UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

BUREAU OF COMPETITION

February 9, 1987

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Health Systems Agency of New York City
275 Seventh Avenue
New York, New York 10001

Attention: Mr. Giri Vuppala
Assistant Director, Planning and Implementation

Dear Mr. Vuppala:

The Federal Trade Commission's Bureaus of Competition, Consumer Protection, and Economics are pleased to submit this response to the request of the Health Systems Agency of New York City ("HSA") for public comment on its draft Medical Facilities Plan ("Draft MFP"). 1/ Our comments address recommendations in the Draft MFP that some acute care hospitals in New York City be closed or converted to non-acute care uses, and that some acute care beds at many other hospitals in New York City be delicensed, in order to eliminate substantial amounts of bed capacity not "needed" under health planning standards. Those recommendations, if adopted, would be implemented by 1990 through the state certificate of need ("CON") regulatory process. In our view, their implementation would be contrary to the interests of health care consumers in New York City.

Our response is divided into two principal parts. First, we express concern about the competitive implications of regulatory reductions of medical/surgical hospital bed capacity of the magnitude proposed in the Draft MFP. Such reductions would substantially reduce the incentives for hospitals in New York City to improve the price and quality of their services. 2/ Second, we urge the HSA to recognize that recent changes in the health care financing system have reduced incentives for hospitals to maintain excessive bed capacity. Careful consideration should therefore be given to relying on the

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1/ These comments represent the views of the Bureaus of Competition, Consumer Protection, and Economics of the Federal Trade Commission, and do not necessarily represent the views of the Commission or of any individual Commissioner. However, the Commission has authorized their submission.

2/ While our comments focus on recommendations relating to medical/surgical beds (the licensure classification of most acute care hospital beds in New York City, and of most of the beds the Draft MFP recommends be eliminated), some points we raise may also apply to recommendations in the Draft MFP for reductions in maternity and pediatric bed capacity.

hospitals themselves, rather than government regulation, to determine appropriate capacity levels. 3/

Interest and Experience of the Federal Trade Commission

For more than a decade, the Federal Trade Commission has engaged in extensive efforts to preserve and promote competition in health care markets. We have been active both in antitrust law enforcement and in advocacy of regulatory reforms, in the belief that competition in health care service markets, like other markets, will benefit consumers by strengthening incentives for providers to meet consumer needs. The Commission's efforts in the health care field have placed particular emphasis on the hospital industry. As a result of Commission antitrust enforcement efforts in that industry (including litigated cases and non-public investigations involving hospital markets in many different areas of the United States), as well as economic analyses of CON regulation 4/, the Commission's staff has gained considerable experience with the economics of hospital competition, and with how health planning regulation affects such competition. We believe we can offer a valuable perspective on the proposals before the HSA by drawing upon that experience.

The Desirability of Retaining Some "Unneeded" Medical/Surgical Bed Capacity

Implementation of the Draft MFP's hospital bed reduction recommendations, which are based on a target occupancy rate of 90%, would eliminate so many medical/surgical hospital beds in New York City that the remaining beds would be operating, for all practical purposes, at or near capacity. As a result, we believe local hospitals will have substantially diminished incentives to attract additional patients by improving the price and quality of their services. These considerations counsel against forcing

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3/ Because the points we raise apply generally to New York state policy regarding reductions of hospital bed capacity, we are sending a copy of these comments to Brian Hendricks, Office of Health Systems Management, New York State Department of Health, for consideration respecting state-level policy.

4/ See, e.g., Hospital Corp. of America, 106 F.T.C. 361 (1985), aff'd, 1986-2 Trade Cas. (CCH) ¶ 67,377 (7th Cir. 1986); American Medical Int'l, Inc., 104 F.T.C. 1 (1984); K. Anderson & D. Kass, Certificate of Need Regulation of Entry Into Home Health Care (Jan. 1986) (FTC staff report).

hospitals in New York City to eliminate medical/surgical bed capacity deemed "unneeded" by the HSA that the market would otherwise support.

The vigor of hospitals' efforts to lower the price, and improve the quality, of inpatient care depends heavily on the motivation and ability of hospitals to increase their market shares at the expense of other hospitals by offering attractive combinations of price 5/ and quality. Hospitals that perform well will be rewarded by increased inpatient business, and hospitals that fall short of the norm will anticipate that other hospitals will compete away many of their patients.

The Draft MFP recommends a reduction by 1990 of more than 16% in the supply of medical/surgical beds in New York City hospitals. The amount of medical/surgical bed capacity that would remain after those reductions would be that which the HSA estimates to be "needed" to accommodate the demand for inpatient care it projects for 1990 -- a level of demand which the HSA expects to be substantially less than existing levels of inpatient hospital utilization -- at an average occupancy rate of 90%. 6/

It is likely that, for all practical purposes, hospital medical/surgical facilities operating at such high occupancy rates would be full, or close to full, and not especially eager to seek additional patients. For a variety of reasons (including,

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5/ While state hospital rate regulation places upper limits on what hospitals can charge, hospitals remain free to compete against others by setting rates below what the state would allow, and by reducing charges to the third party payors entitled under rate regulation to negotiate discounts from standard charges.

6/ See Draft MFP at A52-A53; Health Systems Agency of New York City, Acute Care Bed Needs Methodology (709.2) Update (March 19, 1986) at 1-17 ("Bed Needs Methodology Update") (earlier estimate of beds "needed" to meet 1990 demand, with discussion of various factors HSA expects to reduce demand from present levels).

We note that capacity deemed "unneeded" by health planning standards is not necessarily "excess capacity" in the economic sense. As we discuss below, "unneeded" capacity may sometimes serve an economically useful purpose.

among others, the need to hold capacity in reserve to accommodate fluctuations in demand for inpatient care), acute care hospitals cannot comfortably operate at average occupancy rates of 100%. 7/ Well before a hospital's average occupancy rate reaches that level, its efforts to compete aggressively for new patients to fill empty beds will yield less and less net income. The hospital will more frequently have to turn away patients 8/, making the hospital's efforts to attract patients fruitless, and inconveniencing the patients' physicians by forcing them to use other hospitals. 9/ Information we have received in connection with our cases and non-public investigations in the hospital industry (including interviews with hospital officials and hospital planning documents) suggests that hospitals in New York City generally would become markedly less aggressive in their efforts to attract new patients by lowering price and improving quality once their average occupancy rates climb to around 90%, the HSA's target occupancy rate for medical/surgical beds.

The competitive efforts of hospitals in New York City, such as intensified marketing campaigns and efforts to negotiate

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7/ See Joskow, The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital, 11 Bell J. Econ. 421 (1980); P. Joskow, Controlling Hospital Costs 49-55 (1981).

8/ In other industries, the absence of unused capacity does not necessarily diminish competitive incentives, because capacity can be expanded to meet demand. CON regulation in New York, however, appears to preclude that option here. Also, capacity conservation techniques such as reducing usage of inpatient treatment in favor of outpatient care, and reducing average lengths of stay, have already been incorporated into the HSA's 1990 bed need estimates and thus are not available to further reduce utilization to solve the capacity constraints on increased patient loads.

9/ A hospital that must frequently turn away patients may have difficulty attracting physicians who would like to concentrate their admissions at one hospital.

We understand there may be other problems with operating at high occupancy rates that also make it unattractive to operate near 100% occupancy on a regular basis. For example, placing male and female patients, and smokers and non-smokers, in different semi-private rooms may sometimes be difficult when few rooms have unused beds and the male/female or smoker/non-smoker ratio differs from the norm.

affiliations with health maintenance organizations ("HMOs"), started becoming more and more conspicuous as average hospital occupancy rates fell from their historical levels of around 90% to their present levels of about 82%. 10/ With many hospitals' medical/surgical beds now running at below 90% occupancy, and some running at much lower occupancy rates, a hospital whose performance falls behind its peers runs the substantial risk of losing patients. In other hospital markets (including some that were the subjects of our investigations), these incentives appear to have had a significantly positive effect on the responsiveness of hospitals to consumer needs. 11/ It is unfortunate that just as lively competition seems to be establishing a foothold in the New York City hospital market, the HSA's staff is recommending elimination of the unused hospital bed capacity that appears to be an important contributing factor.

We are particularly troubled that the Draft MFP's hospital bed reduction proposals could hamper the growth of HMOs. The rate of development and growth of HMOs is likely to be affected by how well HMOs can exploit competition in hospital markets to reduce their costs relative to the costs incurred by other third party payors. For example, HMOs can use their purchasing power and their ability to channel patients to the most cost-effective providers to economize on hospital costs by, among other means, seeking discounts and other preferential terms from hospitals (such as hospital assistance to HMO utilization review programs). 12/

10/ See New York Times, Oct. 6, 1986, at B4; Draft MFP at A13. Notably, New York City's average hospital occupancy rate remains substantially higher than the national average. See American Hospital Ass'n, Hospital Statistics (1986 ed.) at vii.

11/ For example, in some metropolitan hospital markets with which we are familiar, levels of unused hospital capacity somewhat higher than those prevailing in New York City have helped some third-party payors negotiate preferential reimbursement arrangements yielding the equivalent of discounts from standard charges in excess of 40%.

12/ See, e.g., P. Fox, Lewin & Associates, Private Health Care Initiatives: A Case Study of the Denver Area (June 1983). Notably, HMOs (unlike other private third-party payors, except for Blue Cross) are permitted under New York's hospital rate regulation system to negotiate preferential reimbursement rates for hospital services provided to their subscribers. See N.Y. Pub. Health Law § 2807-a(3) (McKinney Supp. 1986).

Such economies can, in turn, help HMOs expand their memberships by enabling them to reduce subscriber premiums. 13/

We believe the impact of the proposed bed reductions on HMOs merits special concern, because HMOs often play a significant role in promoting well-functioning health care markets, in addition to benefitting their subscribers through more economical use of health resources. 14/ Moreover, the HSA itself is relying on the prospect of substantial increases in HMO membership in the non-Medicare population during the next few years to reduce hospital utilization, and thus the "need" for hospital beds. 15/ To the extent that implementation of the Draft MFP's bed reduction proposals would diminish the economies HMOs can achieve by taking advantage of hospital competition, HMO membership may not grow -- and hospital utilization may not decline -- as quickly as the HSA's staff expects. Paradoxically, then, efforts to reduce the number of empty, "unneeded" hospital beds may increase the number of utilized, "needed" beds.

All of these reasons counsel against mandatory bed capacity reductions to meet a 90% occupancy target. Such regulatory reductions would remove desirable incentives that encourage hospitals to serve consumers better.

The Diminishing Justification for Regulatory Reductions of "Unneeded" Hospital Bed Capacity

The extent to which there are offsetting public benefits from reducing the amount of unused bed capacity in the New York City hospital market has been the subject of vigorous debate. For example, the HSA's staff has estimated capital cost savings of about $ 500,000 per "unneeded" bed that does not have to be replaced, and operating cost savings of up to $ 150,000 per year per "unneeded" bed taken out of operation. Hospital industry

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13/ Cf. American Medical Int'l, Inc., 104 F.T.C. at 45-46, 49 (1984) (initial decision) (in California during early 1980s, HMOs and self-insured health benefit plans that were able to negotiate preferential hospital rates on competitive basis grew rapidly enough, at the expense of other third-party payors, to prompt the other payors to support legislation enabling them to also negotiate hospital discounts).

14/ See Hospital Corp. of America, 106 F.T.C. at 480.

15/ Bed Needs Methodology Update at 11, 15 (projecting increase in HMO membership to 30% of adult non-Medicare population by 1990).

participants have disputed these claimed cost savings, particularly respecting operating costs. 16/

We are not in a position to contribute substantially to resolving disputes of this type. However, we question whether it is worthwhile for the HSA to second-guess hospitals' determinations as to the costs and benefits of maintaining hospital bed capacity. Market forces are generally far superior to the decisions of government planners for allocating society's resources, and should be allowed to operate absent demonstrable market failures that prevent competitive forces from operating well. Thus, the HSA should consider the effects of ongoing improvements in the health care financing system, including prospective payment mechanisms and prospects for greater price competition. These improvements are eliminating the features of the hospital market (e.g., reimbursement system incentives for hospitals to maintain more bed capacity than economically justified) that may have indicated a need for CON regulation of hospital bed supply in the past. To the extent these features have been eliminated, maintaining whatever "unneeded" bed capacity the market would support may be presumed to create more benefits (including those outlined above) than costs. We believe that the HSA and state health planners should accord more deference than they have in the past to hospitals' determinations as to the "public need" for whatever unused capacity they may choose to maintain.

At one time it was generally believed that the prevailing methods of reimbursement for hospital care (under which the revenues a hospital received for treating patients were based on costs incurred by the hospital) resulted in incentives favoring (or at least in a lack of incentives opposing) overinvestment in capital assets at the expense of third party payors. Under those circumstances, CON regulation of bed capacity was considered necessary to counter hospitals' tendency to build and maintain more capacity than was necessary to serve their patients.

The Draft MFP summarizes the trend toward reforms in health care reimbursement that are eliminating those incentives for inefficient health resources usage. 17/ Most prominent of the new reimbursement systems aimed at eliminating incentives to waste is the Medicare DRG (diagnosis related group) prospective reimbursement system, which pays operating expenses for hospital

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16/ See "14% cut in N.Y. hospital beds urged," Modern Healthcare, Jan. 2, 1987, at 11.

17/ Draft MFP at A7-A9.

care of Medicare patients 18/ at predetermined flat rates not linked to the specific costs a particular hospital incurs. Hospital capital expenditures will likely be reimbursed on a similar basis in the near future. 19/ The Draft MFP suggests that New York's prospective reimbursement hospital rate regulation system, which governs charges for all other payors except HMOs, is also evolving in the same direction. 20/ The salient characteristic of these reimbursement systems is that they reduce or eliminate incentives to maintain inefficiently high levels of unused bed capacity by reducing or eliminating providers' ability to shift elsewhere the costs of inefficiencies.

This effect may well be reinforced by increased price competition among hospitals in New York City. Such price competition may be stimulated by HMOs (which, as discussed earlier, are expected by the HSA to cover an increasingly large percentage of the local population, and which are well-positioned to channel subscribers to hospitals offering lower rates), preferred provider organizations (which are similarly able to direct patients toward cost-effective hospitals), and improvements in conventional health benefit plans to provide subscribers financial incentives (such as copayments) to channel themselves toward economical, and away from profligate, providers. 21/

It should be emphasized that prospective reforms (e.g., elimination of cost-based reimbursement of capital costs under state hospital rate regulation) reinforce the improved incentives arising from reforms that have been or are being implemented. The strong likelihood that any incentives toward inefficiency that now remain will be eliminated should deter providers from making long-lived capital investments whose financial feasibility

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18/ Medicare patients account for about half the medical/surgical patient days in New York City hospitals. See Bed Need Methodology Update at 6.

19/ Draft MFP at A6, A8; see also, e.g., "Lawmakers mull capital payment plans," Modern Healthcare, August 1, 1986, at 20; "HHS' capital plan arouses provider anxieties," Hospitals, June 20, 1986, at 24 (legislative debate on Medicare prospective reimbursement of hospital costs focusing on how, not whether, that should be implemented).

20/ Draft MFP at A6-A8.

21/ Supra p. 5; Draft MFP at A8-A9, A14, A17; see also, e.g., "Hospital industry price wars heat up," Hospitals, Oct. 1, 1985, at 69; Hospital Corp. of America, 106 F.T.C. at 480-82.

depends on shifting costs to third party payors. 22/ And it seems unlikely that providers still harboring such illusions will find support in the bond market for implementation of their plans. 23/

If the "market failure" underlying the need for CON regulation of hospital bed capacity has been or is being remedied, there is less reason to presume that hospitals' decisions respecting unused capacity will be economically incorrect. A hospital unable to shift capital or operating cost inefficiencies onto third parties will presumably not maintain unused, or rarely-used, bed capacity unless it will enable the hospital to earn future patient revenues sufficient to cover the costs of maintaining the capacity. And if the hospital's judgment proves to be faulty, the hospital -- not the government, and not third party payors -- will bear the burden of its error. 24/ Indeed, the Draft MFP indicates that some of the "unneeded" bed capacity it has targeted for elimination is unlikely to survive in the present reimbursement environment, with or without regulatory action, for these reasons.

While we believe the maintenance of at least some "unneeded" bed capacity that the market would support would serve consumer interests, we do not suggest conserving "unneeded" hospital facilities that would require public subsidies to survive, or that the hospitals believe would be more profitably used for purposes other than providing acute care hospitalization. It seems entirely appropriate for the HSA to facilitate the voluntary exit of hospitals and hospital beds from the acute care sector of the health care industry (such as by advising hospitals on possible alternative uses for their

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22/ Cf. Raske, "Assn. seeks sound capital pay policy," Modern Healthcare, Nov. 7, 1986 at 120 (uncertainty about future of reimbursement for capital expenses encouraging hospitals to make more conservative capital investment decisions for inpatient services).

23/ See Draft MFP at A6 (prediction that mortgage financing will be difficult or impossible to obtain for many hospital modernization projects as result of prospect of severe limits on future reimbursement of hospital capital costs).

24/ This may not be true, however, if the hospital is depending on subsidies from outside the reimbursement system (such as loan guarantees or operating subsidies from the state fund for financially-distressed facilities) to maintain arguably "unneeded" capacity the market would not otherwise support.

facilities, and facilitating state approval of such alternative uses).

In summary, the HSA and state health planners should consider whether, in view of recent changes in the reimbursement environment, hospitals still have substantial incentives to make economically incorrect decisions to maintain unused bed capacity, and whether such decisions made by hospitals are any less likely to be correct than the inevitably imperfect decisions made by government regulators. To the extent that such incentives are no longer substantial, the public interest would best be served by exercising the discretion available under New York health planning statutes and regulations to find "public need" for whatever level of bed capacity hospitals choose to maintain.

Conclusion

For the foregoing reasons, we urge that 1) the HSA's recommendations to the Department of Health regarding hospital closures and bed reductions take into account the potential beneficial effects of unused medical/surgical bed capacity; and 2) the HSA consider whether, in light of the trend toward elimination of reimbursement system incentives to maintain economically unjustified hospital bed capacity, hospitals themselves can be relied upon to determine appropriate capacity levels.

We appreciate this opportunity to comment on the HSA's proposals. We would be happy to answer any questions you may have regarding these comments, or provide any other assistance you may need.

Sincerely,

Jeffrey I. Zuckerman
Director
Bureau of Competition