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Good Morning. I am Eddie Alexander, Founder, President and Chief Executive Officer of Surgical Alliance Corporation. It is my privilege to be with you this morning and to share with you my thoughts regarding the changing face of health care delivery and financing and I am pleased to offer advice on today's subject -- single specialty hospitals. I have been involved in the health care industry for the last 16 years, working closely with practicing physicians and medical institutions in both business and financial management capacities. I am a Certified Public Accountant and a graduate of Emory University.

From our headquarters in Nashville, Tennessee, Surgical Alliance Corporation partners with physicians to develop, design, manage, and operate specialty surgical facilities focused on the unique needs of patients with orthopedic neurosurgical problems, and designed to enable physicians, nurses and other medical personnel to deliver the best coordinated patient-focused care.

I had hoped to be joined today by Dr. Adolph Lombardi, an orthopedic surgeon from Columbus, Ohio, with whom I work closely so you could hear first-hand his rationale and support as a practicing physician for an alternative orthopedic surgical hospital model. Unfortunately, Dr. Lombardi's practice and teaching obligations did not allow for him to be here today. Working together with our physician-partners, who, like Dr. Lombardi, regularly face the challenges of our current system of delivering patient services, we have undertaken to develop a new orthopedic neurosurgical specialty hospital that we believe will enhance patient care and also stimulate competition in the central Ohio health care marketplace.

Specialty hospitals are emerging throughout the United States, establishing new models for success in patient treatment. What motivates the evolution to focused, specialized ambulatory surgical centers and specialty surgical hospitals? It is a common sense, intelligent response to a mature health care delivery system and industry gripped by inefficiencies, and to health care spending being out of control. Health care spending represents over 13% of our Gross Domestic Product, or approximately $1.3 trillion and continues to grow, with over 1/3 of those costs tied to hospitalization. While costs have soared, quality of care in the big, traditional several hospitals has deteriorated. Simply put, the current hospital model is, in many respects, outdated, inefficient, and suffering in quality.

Specialized facilities are a natural progression -- a recognition that the system needs to be tweaked, perhaps overhauled, to achieve lower costs, higher patient satisfaction, and improved outcomes. As I will discuss momentarily, the research data from over 100 studies demonstrates superior results, lower costs, and significant efficiencies absent from our current system. Medicine continues to witness a tremendous explosion in knowledge and information sharing. Rapid and exciting technological advancements have resulted in ever-increasing sub-specialization within the various medical specialties. The shared desire to harness this knowledge and to focus their energies to enhance patient care served as a catalyst for Dr. Lombardi and many of his colleagues to pursue the development of a new specialty hospital in suburban Columbus, Ohio, dedicated to musculoskeletal and neurological disorders -- the New Albany Surgical Hospital.

Over 30 leading orthopedic physicians have joined together with Surgical Alliance Corporation to develop this specialty hospital, which will encompass orthopedic surgery, physical therapy and rehabilitation, neurosurgery, neurology, spine surgery, pain

medicine, emergency medicine, and internal medicine. Our shared purpose is to establish a premier central Ohio facility dedicated to offering the patient the latest in technological advancements in the field of orthopedic surgery. Our primary mission is to provide our patients with the best orthopedic care in the entire world. Further, we share a common commitment to continue to be a positive asset to our community, in part by doing our fair share in treating those who cannot pay, which sometimes is referred to as "charity care," and by devoting significant resources to the training of new professionals and to the research and development of better care and treatment for musculoskeletal disease.

What prompted this undertaking? It was not a decision made lightly. Our physician-investors have established, well-respected practices, based in Columbus, with patients from across Ohio and every state surrounding Ohio. Quite simply, we believe that the New Albany Surgical Hospital, or NASH for short, set to open later this year, will allow our physician-investors to provide better, more timely patient care, at a reasonable price, in a more patient-focused and friendly environment. In essence, we want to provide our patients with the best care possible, in a cost-effective manner.

For hospital services, the geographic distances that patients must travel tend to define a market and to be barriers to competition. Our new hospital will be located in New Albany, a suburb of Columbus, Ohio. The local health care marketplace in greater Columbus is dominated by three major hospital systems, OhioHealth Corporation, Mount Carmel Health System, and The Ohio State University Medical Center. Our proposed venture has met with stiff and coordinated resistance from these large not-for-profit hospital systems that control all eight general hospitals and 100% of the inpatient hospital beds for adults in the Columbus market. Their efforts to maintain the status quo are driven not by quality, cost efficiency, or the desire to

preserve the delivery of charity care to the community, but rather by the fear of having to compete, of having to look within their respective institutions to improve efficiencies and to enhance the timely delivery of patient care.

The operating rooms at inpatient hospitals in Columbus are at capacity use. Physicians make efforts to block, or reserve, operating room time. However, if physicians are unable to negotiate adequate time, then they must simply wait on "standby" for an operating room to become available. At least two of NASH's physician-investors have had waits of 30 days in the Columbus not-for-profit hospitals before gaining operating room time, certainly not an optimal situation for a patient needing orthopedic surgery.

Given the relatively small size of NASH (eight operating rooms and only 30 in-patient beds), our intention and expectation has been that much of the work of our physician-partners would continue, as always, at the not-for-profits' traditional general hospital facilities. NASH cannot accommodate, nor was it designed to accommodate, all of the operating room time and staffing needs of its many physician-investors. When completed later this year, NASH will account for less than one percent of the hospital beds in the Columbus area. Our initiative will certainly help the problems our practicing physicians now face of insufficient operating room options, but it is not a realistic threat to the traditional general hospitals.

New Albany Surgical Hospital is under construction and is scheduled to open in November 2003. In an effort to forestall competition, two of these hospital systems -- OhioHealth and Mount Carmel -- recently passed resolutions to revoke existing privileges of medical staff members and to withhold new privileges solely on the basis of a physician's investment interest in NASH or any competing specialty hospital. Dr. Lombardi has dealt with this prohibition firsthand. Although Dr. Lombardi has performed virtually all of his inpatient

surgeries over the last few years at an OhioHealth hospital, Dr. Lombardi has been put on notice that OhioHealth will revoke his privileges at that hospital after NASH opens because of his investment in NASH. In anticipation of this heavy-handed reaction, Dr. Lombardi applied for privileges at a Mount Carmel hospital, and, despite his unquestioned and impeccable credentials as a hip and knee replacement surgeon, his application was rejected solely due to his investment in NASH. As a result, Dr. Lombardi faces the prospect of being unable to serve his patients in a timely manner after NASH opens because he may not have access to sufficient operating room time. These unfair actions stifle competition by punishing physicians who invest in potential competitors through the denial of staff privileges and access to scarce operating room time at the not-for-profit hospitals. This process of "economic credentialing" -- the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges -- is opposed by the American Medical Association, which urges that physician credentialing and privileging be "assessed on the basis of their education, training, experience and documented competence," and not on the basis of their investments. Economic credentialing limits patient choice and access to care, and it eliminates referrals to hospitals or other outpatient facilities that may be more clinically appropriate, cost-effective, or convenient for patients. Requiring a physician to limit his or her referrals to one, or a short list of "accepted" facilities, serves only the interests of the "accepted" hospital and rarely is in the best interests of the patients. Not only is this activity anti-competitive vis-à-vis the affected physician, but also it has a chilling anticompetitive effect on the entire marketplace for the delivery of those medical services.

Not-for-profit hospitals (or "NFPs") account for about 85 percent of all hospitals. NFPs hold a great advantage over specialty surgical hospitals given their existing market domination. Despite their complaints of unfair competition, these large NFPs have more capital,

more resources and the leverage of dominant market positions. In addition, they are accorded, in exchange for certain unprofitable community services, a wide array of special treatment from legislatures and the regulatory community. Not the least of these preferences is the fact that the NFPs pay no state or federal income taxes or local property taxes.

In many states the NFPs are protected from competition through Certificate of Need programs, yet another barrier to new market entrants, and a considerable market advantage for the larger, better capitalized NFPs. Ohio's Certificate of Need program for hospital expansions was eliminated by the Ohio General Assembly in 1995. State Senator Lynn Wachtmann, the Chairman of the Ohio Senate's Health, Human Services and Aging Committee, observed recently that this deregulation is just beginning to yield some good fruit with a more competitive environment.

Specialty hospitals and surgery centers are not a new idea in Columbus, the State of Ohio, or most of the United States. Currently, in central Ohio, OhioHealth, Mount Carmel Health System, and The Ohio State University all are in the process of building specialty heart hospitals. Within the Mount Carmel Health System in Columbus, St. Ann's is currently constructing a specialty Women's Hospital. It is widely acknowledged and accepted that organizing care around a particular disease or population, such as children, creates tremendous efficiencies and precipitates better patient outcomes.

Our new orthopedic specialty hospital affords the same benefits to the community. It seems, however, that the current dominant market leaders would prefer that the creation of these new specialized centers only be permitted if undertaken by them rather than others. This is hardly a policy that fosters innovation. In a September 2002 article in *Columbus Monthly* magazine, Reed Fraley, the Chief Executive Officer of The Ohio State University

Medical Center, stated, and I quote: "In the crass world of competitive business, what we are doing is called gaining market share, we're fighting over market share because that is what we have been told to do. If costs are rising and payments are falling, the only way to survive is by increasing volume."

The natural barriers to entry for a potential entrant into the marketplace (e.g., money, acceptance, etc.) are being supplemented and strengthened in the Columbus area by the existing hospitals. These competitors are using several actions as barriers to entry: threats of denial of staff privileges to physicians who invest in NASH; adverse publicity about NASH; and legislative lobbying to try to obtain legislation that would bar physicians from referring patients to inpatient hospitals in which they have an ownership or investment interest.

It is time for these existing institutions to recognize their own role in perpetuating inefficiencies and escalating health care costs. In a July 22, 2002 article in *Modern Healthcare*, commentator David Burda put it this way:

> "I don't understand the backlash against for-profit specialty hospitals. Healthcare companies are building inpatient facilities that specialize in specific services, most commonly cardiac, orthopedic, and women's and children's care. In many cases, the local investors in these new hospitals are physicians on staff at a soon-to-be competing not-for-profit hospital in town. Nothing could be better for patients (and their employers and insurance carriers) than to have an array of specialty and full-service hospitals of various ownership models in their market to serve all their healthcare needs."

Our specialty hospital will provide better patient care, at a more reasonable price, and in a more patient-friendly and caring environment. The argument for specialization in health care is too compelling and affords too many benefits to be thwarted either by policy or anticompetitive conduct by existing industry leaders. Instead we must encourage superior models of health care

delivery to promote innovation and stimulate improved performance, higher patient satisfaction and better outcomes.

There is some evidence that for profit hospitals provide better patient care than not-for-profits. The Lewin Group conducted a study of MedCath Heart Hospitals, a group of for-profit hospitals, and found that the MedCath hospitals had a higher case mix severity than the peer community hospitals. After adjusting for risk, the MedCath facilities on average exhibited a 12.1% lower in-hospital mortality rate from Medicare cardiac cases compared to the peer community hospitals and had a lower average length of stay. The study also found that specialty hospitals discharged a higher proportion of their Medicare cardiac patients to their homes and transferred fewer discharged patients to other facilities.

The New Albany Surgical Hospital has been maligned in the press and criticized by the existing, large not-for-profit systems in Columbus for being a "for-profit" facility. This is somewhat akin to the pot calling the kettle black. OhioHealth, Mount Carmel, and OSU have all owned "for-profit" physician practices, diagnostic centers, and surgery centers. Both OhioHealth and OSU house "for-profit" specialty hospitals on segregated floors within their own hospitals. Nationally, there are over 750 "for-profit" hospitals across the country and they are an integral part of our national health care delivery system. Many of these hospitals are affiliated with religious institutions, others with major universities. The Cleveland Clinic, the most prestigious medical facility in Ohio, operates its Florida hospital as a "for-profit" facility.

According to National Bureau of Economic Research White Paper No. 8537, the effects of ownership status are quantitatively important. Areas with the presence of for-profit hospitals have approximately 2.4% lower levels of hospital expenditures, but virtually the same

patient health outcomes. The paper concludes that for-profit hospitals have important spillover benefits from medical productivity.

Unfortunately, our struggles need not have come to be at all. Efforts were made by the NASH physician-investors to work with the major hospital systems in Columbus to invite a partnership, but the NFPs unilaterally determined that there was no need for a hospital in New Albany. Meanwhile, many of these same not-for-profit institutions are building competing outpatient surgery centers and diagnostic laboratories, some of them for-profit ventures, and some co-owned by doctors in the hospitals.

Vowing to work arm-in-arm to fight our new specialty hospital, not-for-profit executives and boards are revoking and withholding medical staff privileges for any physician investing, directly or indirectly in a specialty hospital.

In addition to engaging in economic credentialing, the NFPs in the Columbus market have banded together to launch a public relations blitzkrieg and lobbying effort, and they are pushing aggressively legislation to prohibit a physician from referring a patient to any facility in which that physician has an investment interest. This concerted effort against our specialty hospital is conspicuous and aggressive. An OhioHealth media spokesperson acknowledged the arm-in-arm relationship of the not-for-profits in a September 2002 news article, stating: "We are all on the same page, the coalition is far enough along now, it's just an understanding we're all on the same page." In an October 30, 2002, *New York Times* story, Michael Curtin, Chairman of the Board of Mount Carmel Health System, put it bluntly: "We're going to do everything we can to make sure they are not successful."

While the NFPs claim that for-profit hospitals will undercut their ability to provide unprofitable services to the community by "cherry-picking" the best-paying, least

medically complicated patients, the facts tell a different story. First, the NFPs in the Columbus market are doing well financially. According to published reports, OhioHealth showed an operating income of $23 million on revenue of $1.35 billion in Fiscal Year 2002, Mount Carmel made $34.4 million on revenue of $737 million, and the OSU Health System had an operating income of $2.8 million on revenue of $710 million. These NFPs are making money, not losing it.

Second, while the NFPs claim that they would be gutted financially if the NASH physicians referred their business elsewhere, the NFPs have been telling physicians doing inpatient surgeries for years how much the hospitals have been losing on those physicians' referrals. In one recent example, a well-respected, highly productive physician performing inpatient surgeries at a Columbus not-for-profit hospital was told that the hospital where he was working was losing roughly $3.5 million per year on the surgeries that he performed. Having complained for years about such losses, it's hard to believe the NFPs when they complain now about the financial disaster that allegedly will beset them if these money-losing physicians take their business elsewhere.

Finally, in another self-serving double standard, the not-for-profits are pushing vigorously for state legislation that would prohibit physician "self-referral" for inpatient hospital services, while continuing to permit physicians to refer patients to outpatient surgery centers in which they have a financial interest (and in many of which the not-for-profits have an investment interest). If, as the not-for-profits claim, this is a matter of physician ethics, why is it acceptable for physicians to refer patients to outpatient facilities in which they have an interest, but not to inpatient facilities in which they have an interest? The alleged "ethical" concern is identical; the difference lies in the financial interests of the not-for-profits.

The NFPs' concerted actions is not competition on the merits, but instead is anticompetitive conduct -- that is, conduct designed to harm the competitive process itself. To be specific, when existing hospitals collude to enforce a policy of economic credentialing to deter physicians from utilizing NASH (from even treating any patients there) then such conduct is not competition. It is an attempt to preclude New Albany Surgical Hospital from competing. The government should act to prevent such bald anticompetitive conduct. No physician should have his or her livelihood threatened or cut off (since the doctor will still, in view of the small size of NASH, need to practice at the existing large hospitals) simply because he or she invests in NASH. Yet as I have described to you today, the current dominant market forces see it otherwise.

In closing, let me reiterate that, at bottom, Surgical Alliance Corporation and the NASH physician-investors have a primary interest in creating in the New Albany Surgical Hospital a specialized environment that not only assures, but nurtures, collaboration among the most skilled medical and support staff, which, when combined with high-quality patient care that is focused on a distinct specialty, results in better patient outcomes. The artificial barriers to entry to this market are not only harmful to providing the best and most efficient patient care, but also they stifle competition in the central Ohio marketplace at a time when it would be most beneficial to the consumer in terms of timeliness, cost, and focus of care.

The government should not let unfair methods of competition and anticompetitive acts occur without relief, but should act to prevent them, and to restrain them when they do occur.

Thank you.