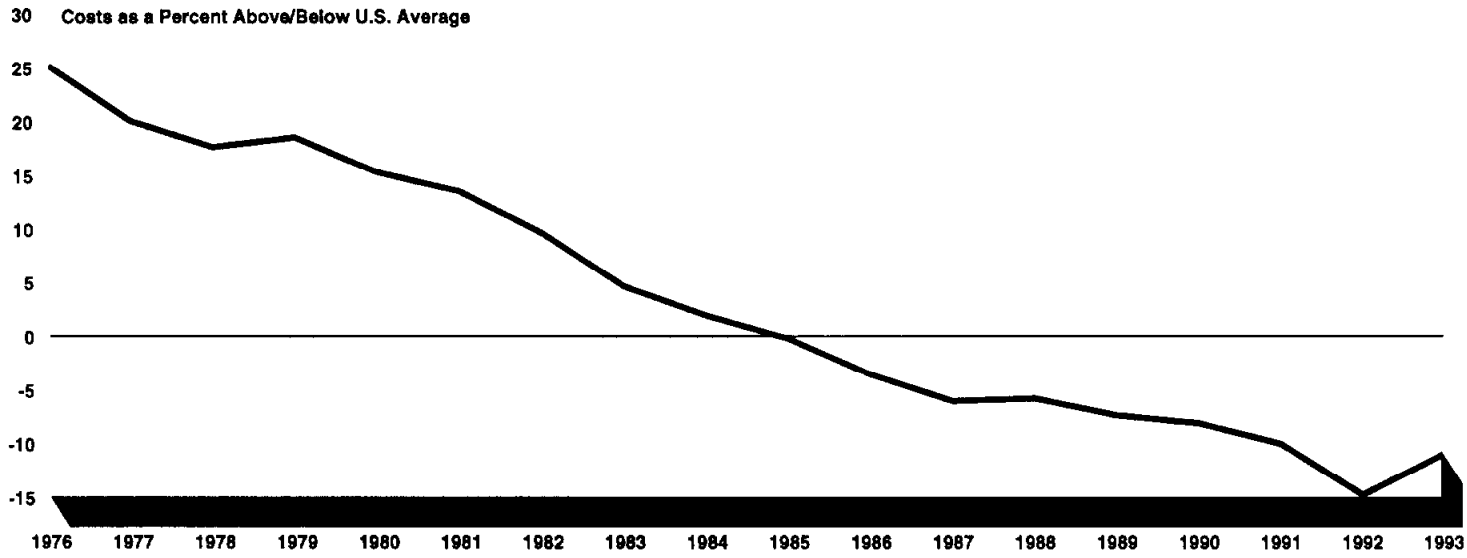
Inflation adjustments are used to modify hospital rates each year for inflation and other factors, such as volume changes. Thus, rates can be adjusted annually without the need for a full rate review. Because this adjustment is based on general rates of inflation, not the actual cost experience of individual hospitals, hospitals have a strong incentive to hold their own cost increases at or below the rate increase granted by the Commission, the Commission's Executive Director told us. Furthermore, because the system covers all payers, hospitals cannot shift costs among

payers. The guaranteed inpatient revenue component establishes a target revenue per admission, similar to Medicare's prospective payment system. This target gives hospitals an incentive to control how services are used, because the hospital can keep the dollar difference if it can serve a patient for lower costs than the approved target amount. The screening component, introduced in 1982, ranks hospitals relative to their peers based on inpatient revenue per admission after a series of adjustments for such factors as case mix, direct and indirect education, labor market differences, and disproportionate share of low-income patients. The Commission's Executive Director told us the Commission attempts to adjust for those factors it believes reflect legitimate differences among hospitals that may not be explicitly accounted for in the marketplace. Hospitals exceeding the benchmark set by the Commission are denied inflation increases and are expected either to request a full rate review or negotiate a spend-down agreement to bring their costs in line with their peers within 2 to 5 years.

The primary goal of Maryland's system is cost control, and the state has been relatively effective in this endeavor. The Commission reported that in 1976 the average cost per admission to a Maryland hospital was more than 25 percent above the national average. In 1993, the average cost was about 11 percent below the national average.[5] (See fig. 1.)

[5]A recent review of literature on hospital rate-setting mechanisms found that Maryland's all-payer hospital rate-setting program was effective in controlling costs per discharge in that state. At the same time, the author found that rate-setting systems have expanded access to services for uninsured persons and have small, if any, effect on quality of care. See Gerard F. Anderson, "All-payer ratesetting: Down but not out," Health Care Financing Review, 1991 Annual Supplement, HCFA Pub. No. 03322, Office of Research and Demonstrations, Health Care Financing Administration (Washington, D.C.: U.S. Government Printing Office, Mar. 1992), pp. 35-41.

Figure 1: Costs Per Hospital Admission in Maryland Versus U.S. Average, 1976-93



Source: Maryland Health Services Cost Review Commission.

These constraints on hospital costs have allowed the state to maintain its waiver from the Medicare hospital prospective payment system. Under this waiver, hospitals in the state are paid Commission-approved rates for Medicare and Medicaid patients.

Maryland's reimbursement system is unique in its treatment of uncompensated care (charity care and bad debts). Medicare, Medicaid, and Blue Cross typically do not pay for such costs, so the cost of uncompensated care is often shifted to private payers or other insurance; however, in Maryland, the burden of uncompensated care is shared by all payers. According to representatives of the Maryland Hospital Association, uncompensated care in 1992 totaled about $400 million in Maryland, about 9 percent of the total costs of Maryland's 51 hospitals. Hospital charges include a markup over patient care costs to cover overhead, uncompensated care, discounts for qualifying payers, and other factors. In 1992, the average markup between hospitals' costs and gross charges nationally was 41 percent; in Maryland, it was 13 percent. According to a

hospital association representative, the markup in Maryland was lower than in any other state because Maryland's hospital rate-setting system does not allow cost shifting.

The Certificate of Need Program

A second major concern of antitrust policy is to assure adequate supplies of goods and services, and Maryland uses its CON program to address this issue. State CON programs are also borrowed from the public utility regulation approach. The main goal of the CON program is to contain costs by preventing the oversupply of expensive technology and health care services. CON laws typically require providers to receive state approval for major capital expenditures, including the purchase of high-technology equipment and addition of services.

Beginning in 1975, the federal government encouraged the development of state CON programs by making the receipt of federal Public Health Service funds conditional on states passing CON laws. Although the District of Columbia and all states except Louisiana eventually adopted a CON program, the effort was short-lived. Start-up problems delayed the law's implementation until 1977. Early state CON laws were designed to create a state network of health planning and development agencies to regulate proposed health services and facilities. With the Reagan administration's emphasis on deregulation, federal funding declined and the Congress repealed the law effective in 1987. Despite the elimination of federal funding, 38 states and the District of Columbia continue to operate CON programs,[6] which are aimed primarily at cost containment. State laws vary considerably, but most state CON programs cover acute care hospitals and nursing homes. Some states also cover psychiatric and rehabilitation hospitals, and some cover ambulatory care facilities and mobile high-technology units (such as lithotripters and magnetic resonance imaging machines).[7]

The goals of Maryland's CON program are to make sure that sufficient health care capacity exists in the state and to restrict development of health facilities and services to what is needed. Maryland requires a CON

[6]Between 1983 and 1988, Arizona, California, Colorado, Idaho, Kansas, Minnesota, New Mexico, South Dakota, Texas, Utah, and Wyoming repealed their CON legislation. Louisiana never established a CON review program, but the state operates a capital expenditure review program for long-term care services eligible for federal reimbursement. See "Certificate of Need: An Overview of 1992 State Legislative Activity," The George Washington University, Intergovernmental Health Policy Project (Washington, D.C.: 1993).

[7]"States Rediscover Certificate-Of-Need Laws," Medicine and Health Perspectives (New York: Faulkner and Gray, Feb. 23, 1993).

before (1) a new health care facility[8] is built, developed, established, or moved to another site; (2) bed capacity is changed; (3) a type of health care service is added or the scope of one is changed; (4) an additional home health agency or home health care service is established by an existing agency or facility; or (5) capital-related expenditures exceeding the threshold, currently $1.25 million, are incurred. An exception allows a hospital to spend any amount it wants for a capital project if the hospital pledges to finance the project substantially out of its existing rate structure. To qualify for this exception, a hospital must pledge not to seek rate increases of more than $1.5 million to finance the project. According to the Commission, 39 hospitals have requested this exception since July 1, 1988 (the effective date); during the same time, six hospitals have applied for and received CON approval for capital projects. Also, a CON is not required for capital expenditures directly related to acquisition and installation of major medical equipment.[9]

The Maryland CON program is administered by the state Health Resources Planning Commission. The Director of the Maryland CON program told us the Planning Commission tries to strike a balance between need and availability of health care services. Hospitals desiring to merge are required to notify the Planning Commission. The Planning Commission may approve a health care facility merger and exempt it from full CON review if the Planning Commission finds that the merger is in the public interest, will result in more efficient and effective hospital service delivery, and is not inconsistent with the state health plan or any institution-specific plan.

Quality Assurance

The final area of concern for antitrust policy is quality of services. Neither the federal government nor the states rely on antitrust law as their major defense against the potential adverse consequences of monopolistic practices on quality of hospital care. Rather, the federal government requires hospitals that participate in the Medicare and Medicaid programs, which include virtually all hospitals, to undergo a periodic survey and certification process. Federal law also requires the Medicare and Medicaid programs, as well as hospitals themselves, to operate quality assessment programs to help ensure that hospitals provide quality services to patients. Finally, every state licenses or approves hospitals to operate and requires

[8]Under Maryland's program, a health care facility is a hospital, ambulatory surgery center, inpatient rehabilitation facility, home health agency, hospice, or related institution, such as an intermediate care facility, nursing home, or substance abuse facility.

[9]The acquisition and installation of major medical equipment is subject to approval by the Office of Licensing and Certification within the Maryland Department of Health and Mental Hygiene.

periodic inspections. Quality of care problems can arise under any hospital payment system, and quality assurance measures are necessary in any case.

Effect of Antitrust Laws on Maryland's All-Payer and Certificate of Need Systems

Because of significant state regulation of and statutory exemptions pertaining to certain hospital activities in Maryland, the likelihood of federal and state antitrust enforcement has been minimized. To the extent that hospital rates are set and monitored by the state Health Services Cost Review Commission, concerns about hospital price fixing are not relevant. Similarly, to the extent that new or existing hospitals receive approval from the state Health Resources Planning Commission to participate in any of the activities requiring a CON under Maryland law, these activities are unlikely to generate significant state antitrust concern. In addition, those Planning Commission-approved activities involving the merger or consolidation of hospitals or the joint ownership and operation of major medical equipment by hospitals are specifically exempted from the application of Maryland's antitrust law.

Depending on the degree of state supervision and control of their activities, hospitals may also be exempt from the application of federal antitrust laws, based on the Supreme Court's state action immunity doctrine. Under this doctrine, the Supreme Court has held that private anticompetitive conduct is immune from federal antitrust liability provided that the state (1) clearly articulates and affirmatively expresses a policy to displace competition with regulation and (2) actively supervises and controls the private anticompetitive conduct. To date, DOJ and FTC have not brought any antitrust actions in Maryland on the basis of hospital pricing, mergers, or joint ventures.

Activities that do not meet the federal standard for state action immunity are not exempt from federal antitrust enforcement. Also, the statutory exemptions in Maryland are limited to certain Planning Commission-approved activities; other hospital activities continue to be subject to state antitrust scrutiny.

Summary

Antitrust laws exist to protect the public from the adverse effects of monopoly power, and enforcement of the nation's antitrust laws will be an important consideration as the Congress considers health care reform. Because Maryland regulates hospital prices similar to the way in which public utilities are regulated, state antitrust concerns about hospital

pricing are not an issue, and Planning Commission-approved mergers and joint actions by hospitals are exempt from the state's antitrust law. Also, to the extent that the state actively regulates hospitals, federal antitrust enforcement concerning such regulated activities may not be relevant under the Supreme Court's state action immunity doctrine. Other concerns about anticompetitive conduct and its possible adverse effect on the public (for example, actions that could restrict access to or lower the quality of services) may still be relevant and covered by federal or state antitrust laws.

Scope and Methodology

We discussed the applicability of antitrust laws in the state's health care industry with representatives of Maryland's rate-setting commission, planning commission, and the state Attorney General's office. We also met with representatives of the Department of Justice, Federal Trade Commission, American Hospital Association, Joint Commission on the Accreditation of Hospitals, and Federation of American Health Systems. We analyzed information obtained through a literature search concerning hospital mergers. We did not attempt to assess the effectiveness of Maryland's rate-setting, CON, or licensure and inspection programs.

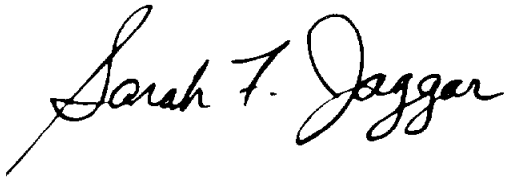
We conducted our work between November 1992 and December 1993 in accordance with generally accepted government auditing standards.

Representatives of both the Maryland Health Services Cost Review Commission and Health Resources Planning Commission reviewed an earlier draft of this report, and their comments are reflected in this report where appropriate.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 7 days after its issue date. At that time, we will send copies to the Director, Office of Management and Budget; the Secretary of HHS; the Attorney General; the Chairman, Federal Trade Commission; the Maryland Health Services Cost Review Commission; and the Maryland Health Resources Planning Commission. Copies will also be made available to other interested parties on request.

If you have any questions, please call me at (202) 512-7119. The major contributors to this report are listed in the appendix.

Sincerely yours,



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