

**Statement of the American Hospital Association
before the
Subcommittee on Intellectual Property, Competition and the Internet
of the
Committee on the Judiciary
of the
U.S. House of Representatives**

“Health Care Consolidation and Competition after PPACA”

May 18, 2012

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record as the Subcommittee on Intellectual Property, Competition and the Internet of the Committee on the Judiciary examines health care consolidation and competition after enactment of the *Patient Protection and Affordable Care Act* (PPACA).

The health care landscape is changing. The reasons for such change are varied; but chief among them are expectations by employers, insurers and government at all levels for higher quality, more efficient health care – in other words, greater value. Meeting those expectations requires building a continuum of care to replace the current fragmented system of health care.

Some pundits decry the changing landscape and hospitals’ need to seek partners to ensure their stability and access to essential capital, as well as to buttress their expertise in quality improvement and efficiency enhancement. These critics, it seems, would have it both ways. On the one hand, they blame the current health care system for high costs and inefficient and uncoordinated care, among other ills. On the other hand, they express alarm over the prospect of *hospitals* trying to replace the current silos with a better-coordinated continuum of care that delivers higher quality care at a lower cost.

These criticisms are often at odds with the assessments of professional observers, such as Moody’s and Standard & Poor’s, for example, and are too often based on flawed data and out-of-date biases. Moreover, they rarely pause to examine the impact that a concentrated health insurance market currently has on health care prices and quality, or to note that the health insurance industry is engaged in a round of acquisitions of its own (*e.g.*, doctors and hospitals).



CHANGING LANDSCAPE BENEFITS PATIENTS

Building that continuum of care is the future. The forces that make it imperative include the need for hospitals to respond to powerful financial incentives for meeting performance objectives and avoiding penalties for failing to do so.

According to a recent Moody's report, "[t]he ability to demonstrate lower costs while providing higher quality will be the key driver in government and commercial reimbursement going forward."ⁱ One estimate is that 6 percent of hospital revenue could be at risk from penalties from government and commercial payers for lack of coordination.

The need for capital to build the continuum is also driving hospitals together. Hospitals are faced with unprecedented demands for capital to invest in new technology such as electronic health records – as much as \$50 million for a mid-size hospital – implement new modes of delivering care such as telemedicine, and build new and improved facilities. Moody's states that "[a]ccess to capital markets has become more difficult for lower-rated hospitals, driving the need for many to seek a partner."

Mergers and acquisitions are often the preferred way to build the continuum because of numerous regulatory barriers. Antitrust laws, outdated fraud and abuse policies and even tax-exempt rulings favor consolidation over clinical integration. It is notable that all of the federal agencies that administer these laws needed to provide guidance or waivers to make the Medicare Accountable Care Organization (ACO) program feasible. However, their coordination ends outside of that narrow program.

Mergers and acquisitions are vigorously policed by two federal and numerous state antitrust authorities. Deals and integrative arrangements that these authorities deemed to be anticompetitive have been challenged. In fact, there has been much more attention paid to the hospital field than to the health insurance industry. The result is that the health insurance industry is highly concentrated and is now acquiring hospitals and providers in an effort to replicate the care continuum hospitals are building.

Despite this activity, hospitals' price growth is at an historic low and is not the main driver of higher health insurance premiums. The growth in health insurance premiums from 2010 to 2011 was more than double that of underlying health costs, including the cost of hospital services. An important feature of hospital costs is that two-thirds of those costs are attributable to caring for patients, specifically the wages and benefits paid to caregivers and other essential staff. This is unlike any other part of the health care sector.

THE HOSPITAL FIELD IS MOVING TOWARD BUILDING THE CONTINUUM

The hospital field has long recognized the need to build a more coordinated continuum of care and the benefits that could have for patients. More than a decade ago in its 2000 report, *To Err is Human: Building a Safer Health System*, the Institute of Medicine (IOM) called for improvements in the way care is delivered and stressed the importance of creating systems that support caregivers and minimize risk of errors. In its subsequent 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the IOM challenged the adequacy

and appropriateness of the current health care system to address all components of quality and meet the needs of all Americans. According to the report, a 21st century system should provide care that is “evidence-based, patient-centered, and systems-oriented.”

As an outgrowth of those reports, a number of commentators, including the IOM, advocated linking provider payment to provider performance on quality measures because such an approach is “one of several mutually reinforcing strategies that collectively could move the health care system toward providing better-quality care and improved outcomes.” Numerous pay-for-performance and incentive programs were launched in the private sector and were incorporated into Medicare payment systems for both hospitals and physicians. Those programs were predicated on collaboration through aligning hospital and physician incentives, encouraging them to work toward the same goals of improving quality and patient safety, and providing effective and appropriate care to create better health outcomes.

A 2005 AHA Task Force on Delivery System Fragmentation found that better alignment among providers was the key to improving patient care and enhancing productivity, and that removing impediments to such alignment created by various federal laws and policies was essential. It called upon a variety of federal agencies, including the Federal Trade Commission (FTC) and Department of Justice (DOJ), to:

Establish a simpler, consistent set of rules for how hospitals and physicians construct their working relationships. The complexity, inconsistency and sometimes conflicting interpretations of federal laws and regulations affecting hospital-physician arrangements are a significant barrier. Few arrangements can be structured without very significant legal expense.

Despite those calls, many of these regulatory barriers remain. As noted, these barriers favor mergers and acquisitions over integration and should be addressed without delay.

Building a new continuum of care will require scrutiny of health plans. The American Medical Association annually reports that an abundance of health insurance markets are concentrated,ⁱⁱ with negative impact on providers. In May 2009, the AHA called upon DOJ to re-examine and bolster its enforcement policy as it applies to health plans in *The Case for Reinvigorating Antitrust Enforcement for Health Plan Mergers and Anticompetitive Conduct to Protect Consumers and Providers and Support Meaningful Reform*.ⁱⁱⁱ

Among the AHA’s requests were that the Antitrust Division:

- Undertake a comprehensive study of consummated health plan mergers; and
- Revisit and revise its analytical framework for reviewing health plan mergers and conduct complaints. The areas of scrutiny should include whether:
 - Proposed mergers by plans with pre-existing market power should be viewed as presumptively unlawful;
 - The ability of merged or dominant health plans to price discriminate against certain hospitals poses particular concerns about likely competitive harm;

- Merged or dominant health plans can wreak competitive harm in ways other than reducing prices below competitive levels, such as adversely affecting the development or adoption of quality protocols or technology tailored to meet the needs of hospitals and the patients they serve; and
- Mergers of health plans with service areas that technically do not overlap because of license or other agreements still pose a risk of competitive harm and, therefore, should be challenged.

While we are pleased that DOJ has increased its enforcement activities against health plans, continued vigilance, commensurate to that applied to hospitals, is essential to ensure continued progress toward building a new health care continuum.

CONCLUSION

Patients receive significant benefits when caregivers work together to provide more coordinated, more efficient and higher-quality care. That is the path we are on and the one that holds the greatest promise for not only improving health but fixing the fragmented health care delivery system.

We look forward to working with this subcommittee to forge ahead toward a shared goal: improving the quality of American health care.

Attachments:

Statement of the American Hospital Association before the Subcommittee on Health of the Committee on Ways and Means of the U.S. House of Representatives, Hearing on Health Care Industry Consolidation, September 9, 2011.

Hospitals: The Changing Landscape is Good for Patients and Health Care. © 2012 American Hospital Association.

ⁱ Moody's Investors Service Inc. (2012.) *New Forces Driving Rise in Not-for-Profit Hospital Consolidation*. Accessed at www.moodys.com.

ⁱⁱ American Medical Association. (2011). *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2011 Update*. Accessed at https://catalog.ama-assn.org/Catalog/product/product_detail.jsp?productId=prod1940016.

ⁱⁱⁱ American Hospital Association. (2009). *The Case for Reinvigorating Antitrust Enforcement for Health Plan Mergers and Anticompetitive Conduct to Protect Consumers and Providers and Support Meaningful Reform*. Accessed at www.aha.org/aha/content/2009/pdf/09-05-11-antitrust-rep.pdf.

**Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
U.S. House of Representatives**

Hearing on Health Care Industry Consolidation

September 9, 2011

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) thanks you for the opportunity to provide feedback on the impact of health care industry consolidation.

The need for greater collaboration among health care providers has never been more compelling. Persistent fragmentation contributes to gaps in quality and efficiency that adversely impact providers and their patients. The AHA has long recognized the importance of collaboration in health care, particularly between hospitals and physicians. A 2005 AHA Task Force on Delivery System Fragmentation supported “the integration of clinical care across providers, across settings and over time” as an important strategy to foster collaboration and, consequently, to improve the quality and efficiency of care. A recent AHA *Trendwatch* publication titled “Clinical Integration – The Key to Real Reform”ⁱ highlighted the crucial role of clinical integration in achieving the kind of systemic change needed in the health care delivery system.

At the same time health care providers are actively looking for strategies to address unhealthy and wasteful fragmentation, they also are seeking to improve efficiency and quality; they are also under internal pressure to reduce costs and achieve higher quality as well as increasing pressure from others – government and private payers in particular. The pressure for efficiency is longstanding. In a 2000 report, *To Err is Human: Building a Safer Health System*, the Institute of



Medicine (IOM) called for improvements in the way care is delivered and particularly stressed the importance of creating systems that support caregivers and minimize risk of errors. In its subsequent 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the IOM challenged the adequacy and appropriateness of the current health care system to address all components of quality and meet the needs of all Americans. According to the report, a 21st Century system should provide care that is “evidence-based, patient-centered, and systems-oriented.”

A number of commentators, including the IOM, advocate linking provider payment to provider performance on quality measures because such an approach is “one of several mutually reinforcing strategies that collectively could move the health care system toward providing better-quality care and improved outcomes.” Numerous pay-for-performance and incentive programs have been launched in the private sector in recent years, and such efforts also have been incorporated into Medicare payment systems for both hospitals and physicians. To be effective, such programs need to foster collaboration by aligning hospital and physician incentives, encouraging them to work toward the same goals of improving quality and patient safety, and providing effective and appropriate care to create better health outcomes.

The AHA Task Force saw that better alignment among providers was the key to improving patient care and enhancing productivity, and that removing impediments to such alignment created by various federal laws and policies was essential. It called upon a variety of federal agencies, including the Federal Trade Commission (FTC) and Department of Justice (DOJ) to:

Establish a simpler, consistent set of rules for how hospitals and physicians construct their working relationships. The complexity, inconsistency and sometimes conflicting interpretations of federal laws and regulations affecting hospital-physician arrangements are a significant barrier. Few arrangements can be structured without very significant legal expense.

We support user-friendly guidance from the antitrust agencies on how antitrust laws and policies will be applied to clinical integration arrangements among hospitals and other caregivers, and urge those agencies to act quickly to provide such guidance.

We also urge the DOJ’s Antitrust Division to be increasingly vigilant about anticompetitive conduct on the part of entrenched health insurers and commend the division for its recent stepped up enforcement. We disagree with those who contend that hospitals – the object of so much antitrust scrutiny – have somehow acquired the power to dictate terms to health plans. Two well-known and respected antitrust economists from Compass Lexecon (referred to below) conclude that these critics confuse patient preference for providers with highly differentiated services or specialized service, with market power. For all the reasons that collaboration is good and fragmentation is bad, we believe that mergers and consolidations can be helpful. Consolidation among health care providers can address fragmentation and lead to the same benefits as less formal collaboration.

THE NEED FOR VIGILANT ANTITRUST ENFORCEMENT FOR HEALTH PLANS

Criticizing the historic lack of a robust and coherent enforcement policy on health insurance plan mergers and anticompetitive conduct in May 2009, the AHA called upon DOJ to re-examine and bolster its enforcement policy as it applies to health plans in *The Case for Reinvigorating Antitrust Enforcement for Health Plan Mergers and Anticompetitive Conduct to Protect Consumers and Providers and Support Meaningful Reform*.ⁱⁱ Among the AHA's requests were that the Antitrust Division:

- Undertake a comprehensive study of consummated health plan mergers.
- Revisit and revise its analytical framework for reviewing health plan mergers and conduct complaints. The areas of scrutiny should include whether:
 - Proposed mergers by plans with pre-existing market power should be viewed as presumptively unlawful;
 - The ability of merged or dominant health plans to price discriminate against certain hospitals poses particular concerns about likely competitive harm;
 - Merged or dominant health plans can wreak competitive harm in ways other than reducing prices below competitive levels, such as adversely affecting the development or adoption of quality protocols or technology tailored to meet the needs of hospitals and the patients they serve; and
 - Mergers of health plans with service areas that technically do not overlap because of license or other agreements still pose a risk of competitive harm and, therefore, should be challenged.

Unlike other sectors of the health care field, such as hospitals and physicians, health plan mergers and other anticompetitive conduct had received comparatively little scrutiny:

In the past eight years, the Antitrust Division has requested only relatively minor divestitures and other relief in two health plan mergers. In addition, the Antitrust Division has offered no explanation for failing to respond to provider requests for more robust enforcement in the last two major health plan mergers.

While enforcement has been stepped up recently, it is noteworthy that since the AHA's May 2009 letter, DOJ has challenged only one health insurance transaction, involving a small provider-owned HMO, while other larger transactions have been cleared.

Contrasting with that lack of scrutiny was the fact that during the same time period, the FTC launched a major retrospective of the hospital field that was intended to lead to more successful challenges to hospital mergers where anticompetitive ones were identified, apparently in an attempt to overcome losing virtually all of its hospital merger challenges in the federal courts. Following that retrospective, the FTC challenged one long-consummated hospital merger via an internal agency hearing and blocked another outright. The FTC also has aggressively applied antitrust law to arrangements between physicians and between physicians and hospitals, all to "protect" patients from any increase in market power resulting from such arrangements. Moreover, while some of these specific hospital and physician cases have been high profile and touted with frequency, numerous other mergers and acquisitions have occurred, many reviewed,

with few challenges, suggesting the infrequency of “anticompetitive” hospital mergers. Where was the comparable focus on health plan mergers and market power?

Today, some would turn the lack of antitrust enforcement against health plans on its head, contending instead that hospitals – the object of so much antitrust scrutiny – have somehow acquired the power to dictate terms to health plans. To examine these claims, the AHA recently commissioned two well-known and respected antitrust economists from Compass Lexecon to evaluate two publications that have been widely cited as support for this mistaken notion: a 2010 *Health Affairs* article about California health care providersⁱⁱⁱ and the 2010 report by the Massachusetts Attorney General on health care costs.^{iv}

In short, the economists from Compass Lexecon concluded, after rigorous analysis, that neither publication contains any credible support for such claims. While the two publications have different but serious flaws, they share one that is particularly glaring: they confuse patient preference for providers with highly differentiated services or specialized service with market power.

A hospital can become highly desired simply by providing excellent care. Indeed strong consumer preferences for specific hospitals and their services provide an incentive for hospitals to improve services, enhance quality or expand output of services in greater demand, and to expect an appropriate return on the investment required to provide these services.^v

Hospitals, in particular, are held accountable for the care they provide to their communities; for example, quality and patient satisfaction are routinely measured and publicly reported.^{vi} Hospitals also have been subject to intense scrutiny by the federal antitrust agencies. Conversely, insurers, which wield enormous – largely unchecked – market power in most markets, have not faced nearly as much public antitrust scrutiny and oversight.

Most importantly, however, patients get real benefits when caregivers work together to provide more coordinated, more efficient and higher quality care. That is the path we are on and the one that holds the greatest promise for fixing a fragmented delivery system. The antitrust laws can make a real contribution to progress if the agencies enforcing them are willing to exercise the same type of leadership and foresight that led to the issuance of the *Statements on Antitrust Enforcement in Health Care*. User-friendly guidance for clinical integration and more vigilance in the health insurer sector are important steps, not just for hospitals, but for the future health and vitality of the nation’s health care delivery system and the patients it serves.

CONCLUSION

The AHA appreciates the opportunity to discuss these issues. America’s hospitals look forward to working with the Committee on Ways and Means and the Administration to improve the quality and efficiency of care for all patients in every community.

ⁱ American Hospital Association, February 2010; *Trendwatch: Clinical Integration – The Key to Real Reform*. <http://www.aha.org/research/reports/tw/2010/10feb-clinicinteg.pdf>

ⁱⁱ American Hospital Association. (2009). *The Case for Reinvigorating Antitrust Enforcement for Health Plan Mergers and Anticompetitive Conduct to Protect Consumers and Providers and Support Meaningful Reform*. Accessed at www.aha.org/aha/content/2009/pdf/09-05-11-antitrust-rep.pdf.

ⁱⁱⁱ Berenson, R., Ginsburg, P., and Kemper, N. “Unchecked Provider Clout in California Foreshadows Challenges to Health Reform,” *Health Affairs*, Vol. 29, No. 4, April 2010.

^{iv} Office of Attorney General Martha Coakley, “Examination of Health Care Cost Trends and Cost Drivers,” March 2010 and Letter to Partners HealthCare, June 2010.

^v Guerin-Calvert, M., Israilevich, G. (2010). *A Critique of Recent Publications on Provider Market Power*. Compass Lexecon for the American Hospital Association. Accessed at <http://www.aha.org/aha/content/2010/pdf/100410-critique-report.pdf>.

^{vi} Guerin-Calvert, M., Israilevich, G. (2011). *Assessment of Cost Trends and Price Differences for U.S. Hospitals*. Compass Lexecon for the American Hospital Association. Accessed at <http://www.aha.org/advocacy-issues/letter/2011/110308-let-hatton-dojftc.pdf>

Hospitals: The Changing Landscape is Good for Patients & Health Care



American Hospital Association.

Hospitals: Care Integration for the Right Reasons

Coming on the heels of the recession, hospital merger/acquisition activity began to accelerate. Hospitals began acquiring other hospitals and hiring medical staff in an effort to provide the leadership needed to reform a siloed health care system that nearly everyone from Institute of Medicine to the Medicare Payment Advisory Commission (MedPAC) singled out as one of the main culprits in higher cost lower quality health care.

Both government and the private sector are creating incentives that are driving hospitals toward one another and toward their medical staffs with new global and fixed payments schemes, new incentives for meeting quality, efficiency, and patient satisfaction goals (and penalties for failing to do so), and rescinding payments for certain readmissions.

Both Moody's and Standard & Poor's report a negative financial outlook for hospitals, attributable in large part, to the fact that "[t]he healthcare industry is undergoing a period of fundamental transformation in which the very model of healthcare delivery is being questioned and changed."

—Moody's Outlook 2012

"[H]ospitals that successfully improve operating efficiencies, engage in growth strategies, and align more closely with physicians will be better poised to adapt to ongoing challenges."

—Moody's Special Comment 2012

Meeting these myriad challenges requires building a continuum of care that includes healthier, leaner hospitals and closely aligned medical staff.

"The ability to demonstrate lower costs while providing higher quality care will be the key driver in governmental and commercial reimbursement going forward."

—Moody's New Forces 2012

To achieve these worthy goals, mergers may be the only recourse as decades old regulatory barriers can keep hospitals and doctors from working closely together to improve care and reduce costs unless they are under the same ownership umbrella. Gainsharing demonstration projects in New Jersey, for example, show care and cost improvements from closer collaboration, yet the barriers remain.

"We believe physician employment . . . will continue to grow because of the expected incentives . . . call for tighter care coordination to manage services that are bundled together . . . or simply to better manage patients with chronic conditions."

—Standard & Poor's 2012

Hospitals: Antitrust Watchdogs Prevent Anticompetitive Mergers

Hospitals have been under the watchful eyes of the federal antitrust authorities for decades. When the Federal Trade Commission (FTC) believes a hospital merger threatens competition, the agency has not hesitated to step up.

The FTC alone investigated a dozen completed hospital mergers and challenged or threatened to challenge at least that many proposed mergers in recent years.

New care models, like accountable care organizations, will continue to get the FTC's closest scrutiny. In response to a question about ACOs, the FTC's chairman said:

"We're not going to roll over and play dead and allow a lot of health-care consolidation."

Not so for insurance companies. Over the past decade, no merger between major insurance companies has been completely rejected by the federal antitrust authorities. Indeed, as well documented annually by the American Medical Association and observed by others:

"[T]he vast majority of health insurance markets in the United States are highly concentrated . . . this strongly suggests that health insurers are exercising market power in many parts of the country and in turn causing competitive harm to consumers and providers of care."

—Competition in Health Insurance 2011

"Payers have consolidated over the past several years . . . providing greater negotiating leverage for the payer."

"In most markets dominated by large payers, hospital commercial reimbursement rates are lower than average."

—Moody's 2012

Some payers tend to blame hospital mergers for high insurance premiums. Two economic consulting firms examined charges that hospital mergers in the 1990s drove up prices. They said:

"There is no valid empirical basis for [that] conclusion."
—Competition Policy Associates and Economists Incorporated 2003.

That is still true today.

—Continued



Hospitals: Consumer Preference Matters

Like firms in every other sector of our economy, hospitals are not all the same. Some hospitals with high-level or more costly services, like burn or high-level trauma units or other highly specialized care, have higher costs and may charge higher prices. These may also be the very hospitals that consumers most want to go to when they are seriously ill or badly injured.

Pundits often confuse such consumer preferences with market power – they are wrong to do so.

“Even the FTC acknowledges that for hospitals, different prices are “neither necessary nor sufficient to demonstrate ... market power.”

—FTC Working Paper 2009

Hospitals compete to be the best and invest the resources needed to maintain consumer trust and loyalty.

—Compass Lexecon 2010

In a radio interview, small business owners in California said they were willing to pay more for the hospitals their employees believed were the best.

—KQED, November 20, 2010

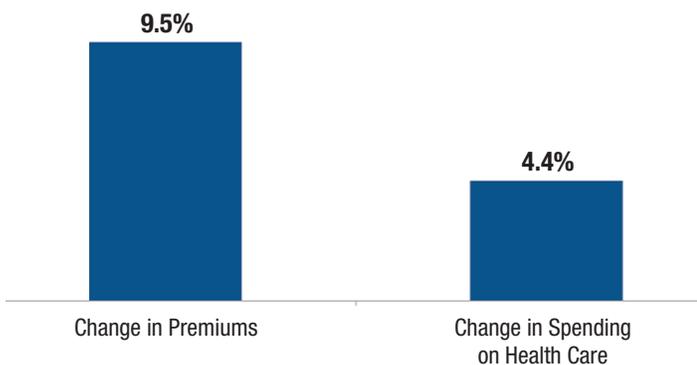
Hospitals: Price Growth is at Historic Lows

Despite renewed merger activity, the growth in spending on hospital care is at historic lows.

—Altarum 2012

It is *not* hospital prices that are driving the rise in insurance premiums. The growth in insurance costs from 2010 to 2011 was more than double that of the underlying health care costs, including hospitals.

Percent Change in Premium Levels vs. National Spending on Health Care, 2010 to 2011



Source: The Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits Survey*. Data released 2011. Link: <http://ehbs.kff.org/pdf/2011/8225.pdf>. Altarum Institute, Insights from Monthly National Health Expenditure Estimates through December 2011. Link: <http://www.altarum.org/research-initiatives-health-systems-health-care/altarum-center-for-studying-health-spending/health-indicator-reports>.

Insurance companies are expected to drive hospital rate increases even lower, according to Moody’s, “continuing a multi-year trend.”

“[T]he opportunities to gain leverage and higher rates from commercial payors are quickly dissipating...”

—Moody’s *New Forces* 2012

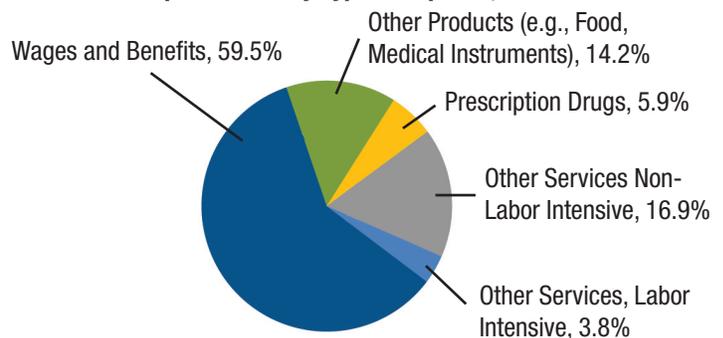
“We expect commercial payers to remain highly aggressive in negotiating lower reimbursement rates with hospitals in 2012.”

—Moody’s 2012

Unlike other health care sectors, study after study has shown that hospital prices are directly related to the cost of caring for patients. Funds needed to hire and retain doctors, nurses and other medical and support staff with the right qualifications and training are the single largest cost for hospitals – they account for two-thirds of total expenses.

About two-thirds of hospital costs go to the wages and benefits of caregivers and other staff.

Percent of Hospital Costs¹ by Type of Expense, 4Q09



Source: IHS Global Insight, Quarterly Index Levels in the CMS Prospective Payment System (IPPS) Hospital Input Price Index, 2009 Q3.



Hospitals: Investing in Technology and Upgraded Facilities

Other significant outlays for hospitals involve IT. Every hospital is expected to meet new standards for having and using electronic medical records for its patients or face penalties in 2015.

Meeting that requirement safely will cost as much as \$50 million for a midsize hospital.

—National Journal 2012

Moody's lists "[i]ncreased need for capital relating to plant modernization and IT systems" as one of the top reasons for its negative outlook for hospitals in 2012.

—Moody's 2012

Getting and making this new technology work for patients and meet new and far-reaching government and

private-sector requirements (coming from employers and payers) is a major investment for all hospitals. For cash strapped hospitals it may be beyond their reach without merging with another hospital that can provide those funds.

These same hospitals may not be able to borrow to do so because of depreciation rules.

"Independent hospitals tend to have narrower margins, meaning they can't simply fork over the cash ... to digitize their records."

—National Journal 2012

Doctors must meet similar requirements, yet regulatory barriers make that difficult or impossible to do so in collaboration with a hospital without being in its employ.

Hospitals: Essential Capital is in Short Supply

There is no doubt that limited access to capital for IT and other investments essential to providing high quality care at lower costs is driving mergers.

Capital markets for not-for-profit hospitals have still not fully recovered from the recent financial meltdown. Three temporary federal financing options that helped ease the credit crunch expired in 2010. For many hospitals, particularly those with lower bond ratings, the best and perhaps only strategy to remaining viable in their community is merging with another hospital that has the financial resources it lacks.

"Access to the capital markets has become more difficult for smaller and lower-rated hospitals, driving the need for many to seek a partner."

—Moody's New Forces 2012

The Michigan Attorney General recently approved a hospital deal citing access to capital as its primary benefit. The AG said that lack of capital made it impossible for the hospital to "perform necessary renovations, improvements, and expansion of its aging structures and equipment" The deal, the AG said, "offers hope that the [community] will continue to be well served ... for a long time to come."

Hospitals: Need to be Healthy to Provide the Most Value

"Of all the transformations reshaping American healthcare, none is more profound than the shift toward value."

—Value through Partnership 2012

Quality outcomes, affordability, and patient satisfaction are rapidly becoming the touchstones employers, payers, government and, most importantly, patients expect and demand. Meeting these challenges requires reshaping the hospital field, sometimes through mergers, alliances, partnerships or other innovative relationships.

This transformation will require time, patience and capital investment to build a continuum of care that accommodates 21st century technology and standards of medical care. When mergers are needed to help financially, geographically or otherwise challenged hospitals avoid "closure, bankruptcy, or payment default," or to become stronger and more efficient to meet current challenges and fulfill community needs, that should be a welcome development.

References available at www.aha.org