THE FEDERAL TRADE COMMISSION PRESENTS:

HEALTH CARE AND

COMPETITION LAW AND

POLICY WORKSHOP

SEPTEMBER 9, 2002

FEDERAL TRADE COMMISSION

6TH & PENNSYLVANIA AVENUES, N.W.

WASHINGTON, D.C.

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**Introductory Remarks**

Chairman Timothy J. Muris

Speaker 1: William Brewbaker,
University of Alabama

Speaker 2: William Vogt,
Carnegie Mellon University

Speaker 3: Cara Lesser,
Center for Studying Health System Change

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Joe Simons, FTC
J. Howard Beales, III, FTC
David Scheffman, FTC

Speaker 7: Deborah P. Majoras,
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MR. HYMAN: Good morning. Thank you all for coming to our Health Care and Competition Law and Policy Workshop. My name is David Hyman and I'm a special counsel here at the Federal Trade Commission. Rank has its privileges, and the chairman of the Federal Trade Commission is here to kick things off, Chairman Tim Muris.

CHAIRMAN MURIS: Thank you very much, David.

On behalf of my fellow Commissioners, it's my pleasure to welcome you to the Federal Trade Commission's Workshop on Health Care and Competition Law and Policy. This two-day event will consider the impact of competition law and policy on the cost, quality and availability of health care, as well as on the incentives for innovation.

Health care spending accounts for a substantial part of our nation's GDP. Competition law and policy should support and encourage both the efficient delivery of health care products and services and innovation, through new and improved drugs, treatments, and delivery options. Developing and implementing competition policy for health care raises complex and sensitive issues.

The goal of this workshop is to promote dialogue, learning, and consensus among all interested
parties. I want to thank David Hyman in the Office of the General Counsel, who with Bill Kovacic, Susan DeSanti, Angela Wilson, and Sarah Matthias organized the workshop. They have put together two days of proceedings, featuring five panels and more than a dozen experts. We appreciate the willingness of those participating to share with us their perspectives.

The FTC has a long history in applying competition policy to health care. In the mid-1970s, the Bureau of Competition formed a group to investigate potential antitrust violations involving health care. As an Assistant to the Director of the FTC's Policy Office, I was proud to help launch this effort.

A series of important cases followed, as the Commission identified and addressed anticompetitive conduct by every conceivable entity involved in health care. The Bureau of Consumer Protection has also had an important role in health care, challenging the deceptive advertising of a variety of health-related products and services.

The Bureau of Economics assists the other bureaus in pursuing these enforcement initiatives. It has also published several important papers on health care and competition. The Bureau of Economics sponsored a major conference on the role of competition in health care.

We are pleased today to have the person who organized that conference and edited the book, Warren Greenberg, on our first panel this afternoon. At the time of that conference, Warren was a staff economist at the FTC. He is now a professor at George Washington University.

More recently, the Commission has brought cases involving price fixing by physicians and unfair methods of competition by pharmaceutical companies that delayed the entry of generic drugs for the treatment of high blood pressure, anxiety, and angina. Details of these cases are in the bound materials you received this morning.

We are also looking hard at consummated hospital mergers to determine whether there have been anticompetitive consequences. We will seek administrative redress if we find evidence of such conduct and have a viable remedy.

The heads of our Bureaus of Competition, Consumer Protection, and Economics, who are speaking later this morning, will detail the Commission's recent initiatives in health care. We have increased the
resources devoted to this industry and we are now seeing the results.

Our enforcement efforts in the health care sector have been complemented by our partners at the Department of Justice and the State Attorneys General. You will be hearing from representatives of both later this morning as they discuss their own initiatives.

In addition to enforcement authority, the Commission has unique jurisdiction to identify, analyze, and report on competition and consumer protection issues of major importance. Using this authority, in July, we released a study on certain aspects of generic drug competition under the Hatch-Waxman amendments. The study examined whether the Commission's enforcement actions against alleged anticompetitive agreements, which relied on certain Hatch-Waxman provisions, were isolated examples or represented conduct frequently undertaken by pharmaceutical companies.

The study also examined, more broadly, how the process that Hatch-Waxman established to permit generic entry prior to expiration of a brand name drug patent has worked between 1992 and 2000. Michael Wroblewski of the Commission staff will speak in more detail tomorrow afternoon about this study.

This workshop is also part of the FTC's research
agenda, and we hope to continue with other research projects.

The FTC is the only federal agency with both consumer protection and competition jurisdiction over broad sectors of the economy. The Commission enforces laws that prohibit business practices that are anticompetitive, deceptive, or unfair to consumers. The Commission also promotes informed choice and public understanding of the competitive process.

I hope this workshop will help illuminate the ways that competition law and policy can have a positive impact on the health care sector, and ensure that Americans receive top value for their health care dollars.

Obviously, a two-day workshop cannot do justice to the scope and complexity of a subject like health care and competition. There are at least a dozen important topics we will not cover, such as hospital mergers, fraudulent health claims, vertical integration, and the boundaries of the State Action Exemption. We hope to address these issues in the future.

So, welcome, and thank you very much. I look forward to learning a lot from you all. Thank you.

(Applause.)

MR. HYMAN: Thank you, Chairman Murris.

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Some basic logistical announcements. First, the technology people requested that everyone turn off their cell phones, because they apparently interfere with the taping of this workshop. It's also irritating to the people near you, but that's a separate issue.

Second, there are bathrooms right outside and there are bathrooms on each floor, if you're in one of the overflow rooms.

Third, there will be about an hour and a half for lunch. There's a hand-out sheet that lists a variety of nearby locations for lunch, if you're not familiar with the neighborhood.

Fourth, there are hand-outs outside. There are four hand-outs that the Commission has prepared. There's the tan book that includes biographies of all of the speakers and a variety of documents relating to actions that the various bureaus have taken, both enforcement and research related. There's the generic drug study that was prepared by the Office of General Counsel that the chairman just alluded to. There's an annual report from the Commission, and then there's an agenda separate and apart from the agenda that's included in the tan book, although they're identical. We just thought it would be simpler if you had two. Individual speakers may have hand-outs. There are three of them out there currently. There may
be more during the course -- actually four of them --
there may be more speaker hand-outs during the course of the workshop.
So, please check periodically.

We're going to very aggressively try to keep on
time, because we know people have schedules to keep as well.
To the extent we don't, your indulgence is appreciated.
There will not be questions from the floor. However, as the
Federal Notice Register reflects, the deadline for comments in response
to the workshop is September 30th. So, you have several weeks to go
back and if you were very unhappy with something someone said, the
ability to respond at length in writing, I suggest, is probably far
superior to yelling at them in front
of an audience.

And let me see if there's anything else. Our
first speaker today who will be providing an overview of
the health care industry -- oh, one other announcement
before I do that. Please, keep your name tags on if you
leave the building. It will make it much easier to get
back in after lunch; otherwise, you have to go through
the entire extended process again.

Our first speaker today is Professor William
Brewbaker from the University of Alabama School of Law,
well-known in health law, co-author of a two-volume
treatise that systematically goes through various parts of
the health care market and addresses the legal issues. This treatise
is very widely used by practitioners. Bill has also written on a variety of other health law related subjects. He will present an overview on institutions, entities, incentives, and realities of the health care marketplace.

Professor Brewbaker?

MR. BREWBAKER: Thanks, David.

It's a pleasure to be here this morning. My job is to give the view from 10,000 feet, as it were. My wife, a physician, had the following reaction: Can you see anything from 10,000 feet when it comes to health care? Well, I hope you can. If you can't, there will be lots of people looking more closely at individual matters later throughout the next couple of days.

I want to start by asking a fairly obvious, but nonetheless important, question, and that is: What's the point of competition policy? We like markets for all sorts of reasons, I suppose. Some of them have nothing to do with the consequences they produce for us, but in a room like this, and in this setting, clearly we like competition, or we presuppose competition is a good thing, because it does important things for us in health care markets.

We expect it to contain cost. We hope that by containing cost, it will enable us to extend coverage to more people. And we assume, sometimes in the face of
the evidence, that competition can have a favorable effect on the quality of the health care that we receive.

Well, I would like to sort of divide the talk in two parts: First I want to look and assess how we are doing on the various indicia of health care cost and quality: Second I will have some general observations on health care and competition law and policy.

In this first part, I want to begin with some facts, sort of unrelated to cost, and then move into the cost area. First, where does the money that we spend on health care come from? You can see from the slide, we've got total national health spending of about $1.3 trillion. There's about a 55/45 split between the private and public sectors, in that spending.

It's fairly self-explanatory. The money goes in a variety of different directions, not surprisingly, the lion's share to hospital care and physician and clinical services, but again, a big chunk for prescription drugs. Then this mysterious other spending block includes things like non-physician providers, home health, DME, over-the-counter medicines as sort of a catch-all category.

Again, another self-explanatory slide, but it's interesting to think about, it helps you get a sense of

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just how large this sector of our economy is. A million, almost, physicians, 6,100 hospitals, numerous other facilities as well.

There's been a lot of talk about the make-up of hospitals, and the trend toward investor-owned hospitals, the consequences of a shift away from a non-profit mode of delivering care. Some people are concerned that patients may do better in an environment where there's no incentive to exploit them somehow through market mechanisms.

This slide is interesting in a couple of respects. It certainly shows a slight trend in the direction of investor-owned hospitals, although you will see that the data are not all that recent. Nonetheless, still, the vast majority of hospital care is provided in the non-profit and public sector.

Trends in the identity of providers, and forgive me if I go through this a little bit fast, but David said he was going to tackle me if I went past 10:25. A not surprising trend here, the big growth in the provision of home health care agencies, and a corresponding decline in hospital numbers. Again, about a 10 percent decline since 1980, in the number of hospital Medicare providers. Again, not surprising to see corresponding increases in ambulatory surgery
centers, outpatient physical therapy. Of course there may be a number of different things besides declining lengths of stay going into these numbers, but an important general overall trend.

All right, finally, cost. We're coming out of a period of probably what seemed to many of us to have been good news. You look back in the '80s, this period of double-digit health inflation, ever-increasing percentage of GDP, dedicated to the health care industry because medical price inflation is growing so much faster than our economy is. Then in the late '90s, a period of stabilization, where we still have some inflation, but the economy is growing. The numbers are coming down, it looks like we're able to keep our level right there between 13 and 14 percent of GDP.

Well, the bad news, as I suppose most of you probably know, is that all predictions now are to the contrary of that previous slide. You can see the tail end up there, and tacked on is a prediction that says that over the next ten years or so, we'll probably see medical price inflation at a rate of about two and a half percent over the growth of the economy.

Now, of course, we don't exactly know how fast the economy is going to grow and we don't exactly know how fast health care prices will increase, but again,
we're looking at perhaps a situation where we have 17 percent of our gross domestic product spent on medical services by the end of the decade.

This is an interesting slide. Again, it's sort of a general 10,000 foot view of trends in terms of price inflation. If you look back in the early '80s there, you see we've got terrible inflation, double-digit annual inflation. Most of it is from medical prices. That's the yellow bar on the graph. We've got modest gains in utilization, and we see a general trend until we find this sort of good graph here, where we've still got a modest amount of utilization growth, we're seeing prices come down.

Again, a trend that seems to be going in the wrong direction. I'm sorry to say that may be a bit of a theme in my presentation this morning.

Expenditures, where are we spending our money? Again, I know it's hard for you to digest these graphs in the 20 or 30 seconds you have to look at them, but the main point of this graph is to show between 1990 and 2000 a decrease, a significant decrease in spending on hospital care and then a fairly significant increase on prescription drug spending with the other main categories staying more or less stable.

Spending for in-patient treatment. Again, what
you see is a dramatic increase over the past 30 years in Medicare percentage spending on in-patient treatment, and a significant decrease overall as well. Again, this is a matter of importance to this particular conference, this question of prescription drug expenditure growth. You've got here a chart that shows the annual percentage growth in prescription drug expenditures.

If you look back, you'll see that we've had double-digit inflation in prescription drug expenditures pretty much consistently for the last 20 years or so. Even when we've dipped down here in this decrease in the rate of increase, we're still talking about six percent growth, and of course now we're around 17 percent growth annually in prescription drug spending.

Again, the lower line shows you the share of national health expenditures that we would attribute to prescription drug spending, and you find, again, a sizeable increase in the percentage of our spending that's being directed toward pharmaceuticals, from about five percent all the way up to 9.4 percent in the data on which this slide is based.

Another important trend is who's bearing that increased cost? If you look back in the late '80s, you see most of the spending on prescription drugs was done by consumers out-of-pocket. By a couple of years ago,
private health insurance is absorbing a significantly
greater percentage of that spending, and of course
between 1988 and 2000 we've had lots of spending
increases.

So, this has put a lot of pressure on private
health plans to deal with this particular source of cost
increases. Not surprisingly, what you see is increasing
portion of spending being done out-of-pocket by
consumers, as there's probably some effort to shift
those costs back on consumers to encourage
cost-conscious spending on prescription drugs as well.

Well, so much for 10,000 feet in the air on
cost. What about coverage? Again, we've got the same
story. Here's the happy slide, I can almost put a happy
face, I suppose, on this one. This shows data from last
year, which shows an increase in the number of people
who are employed that have health insurance. Most of
them have their own employer coverage, some have other
coverage. In lots of cases that's going to be coverage
through a spouse who also works, and so an employee who
is offered coverage may decline it because he or she is
able to participate in family coverage through a
spouse's workplace.

We see a good trend there on the uninsured line
in terms of employed people, and in fact, even though
the economy was in the middle of a downturn last year, we still had a fairly tight labor market, and even though medical prices and premiums were rising, there was still a tendency of employers not to cut back on the health insurance benefits they were offering.

Well, just last week, the Kaiser Foundation and HRAT released their annual survey of employer-sponsored health benefits, and this is the bad news section of the presentation. I'm just going to show you what's on their website and what's also an interesting discussion in the most recent issue of Health Affairs, if you would like to have a look at that.

But basically, here's the bad news: 12.7 percent annual increase in family premiums paid for employees. Following along, of course, an 11 percent increase, and almost a double-digit increase the year before.

The really bad news about this is that there's reason to believe this is not just the result of the underwriting cycle. Of course the underwriting cycle in insurance would correct itself, but Gabel and colleagues in this same issue of Health Affairs suggests that this is actually due to an increase in underlying medical claims expenditures, and is not then likely to be necessarily self-correcting.
Percentage of all firms offering health benefits, here we see sort of the end of this era where you're seeing more and more employers offering benefits, at least it looks that way. It's hard to tell from a year or two, but certainly the news isn't good on the information we do have.

Finally here a slide that shows the sort of coverage that employees have. This is an important point to realize, this isn't just a binary decision, an employee is covered or is not covered at the workplace. There are all sorts of different permutations of what different coverage means.

Not surprisingly, this chart in the black area documents the decline of conventional indemnity health insurance over the past couple of decades, where it's a negligible part of the employer market right now.

Again, remarkable growth in PPO plans as well. So, this tells a story of HMO growth, a little backlash as the HMO numbers go down, continuing movement into PPOs, and then again interestingly, a little bit of an increase this past year in selection of HMOs by employees.

It's hard to know exactly why that is, perhaps more employers are offering HMOs in the face of price increases. It may be that HMOs as they have moved to

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looser coverage arrangements have been able to attract consumers again. Consumers may be more price sensitive in an economy that's trending downward, perhaps, as well.

Again, another feature of the employment market is that most consumers or many consumers certainly don't have a great deal of choice in the health care they receive. Certainly if you work for a small employer, defined as under 200 workers in the firm, there's a nine out of ten chance or better that you will just be given a take-it-or-leave-it offer of health insurance through your employer with a plan that the employer picks for you.

There's about a 50 percent chance that the same situation will exist even if you're in a mid-size firm, that is defined as one up to a thousand workers. Only when you get in the large and jumbo firms, meaning firms of more than 5,000 workers, is a pretty good assurance that you are going to have a choice of between two and three and even more health care plans. These results are not surprising, given the administrative costs of organizing that coverage.

This is some survey data, and the question asked is: What decisions are large employers likely to make if the bad economic news continues? And this

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basically, you can see here, it's somewhat likely, very likely. So, it's the purple and white bars that give you a sense of the direction that employers seem likely to move should the economic downturn continue.

You see one thing that's not at all likely is that the employers are going to drop coverage. Most of them say that's very unlikely or perhaps only somewhat likely, and you get up to two percent when you do that.

Restricting employee eligibility, somewhat more likely response. The most likely response, of course, is to increase the amount employees pay, whether it's through cost sharing or through increasing the monthly paycheck deduction for premiums. I know that's a -- that may sound like a nonsensical statement to the economists in the room, but in the short-term sense, at least, that's the idea.

Reduce the scope of benefits, also another possible strategy, but it looks like there's a trend toward greater financial burden by the employees for the health insurance that employers are providing.

There's another trend that's been noted a lot, and I think we don't really have good data to know whether this is a trend or an aberration or a flash in the pan or what, is a trend towards so-called defined contribution plans in health care.
Now, if you're talking about a so-called pure defined contribution plan where the employer basically says, I'm tired of worrying about your health insurance arrangements, here's some money, go buy your own, I don't think that anybody thinks that's a very likely scenario. Certainly the surveyed employee benefits managers weren't interested in that option.

But you do see an interest reflected in the offerings of certain large health plans in MSA type coverage. That can take a variety of different forms that could or could not include flexible spending accounts for employees, but do include, certainly, higher deductibles, a more catastrophic insurance orientation, we're seeing some more of that.

Another sort of option is to provide employees with coverage that is simultaneously potentially broader, more flexible, but more shallow. What does this mean? Broader in the sense that employers in some cases are showing a willingness to cover more items, more items they've particularly been worried about moral hazard in connection with. Procedures that some people would consider optional or a dubious benefit.

The reason that they may be willing to do that is because where coverage is becoming more shallow, that is where there's more cost sharing or co-insurance or a

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greater premium contribution on the part of the employee, then the moral hazard problems tend to take care of themselves. There's a sense that the employee is paying for more of these questionable services if indeed they're questionable, out of his own pocket, and therefore the employer isn't taking the same degree of risk that would otherwise be the case.

Also a trend toward greater co-insurance as opposed to copayments. Again, the point here is that in a copayment situation, say you had a $25 copayment for a physician visit, the consumer's indifference to the complete price that is charged the payer in a situation like that. Whereas if you have coinsurance, the consumer has an incentive to care about the overall price structure of the provider. So that if a consumer chooses to seek care through a relatively expensive network, then the consumer bears at least some of the consequences of that choice, whereas in a copayment arrangement, maybe the copayment varies a slight amount, but once that initial payment is made, the consumer doesn't have much of an incentive to worry about the cost structure that the health plan itself or the employer is facing.

What are the policy trade-offs with these new defined contribution or consumer-driven plans? If we
are going to have shallower coverage and more flexible
coverage and more choice where the consumers can go on
the web and select benefits they want and select networks
they want, that immediately raises the specter of adverse
selection. We get all the healthy people going to the
thin coverage and all the sick people going to the thick
coverage, and soon the thick coverage, the comprehensive
coverage becomes unsustainable.

And of course that's a real obvious problem.

Interestingly, though, and here let me credit Jamie
Robinson, a very interesting discussion of these trends
on the web, the Health Affairs webpage, there are
trade-offs here, though. One of the advantages is to
incentivize cost-conscious employee purchasing, and
given the tax structure that we have, that may be a
benefit that is worth having in some way, assuming we
can find some way to muddle through.

Similarly, if you allow consumers to go on the
web and pick from a range of networks, a range of
benefits and mix and match, you're introducing an
enormous amount of administrative complexity. Indeed,
that complexity is also increased by the fact that
you're seeing different gradations of copayments and
coinsurance, depending on benefit selection in many
cases.
How do you handle all that administrative complexity? Doesn't that create all sorts of efficiency problems? Isn't that confusing for consumers? Well, of course it is, right? The trade-off there is, though, greater consumer choice. So, similarly, diminished cross subsidies, as you focus purchasing and focus price selection, creates a problem, but it also creates an opportunity for lower income consumers who aren't covered in public programs to avoid having to purchase so-called gold-plated coverage if that's not what they want.

Finally, of course, as we all know, I suppose, from the Rand Insurance Experiment a couple of decades ago, cost sharing tends to discourage care that's needed and unneeded, if it's not pretty carefully done. So, there's an issue of diminished access here. But again, Robinson argues that it's not entirely obvious what the policy consequences of that are, and again, there's a possibility to do something about an entitlement mentality that has developed in our society about health care spending and services. Some interesting food for thought at the least.

All right, what about quality? What are we doing about quality? Now this is a subject about which certainly almost everybody in the room has heard
something in the past year or so. I want to talk about it, again, from 10,000 feet, along two dimensions: The first dimension is safety, and the second, we'll just use the word appropriateness, there are different definitions of that.

Patient safety. Well, the IOM published a report a couple of years ago, extrapolating from the data, showing a really deplorable rate of deaths from medical errors. If their extrapolation is right, medical error turns out to be something like the eighth leading cause of death in the United States in 1997. 7,000 deaths alone from medication errors, in that year, and look at the total national costs of preventable injuries.

Preventable injuries. If we're talking about the relationship between quality and cost and coverage, I think we see something important here. Not to mention other social costs that don't come back through the health insurance system.

What about appropriate care? Now, I apologize in advance for using this slide, it's a little bit complicated, but let me try to explain it to you as best I can. On the left axis here, the -- what's that? That's a vertical axis, isn't it? I'm a lawyer, not an economist, but I think that's what that is.

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We have the percentage of these are geographic areas, basically. And what we would like to see in this slide which deals with optimal treatment for heart attack victims is that these four recommended interventions that occur at discharge are occurring for the vast majority of heart attack patients. These are non-controversial interventions that anybody that's had an acute heart attack should have.

All right. So, what we would like to see is that 80 percent or more of the appropriate candidates, in any given region, are getting appropriate care. Well, what would that graph look like? That would be four purple bars going all the way to the top, okay? And we would like to see the green bars and the red bars where it says, these are 60 to 80 percent are getting appropriate care, 40 to 60 percent are getting appropriate care, less than 40 percent are getting appropriate care. We would like to see none of these blue bars and lots of purple bars, okay?

Well, what do we see? Well, we see two -- we see two things here. The first thing that we see is lots of variation. Lots of variation across regions. Right? These are geographically-based distributions, and we see that if you live some places, there are a few places in America where you might actually get beta
blockers at discharge in 1994 and 1995. Hopefully there are more places in '02. So, you hope you live there, right?

And then the question is, how come you get them there, and if you live over here or in most places, it looks like only 40 to 60 percent are going to get them? All right, so we've got this repeat of the story of geographical variations without any apparent rationale in medical science.

The second story, which is at least as disturbing, is just intrasystem performance. Poor performance. Here you have only 2.6 percent of these geographic areas where people are basically getting appropriate care with respect to this measure. 3.6 percent here, 8.5 percent here, and thank goodness, we can remember to give people some aspirin on the way out the door, that's an easier intervention, but one that's very important.

What's notable, not to be carrying a dark cloud around with me, is that in 60 percent of the cases we can't do that or weren't able to do that then. Certainly we can do that, no doubt we are doing better now than we were before, but this is a serious problem. Another example, same sort of thing, I'm not giving you a Rorschach test or anything here, each one
of these little orange dots is in another one of these geographic regions. Now, how many women between the ages of 65 to 69 should have mammograms in a year? The answer should be 100 percent, okay? So, the goal here in terms of appropriate care for this slide is 100 percent.

The top rated geographic area shows that 50 percent were getting the one appropriate intervention. The bottom rated, 12, 13 percent. Where is most of the United States at the time this data is produced? Right down here in a pretty deplorable 20 to 40 percent range. So, again, this is not a pretty picture.

This I'm going to spend a little time on, this is the same song, third verse, and it's harder to explain, but basically what you see here is a big gap. We should have 100 percent eye examination, hemoglobin testing and blood lipids testing for diabetics. We're seeing variation across regions on each of these scores, and overall, a big gap in each of these interventions between where we should be, where we want to be, and even where a benchmark HMO would be.

So, this is a Medicare screening. The slide is not entirely visible, but I think you're beginning to get the point probably.

Okay, what can we do? What can we do about
quality? Well, one thing we could do is decide we're not spending enough, for example, in the Medicare program, and raise costs. Now, my point in showing this slide is not to suggest that Medicare spending is evil or bad or anything like that, it's just to show that it's possible to spend lots of money and not get very much back from it.

So, what you see here is that Texas, for example, Medicare spends lots of money on patients in Texas, per capita. See that? Now, at this time $5,000 to $6,000. What's the quality rating for the care that they're getting Texas Medicare recipients, down at the bottom? You're about 42, 43. Similarly, look at Minnesota, spending much lower, significantly lower, the quality indicator near the top.

So, again, the point is not that Medicare spending is bad, it's just that you have to be careful to consider what it is that you're buying.

I hesitated to bring this slide with me, but I'm going to do that anyway. This slide is not intended to show that physicians are bad either. Physicians are good, even orthopedic physicians and neurosurgeons are good. I can walk today because of something good an orthopedic physician did for me last year. But interestingly, if you notice there's a little trend
Do you see this trend line? This is back surgery rates, normalized where the U.S. is one, and this is supply of orthopedic surgeons and neurosurgeons. What does this tell you? Well, what are orthopedic surgeons and neurosurgeons trained to do? Operate on backs, right? So, what do they do? They operate on backs. Does that mean all this care is inappropriate? No. But it is suggestive that there might be other things we might want to consider as we allocate these resources. Is this back surgery effective? Is it cost effective? Are we getting good outcomes?

Certainly this is not to suggest any sort of venal behavior on the part of the surgeons, the surgeons may not have good data as to what the health outcomes from these interventions are. It's a big problem. If good data exists, it might be very hard for them to get access to it. But it's an important point I think as we go forward.

Okay, quickly, challenges for competition policymakers. Well, I've tried to organize these according to cost and coverage and quality, but obviously there's some overlap there. One is market structure. There are some intractable, or seemingly to us, intractable problems in the way health care markets
work that are challenges as we make competition policy.

   The first is geography. If you live in Alabama like I do, there's places where there's one hospital, one doctor within shouting distance for each sort of intervention you might want to have, and competition seems like a difficult thing to implement. It doesn't mean it's impossible, but it means that you might not be able to have a one-size-fits-all strategy for the entire United States.

   Differentiated products. These are sort of classic competition economics things. You don't have perfect competition where you have differentiated products, or you have information problems. Well, all these things we have in health care. We have an aging population. When we're talking about costs, that's important. We have technological growth at a rapid rate. We have difficulties assessing that technology.

   So, we've got some considerable cost drivers, and lots of the additional spending we may be faced with the choice of doing, lots of it will be very valuable. So, we can't always presuppose that more spending is bad, we have to sort of separate the wheat from the chaff and figure out how we're going to pay for it.

   A second feature that affects our ability to use competition to control cost is the political structure.
And here, let's just begin with the conflicting expectations that we have of markets. We expect markets to control cost for us, but we don't like it when they eliminate the cross subsidies that allow hospitals, for example, to provide things like indigent care. We expect markets to control appropriate utilization, but when a utilization reviewer makes somebody get out of the hospital sooner than they wanted to, we don't like that either.

We expect markets to rationalize our investment in health care facilities, and infrastructure, but we don't like it when local hospitals close and when providers, individual providers are dislocated or watch their economic situations change dramatically in the course of months or years.

So, we live in a democracy. What are those people who come out on the short end of this reallocation do? Well, they come to Washington, or to Montgomery, right? That creates problems to the extent we view competition policy as rooted in some sense of economics, that's good economics or bad economics, this creates a real tension for policymakers.

Now, most of us don't want to do away with democracy either, right? And the same sort of observation I might make about our regulatory
enforcement structure. There might be great ideas emanating here at the FTC, but guess who can undo them? State legislatures can often undo them with the State Action Exemption for example. So, there are numerous venues for rent-seeking activity, and I don't want to get too normative on that, but it's a fact, that you can go lots of places to get relief in our system. That's a good thing, that's one of the reasons most of us like living in America, but it creates problems for enforcement policy.

Similarly, we've got separation of powers. We see the -- a number of different health care competition decision makers in courts and administrative agencies and legislatures. Here in Washington, of course, we've got two different administrative agencies that have something to say about health care enforcement policy. Sometimes even when they try to work together, some politicians won't let them.

In any event, these are the challenges we face. I don't think any of us wants to get rid of democracy or federalism or separation of powers in order to solve them.

Finally, or sorry, I've got two more slides. Oh, good, I'm going to make it and not get tackled.

Coverage. One of the problems that competition policymakers face, too, is the tendency of markets to be
what I've called uncooperative as well as unpredictable. I think if you look back ten, 15 years ago, when the managed care revolution was starting, many of us wanted to pull out Alan Enthoven's book, which talked about consumers having choices between tightly integrated health plans, it made so much sense at a theoretical level that we just assumed that we would know a good market had come to pass, a well-functioning market had come to pass when we observed on the ground the specific entities that were predicted by managed competition theorists.

Well, lo and behold, what happens? Consumers, at least in the past ten years or so, have said, we don't really like tightly integrated networks; we like being able to choose our doctor; we're worried about maybe the excesses of utilization review; if we're given a choice, we want a PPO or a POS plan or something like that. Is that a permanent choice? Can we assume that the market is always going to look like that? No, we can't.

I think the place this comes up is in the question about whether we're going to a defined contribution system and broader, narrower, more flexible coverage or not. We don't know if that's a genuine market response that we ought to try to really deal with and accommodate. Is it a flash in the pan? Is it

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unsustainable? The good thing about economically unsustainable arrangements is they usually don't stay sustained. So, maybe we don't have to worry about that too much, but one of the dangers we can get into is presupposing the final outcome of the market.

Again, we've got vexing insurance problems, I've alluded to some of those about adverse selection, and we still don't do risk adjustment very well to solve that. We don't have good technology to deal with that problem yet. Maybe we're getting better at it, but it's not good.

Finally, rewarding quality. I think there's a good argument that this is the biggest challenge markets face right now. Why? Because quality affects costs, affects coverage, we've talked about already. There's some big obstacles here. The first is just medical uncertainty, right? We just don't have data about the effectiveness of lots of the interventions that are performed on a regular basis.

So, how can you make a good decision if you don't have good data? Well, you have to guess, right? People are going to guess differently about those things. It's hard to know which guesses are right and which guesses are wrong, which is something we would like to know when we're talking about quality without
that data.

Even when we do have the data, providers don't always have it, and if the providers don't have the data, they don't do the right thing and we don't get the quality we want. Focus on systems, again, is something we're working on.

Here's the final slide. Can markets reward quality? I think some people are pessimistic about that. I'm not necessarily pessimistic about that, but here's what you have to have: Some sort of demonstrable differentiation among the people who are giving the service. Markets can't reward or punish very well if consumers can't vote with their feet. And to vote with their feet over quality requires knowing the difference between a high quality provider and a lower quality provider.

So, if you know that, and if the information gets to the consumers, or to the consumers' agents, whether that's an employer or some sort of cooperative, then the possibility is there that people who don't care about quality, don't invest in quality, don't invest in error prevention, get punished for it. That probably would be a good way of getting people more interested in preventing errors and giving appropriate care.

Finally, there's got to be some sort of choice

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and accountability. And again, maybe that choice takes place at the employer level, so that it's not necessarily a disaster if consumers don't have a choice of health plan everywhere they turn in their employment situation. Of course I think most of us would feel better if consumers had more choices on the ground themselves.

All right. I don't want to be entirely negative, I think one thing that you can say positive about our situation, and I think the market deserves some credit for this, is out of the industrialized countries, we are doing the best at investigating the quality that we provide. I think one of the reasons for that is the people who are buying the quality. I think a lot of the large employers have done some helpful work on this, are insisting, are asking the question, what am I getting for the amount of money I'm spending?

That's a very helpful question. To be sure we've got an awful long way to go about answering that question and about disseminating the answers to the public in the form of usable information, but we've come a long way over the past ten years on that score, too. Who had heard of report -- whatever you think of health plan report cards and their effectiveness, who had even heard of one 15 or 20 years ago?

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So, we are making strides. I think the direction we're moving in is good. So, we see some policy opportunities here. I think a critical area is information flow. At the risk of inadvertently offending somebody, I think our competition policy just has to be hard on people who want to restrict the flow of information about what they're doing.

I know there are good reasons to be careful with the way information is presented, but when providers don't want to see that information out there and they ban together to prevent it, I hope as a citizen that the people I'm looking to at the Federal Trade Commission will do something about that.

Well, this has been a story of a transition from, as I said, from a sort of happy last few years, a smiley face the last few years in the health care sector, to one where the future looks considerably more interesting. It makes me think of the old Confucian curse, may you live in interesting times.

Thanks a lot.

(Applause.)

MR. HYMAN: Bill actually spent the last year on sabbatical in England, and I am pleased to hear that the year that he spent living under a constitutional monarchy hasn't changed his view of federalism and
democracy, but one never knows.

Our next speaker is Professor William Vogt, he
is an assistant professor of economics and public policy
at the Heinz School of Public Policy and Management at
Carnegie Mellon. He is also a fellow at the National
Bureau of Economics Research and he is spending -- last
but by no means least -- the year working here at the
Federal Trade Commission doing research in the Bureau of
Economics, and as soon as I get his presentation up, he
can come up and talk.

Bill?

MR. VOGT: I want to thank the Federal Trade
Commission for inviting me and David for all of his hard
work organizing this conference.

So, what I am going to be talking about today is
competition and antitrust in health care markets. So, I
should go on to my disclaimer that, the views that are
presented here are my own and don't necessarily
represent the views of any of the organizations that I
am affiliated with, and in particular they do not
necessarily reflect the views of the FTC or any of its
commissioners.

So, what I am going to talk about today is I am
going to play to my comparative advantage and I am going
to talk about what does the economics literature have to
say about antitrust in health care. My presentation is going to be based on a book chapter that I co-wrote with a colleague of mine at Carnegie Mellon, Martin Gaynor, the chapter is entitled Antitrust, and it's a chapter in The Health Book of Health Economics.

So, when I am doing a review of the academic literature, what I am going to talk about is naturally going to be a lagging indicator of the policy concerns of the moment. Both because the academic literature is a lagging indicator of the policy concerns of the moment because it takes a while to do academic research, and also because the chapter was written a little while ago, it was written in 1999, although I am going to try to update the material presented there where that's relevant.

It turns out that the academic literature on health care antitrust is very hospital merger-centric. Hospital mergers were a very hot issue in the '80s and the early '90s, and academics produced a vast profusion of work on that topic. That's mostly what I am going to talk to about today, because that's mostly what academics think they know something about.

However, there's also some work that's been done on HMO mergers, there's a little bit of work on monopsony and there's a little bit of work that's been
done on vertical restraints and integration.

The first thing that I am going to talk about is hospital mergers. When a court or internally at the FTC or the DOJ, when I do an analysis of a merger to see whether that merger should be challenged or whether that merger should be permitted to continue, they go through a fairly routine set of steps in their analysis. The ultimate goal of the analysis is to decide will this merger harm consumers, either by increasing price, or reducing quality, or by having some other affect adverse to consumers?

What they do when they analyze one of these mergers is the first thing they have to do is define what market are these merging firms in. There are two characteristics of the market that they want to define.

The first is the product market: What do these firms sell? Typically in a hospital merger case, the product market that the firms are found to be in is the market for in-patient hospital services. It's kind of an agglomeration of the hundreds and thousands of kinds of treatment that the hospitals actually produce.

The second thing that the antitrust agencies and the court have to do is to determine what's the geographical market for the service. If the geographical market for hospital in-patient services were the entire
United States, then that would be 6,100 firms in that market, and a merger between any two of them would probably raise no antitrust concerns whatsoever.

So, the objective, then, is to draw a line around the two merging hospitals and to determine how big is the market and how many of those firm's potential competitors should we count at competitors in thinking about whether competition is going to be harmed. So, the next step is the identification of competitors, that just amounts to looking inside the circle that's been drawn. And then they calculate indexes of one kind or another to try to determine how concentrated is the market before the merger, how concentrated is the market after the merger and does this change in concentration lead us to think that price will go up or quality will go down?

Finally, the courts or the enforcement agencies consider what other factors might mitigate or exacerbate the exercise of market power and the harm to competition. Typical things considered there are the efficiencies defense. Often the firms argue, if you let us merge, we're going to realize huge cost savings, those cost savings are going to be passed on to consumers so prices won't go up.

Another mitigating factor often considered is
entry. The firms might argue, look, maybe we could harm consumers if we merged, but what's going to happen is as soon as we try to harm consumers, some other firm is going to enter, because that's going to provide them with an opportunity to serve consumers better.

Another mitigating factor that's been brought up in health care antitrust is the sort of the not-for-profits defense, which is that the merging hospitals say, yeah, maybe we can get market power by merging, maybe we could theoretically harm consumers with this power that we get; however, we're not-for-profit institutions, we care about the welfare of the community, and so we're not going to use any market power that we get to hurt consumers.

So, this is to sort of set a framework for what goes on in analyzing a merger so that I can then point to which parts of that I think the academic literature has something to say about.

So, here's a list of hospital merger cases. They are more or less in reverse chronological order, and I believe that the most recent ones. And as you can see, and let me point out that the column winner does not necessarily reflect the final disposition of the case.

In particular, the District Court's decision in
the Augusta case was eventually overturned by the Circuit Court, and it's roughly correct to say that the government ended up winning that case. However, the District Court did decide in favor of the hospital. So, since the purpose of this graphic is to show you the kinds of places in that structure that I presented on the previous slide that economic analysis might help us with the fact that some courts thought the not-for-profit defense is relevant.

So, the obvious thing here is that the hospitals always win, that's true since 1991. And the variety of different reasons that the government loses. So, going back just quickly to this merger analysis, what happens is the government presents to the court proposals for what they think for each of those bullet points the correct analysis is. And if the government wins on all of those points, then the merger is stopped. If the people trying to merge manage to break the government's case on any one of those points, the merger is allowed to go through.

So, this column that says Reason, there isn't any reason to give you when the government wins, the reason the government wins is that it wins on all of its points. So, when the government loses, there has to be some reason that the government loses from those points.
So I am giving you the typical reasons. The typical reasons are geographic markets, product markets or this not-for-profit defense.

So, now, again, referring back to the slide two slides ago, I talked about calculation of indexes of competition. The most common index of competition that's used, or that has been used in hospital merger cases is something called the Herfindahl-Hirschman Index. The Herfindahl-Hirschman Index is an index of how concentrated a market is.

The highest value the HHI can take is 10,000, and that would represent a monopoly, one single firm controlling the market. The lowest value it can take is zero, and that would present sort of textbook perfect competition, so an infinite number of firms each with no market share.

And the government has a benchmark for what makes a market highly concentrated. So in highly concentrated markets, the government would argue that one should be very suspicious of merger.

The government's threshold for a highly concentrated market is an HHI of 1,800. So, what I want you to take out of this slide is if you look in the post HHI column, in essentially all of the markets that this slide considers, the Herfindahl-Hirschman Index was high.
enough that one would think that all of these mergers should have been illegal.

The government lost in particular in the three rows of the table in red. Now, I can't have entries in this table for cases where the government lost on market definition, because if the government lost on market definition, then there isn't really a calculation of the Herfindahl-Hirschman Index.

The Poplar Bluff case I've left in the table because of the District Court level the government won on market definition, so I can calculate HHI, but then at the Circuit Court level the government lost on market definition, so this disappeared.

So, in the cases in red, the government lost, even though in all of those cases -- well, not in Joplin, but in the other two cases, the market was highly concentrated and the merger caused a large increase in the Herfindahl-Hirschman Index, in this index of concentration.

So, the reason the government lost, the most important reasons, the first is the not-for-profit defense. In Grand Rapids, Joplin and the Augusta cases, the hospitals argued, look, we're not-for-profit organizations, if you let us merge, maybe we could get market power, maybe we could harm consumers, but we
won't. And we won't because we have good motivations.

We don't want to harm consumers, we're not trying to 
maximize profits, we're trying to serve the community.

In the Grand Rapids case, the court also found 
the efficiencies defense persuasive. In the 
efficiencies defense, the hospitals argue, look, we're 
going to merge, we're going to realize great cost 
savings from this merger, and we're going to pass those 
cost savings on to consumers, so actually we're going to 
help consumers by merging.

Finally, all the other cases were on market 
definition, that was typically on geographic markets,
sometimes on product market.

So, the things that economists have thought 
about, at least a little bit, that are relevant to this, 
is the question of are not-for-profits different?

There's actually a huge economic literature on whether or 
not not-for-profits are different, and there's a pretty 
large economic literature on the question of whether 
not-for-profit hospitals are different from for-profit 
hospitals.

Another point we believe, some research of 
whether or not there are efficiencies, and there's 
actually a pretty big literature on the question of 
what's the right size for a hospital, does making a
hospital bigger actually reduce costs per case, and so on.

There's a large literature asking the question is it the case that when a hospital market is more concentrated, prices are higher? There's also literature on whether hospital prices rise after a merger.

Okay. So now I'm going to talk about not-for-profit status. Well, the question of whether or not not-for-profits are different is, as I mentioned, actually very well studied in economics. There's a very good chapter, again in the health book Handbook of Health Economics by Frank Sloan in which he basically analyzes this literature about whether not-for-profit hospitals are different from for-profit hospitals.

So, the questions that we might want to ask ourselves about not-for-profit hospitals is first of all just the general question of is it the case that not-for-profit organizations which provide outputs in a goods market actually behave differently from for-profit organizations at all.

Suppose the answer to that question were to be yes. That still wouldn't be enough to justify the not-for-profit defense because we would still want to know, well, is that difference in behavior relevant for
antitrust purposes? So, maybe these not-for-profit organizations do behave differently from for-profit organizations, maybe they like to generate profits and then spend it on high-tech medical equipment or they like to generate profits in order to fund lots of charity care and so on and so forth.

For those kinds of motivations, it probably is not the case that the differences in motivation between for-profits and not-for-profit organizations would be relevant from an antitrust perspective because still, if the not-for-profits merged, they would have an incentive to jack up the prices on the people who can pay in order to get this fund of money to spend on all the nice things that they like to spend money on.

So, the difference between not-for-profits and for-profits has to be such a difference that it makes them want to pass on any savings to consumers, and it makes them want to not jack up prices on people who can't pay.

First on the general question. As I said, there's a pretty big literature on this, and Frank Sloan reviews it very ably. He goes through all of these different points on how might the behavior of not-for-profits and for-profits differ. One thing you might think is that costs might be different between not-for-profits and for-profit organizations, and there
are lots of reasons to think costs might be different. You might think that not-for-profits, not having the discipline of stockholders and the potential for takeovers and so on, might become lax and inefficient and have high costs.

On the other hand, you might think that because not-for-profits often have access to debt financing at tax advantaged rates, then maybe they should have lower costs than for-profit hospitals.

The literature on this point basically says that there isn't a difference, or at least there isn't a detectable difference in costs for for-profit and not-for-profit hospitals, they're very similar. The same thing is true for pricing. Perhaps there's some evidence that not-for-profits charge a slightly lower price than for-profits, but the evidence is decidedly mixed on pricing as well.

So, the place that you might really believe that there would be a difference is in charity care. Not-for-profits invariably in their mission statements claim that charity care is one of their missions, and of course for-profits don't have charity care for one of their missions. They may do it because they're required to do it, but certainly it doesn't enhance the bottom line.
But, even in this case, the literature is reasonably clear that the not for-profits don't provide very much more charity care, if more charity care at all. In fact, what small difference there is in charity care is accounted for by the location of the not-for-profit hospitals.

So, for-profits and not-for-profits located in similar markets, in similar places, provide the same amount of charity care. It's just that not-for-profits tend to locate more often in central cities where there's more charity care to be done. So, in fact, the behavioral difference in charity care is very small or nonexistence.

Similar things are true with technology. It is the case in general that not-for-profit hospitals are larger than for-profit hospitals, they treat more patients in average, they have more beds on average, and so on. But if you control for the size of the hospital, it's not the case that not-for-profit hospitals are more or less technologically advanced than for-profit hospitals in general.

Again, for all of these points, I am generalizing over a large literature, so there are likely to be particular findings in particular studies where what I am saying isn't exactly true. I'm talking
about sort of the broad pattern of evidence.

Again, the same thing is true for quality.

There aren't any detectable quality differences in terms of, say, mortality between for-profit and not-for-profit hospitals.

A final source of evidence that you might look to is it makes the news quite a bit that many hospitals throughout the '90s, in particular, were switching ownership status from not-for-profit to for-profit or from for-profit to not-for-profit. There are actually quite a few switches in each direction. It is the case that switching status, either from for-profit to not-for-profit or not-for-profit to for-profit does change outcomes you might be interested in. Prices, cost, profits and so on, but it seems to be the conversion itself that causes the change and not the ownership status.

So, a hospital changing from not-for-profit to for-profit looks about the same in terms of its changes as a hospital changing from for-profit to not-for-profit.

Finally, the evidence from other sectors of the economy where not-for-profits and for-profits compete in good-producing sectors, and from other countries as well, is that the critical factor is not the ownership.

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of the institution, the critical factor is how competitive is the market?

Monopolies, whether they're for-profit, not-for-profit or government-owned, tend to be lax about cost, not innovating, whereas institutions in highly competitive markets tend to have low prices, low costs and so on. The ownership status is not nearly so important as the competitiveness of the market that it's in.

Pricing and competition I am going to talk about a little later. So, let's go on to talk about efficiencies. The question that's usually posed in terms of efficiencies are whether there are what's called economies of scale. Remember these hospitals are claiming in their efficiencies defense, all right, we're going to merge, we're going to save lots of money and we're going to pass on the money to consumers.

The way that this is addressed in the economics literature is the economists have looked at hospitals of different sizes, and asked: Do the big ones have a lower cost per case than the little ones? If so, that's evidence that being big saves money.

Well, there are two problems with using that literature that answers the efficiencies defense question. One is that when two small hospitals merge,
it's not clear that what they make is one big hospital, because they often keep both campuses of the hospitals open, so no one achieves the kind of integration that you might expect to lead to these economies of scale.

The second problem with that literature is that if cost per case goes down, that doesn't necessarily tell you that the savings are going to be passed on to consumers. Even if you ignore that first problem, the fact that costs are going down doesn't mean that the consumers are going to save money, it means the costs are lower.

With that being said, there's a pretty large literature on this question of hospitals, and again that literature compares big hospitals to little hospitals and looks at cost per case. What this literature basically says is that I think a fair summary of this literature is that it's all over the place. But if we're willing to be very broad-minded about what patterns we want to draw out of this literature, it's probably the case that there aren't very large scale economies above about 200 beds.

So there's an older literature and a newer literature, but both are about the same. There's one, at least is I see it, big problem with this literature, which is that there are usually not very good controls
for case mix. So, let's take my broad-minded summary as given. Let's suppose costs per case are exactly the same at little hospitals and big hospitals. Or at least as long as they're bigger than 200 beds.

Well, if it's the case that big hospitals tend to treat sicker patients, and lots of people think that is the case, then the fact that they have the same cost per case, little hospitals and big hospitals, actually says that there are economies of scale. That big hospitals are cheaper and they only look like they cost about the same because their patients are sicker.

And there is some recent work examining this, somewhat obliquely, which basically says that that is a big deal. That if you omit these important variables like case mix, that biases greatly your measure of scale economies.

So, I'm going to go back to my previous point, which is it's often the case that these hospitals don't actually combine their campuses, they keep their campuses separate. So, their efficiencies defense tends to rely on things like, well, we're going to integrate our laundry services and we're going to eliminate our administrative services and that's where all the savings are going to come from. This isn't the case, by the way, in every hospital merger, but most of the time this
is what the efficiencies defense looks like.

There's a paper addressing exactly this question, which is, okay, let's not look at overall scale economies, let's just look at scale economies in laundry and administrative expenses and so on. Interestingly enough, that paper comes to exactly the same conclusion that the broad-minded summary of the overall literature comes to, which is that there are some scale economies but they're mostly gone by about 200 beds. Once you get up above 200 beds, there aren't any scale economies left to be had.

On the related question of do mergers raise prices, there are two paradigms for addressing that question. One is called the structure conduct performance paradigm. The structure conduct performance paradigm basically says, we're going to look across markets. We're going to look at markets where there are only a few competitors and we're going to look at markets where there are lots of competitors and we're going to compare prices in those two kinds of markets, controlling for everything that we think we can control for.

A second method of looking at this question is to do event studies. An event study means we go and we look at a merger and we say, okay, in this market two

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hospitals merge and we look at before and after and see
how the prices moved compared to some control group
somewhere where there was no merger. Let me start with structure
conduct performance studies. There are a very large number of these
studies, there are two slides worth. And let me talk about how the
price effects in these tables are calculated.

What we did was to take a large bunch of
studies and to ask the same question of every study,
which is let's imagine that there is a market with five
equally-sized hospitals in it, and let's imagine that
two of those hospitals merge. So, a market with five
equally-sized hospitals would have Herfindahl-Hirschman
Index of 2,000, so it would be highly concentrated. And
we're going to ask, what would happen to prices if two
of those hospitals merged?

Here are the results of a bunch of
studies. You can see that because data is very easy to
get in California, and because California is a big
state, lots of studies are done in California.

Now, for the most part these studies find that
prices go up in markets that are more concentrated. So,
the fewer firms there are, the higher prices are in
general. But first of all, you notice the empirical
base is quite narrow, it's mostly California, and even
if we look at some of the older studies, it's still the
case that most of the empirical basis is California.

Now, there are a couple of interesting patterns in these two tables. The first is that in general the California studies show bigger price effects than the studies in other places. So this Michigan study actually showed a price decline from the merger and this study of Indiana showed a very small price effect, and note the study of the entire U.S. showed a negative price effect.

In general, the California results show a bigger merger effect than the results from other places. It's also the case that these studies tend to show that the price effects are bigger in more recent years. So, hospital mergers look more and more like what we think of as normal markets, as normal mergers in more recent years.

And what both of those points might make you think is that managed care is important. California has higher managed care penetration than the rest of the country, and it's the case that managed care penetration has been going up over time. So, maybe the fact that more recent data in California data give you a bigger effect is because managed care is somehow important. You might think that's important because managed care organizations tend to be sort of aggressive shoppers for
price discounts, and so should make competition more important.

There are a couple of studies that find exactly that. Where managed care penetration is higher, there are lower costs, lower prices, and when managed care penetration is higher, the association between price and concentration is stronger. Managed care organizations do a better job of playing competitors off against one another than non-managed care payers.

So, let me go back to this other question of other not-for-profit differences. There are a few studies that break out the effects of the standardized merger between for-profit organizations and not-for-profit organizations. In general, there's a finding of larger effects for for-profits, but with the exception of a couple of studies by Bill Lynk, in general, the not-for-profit mergers also cause price increases.

So, it's hard to just generalize greatly based on five studies where the vote is three to two, but there's more evidence that not-for-profits are the same than there is that not-for-profits are different.

Another place that you might think consumers might be harmed by merger is in quality. There is some literature on the relationship between
concentration and quality. There's an early literature from the '80s which is called The Medical Arms Race Literature, and the idea of this literature is, let's see whether or not hospitals compete on quality dimensions.

This literature look at things like are costs higher where there are more competitors, that being some kind of indication of the hospitals spending more on quality. Or are there more high-tech services in markets where there are more competitors? Again, some kind of indication that the hospitals are competing on quality.

That literature found that yes, both of those things were true. Where there were more competitors, there was higher costs, and more technology.

There are a few recent high quality papers which show some association between concentration and mortality. What these two papers show is that in markets with a high concentration, in markets closer to a monopoly, risk adjusted mortality is higher. The second paper, they don't find that for the Medicare populations, although they do find it for the private insurance populations.

Next, event studies. I am going to blaze through these event studies. I have two event studies to talk about, one is by Krishnon in the Journal of Health Economics, the other is by Vita in the Journal of Health Economics, the other is by Vita in the Journal of...
Industrial Economics and there are a couple of papers by Connor, Feldman, Dowd & Radcliff. We'll talk about the first two first.

The Vita study and the Krishnon study, the methodology of all these studies is the same, they identify the mergers and look at how was price moving before the merger, how was price moving after the merger, and then they found comparison groups and note out how was price moving in comparison groups before and after the merger.

What the first two papers show, what Vita and Krishnon both show is that price goes up when the merger occurs. Krishnon's findings is about nine percent, and Vita's finding is 25 percent.

There are also several papers by Connor, Feldman, Dowd & Radcliff. They examined 122 mergers from '86 to '94, and they find basically no price effect. They find actually a small price savings to consumers from the mergers.

There's one kind of odd thing about these studies which is that the Herfindahl-Hirschman Index actually decreased in the merging markets relative to the non-merging markets. And that doesn't make a lot of sense if you think that the merger is increasing concentration. It should happen that the
Herfindahl-Hirschman Index goes up.

So, I think one interpretation of their findings, and an interpretation that I don't think they would be terribly distressed about, is that a lot of these mergers went back to the failing firm mergers. There were a bunch of firms that were going to fail, some of them merged and some of them didn't. In markets where they didn't, the Herfindahl-Hirschman went up because the firms failed, and in the markets where they did, the Herfindahl-Hirschman went up because of the merger.

There is also a small literature on HMO mergers, looking at HMO mergers between '85 and '93 in papers like Christianson, Engberg, Feldman & Wholey. They found no detectable effects in mergers on premiums. However, in cross section, if they did obstructed conduct performance kind of analysis rather than an event analysis, they did find that prices were higher in markets that had fewer HMOs.

So, those two findings are obviously in tension with one another, one says mergers have an effect, one says that mergers don't. And the way that they resolve that is again with this kind of failing firm idea. So, from '85 to '93, it's the case that there's a shake-out in progress in the HMO industry and lots of plans are failing.
And those plans could fail in two ways: They could fail by going out of business or they could fail by being taken over by some other HMO's plan. And what they did is look across states at the aggressiveness of antimerger regulations. And they found that in states with very aggressive antimerger regulations, mostly HMOs fail. In states with not very aggressive antimerger regulations, most of the HMOs were acquired. So that most of the mergers that were going on at this time period in their data, I think, are mergers of a failing firm. So, it isn't particularly surprising that there isn't a big competitive impact with that.

Monopsony. There's a relatively small literature on monopsony power, and monopsony is sort of the opposite of monopoly power. Monopoly power the idea is that monopolists can jack up prices for a service that it sells. In monopsony power the idea is that a big buyer can jack down prices for a service that it buys.

So, there is a fair sized literature with, I think, actually, pretty serious problems, so I wouldn't put a whole lot of stock in the development of this literature, which basically says that hospitals that have a higher share of their patients from Blue Cross/Blue Shield give Blue Cross/Blue Shield a bigger
discount.

Again, there's a small literature on bilateral monopoly. It has been argued that given that the payer side is highly concentrated, it might be a good idea to let the provider side become highly concentrated, so that both sides have bargaining power and their bargaining power can balance off against one another.

Again, this literature isn't especially strong or large, however there is this one study by Melnick in 1992, again, about Blue Cross/Blue Shield which finds that hospitals that have a high share of their patients coming from Blue Cross/Blue Shield get lower prices, but hospitals which provide a high proportion of Blue Cross/Blue Shield's care in a particular market area get higher prices. And the idea is that maybe the first bullet point is a measure of Blue Cross/Blue Shield's power pushing down prices and second is -- sorry, the third is a measure of the hospital's power pushing up prices.

Finally, vertical restraints in integration. There have been two kinds of vertical restraints which have been studied at all in health care cases, and the literature here is very, very thin. First most favored nation clauses, and then physician hospital organizations.

Let me tell you what a most favored nation
clause is. One contractual form that you can have

is that the buyer of a service negotiates with the

seller and says, okay, let's agree on a price. They

agree on a price, and then the buyer says, oh, but by

the way, if you sell to any other buyer at a price lower

than this, I want the lower price. If the seller agrees

to that, that's called a most favored nation clause.

There's sort of a reason, and at first blush, of
course, you might think, well, that's no problem at all
for competition, because that's just ensuring that

everyone is getting the low price and isn't that what

markets are supposed to do, deliver on the low price?

But that contract term does create incentives for conduct that

undermines competition by the seller.

If you think about the seller that signed a

most favored nation contract, and they are now going to

negotiate with another buyer, and that buyer is trying
to push down their price. When they think about their

incentive to cut their price to that new buyer, that

incentive is blunted by the fact that if they cut their

price to the new buyer, they have to cut their price to
the old buyer, too. So, their loss and profits from the

lower price is much larger than it would be absent the

most favored nation clause and that gives them incentive
to keep their price higher.
All right. So, there's one paper that I know of about this, which is that effective in 1991, Congress passed the law in 1990, Congress imposed essentially a most favored nation clause for drugs for the Medicaid program. Actually the law is much more complicated than that, but one of the things they did is create a most favored nation clause.

Now, if it's the case that most favored nation clauses increase the price, then we ought to see the price of pharmaceuticals going up in the aftermath of this, and that's roughly what happened. So, there is a paper in the Rand Journal of Economics which found that there is about a four percent price increase caused by this most favored nation clause.

Finally, there's a working paper about the integration of physicians with hospitals. The kind of things they're interested in are physician hospital organizations and in particular they're interested in physician hospital organizations that are exclusive. So, these are agreements in which the physicians say, we're not going to practice at any hospital except yours.

Again, there are two sides to these regulations, one side which is sort of the old Chicago School way of thinking about this stuff is that, well,
that's got to be a good thing. It must be the case that there are efficiencies to be had from coordination. In fact, in this case, there are reasons to believe that. You would think that you might save on duplicative tests and other things by having the physician in the hospital integrated.

On the other hand, when one hospital in a market locks up a group of physicians, that means those physicians aren't available to the other hospitals in the market which is likely to decrease their attractiveness to patients and payers, which is likely to increase the demand for the hospital that has the exclusive arrangement, allowing them to increase the price.

So, this paper is about figuring out which of those two is going on. What they find is that closed physician/hospital organizations, but not open ones -- the open ones are ones that permit the physicians to practice at other hospitals -- closed physician organizations generate about a 30 percent increase in price. Simultaneously, they generate an increase in volume, and the idea is that increase in volume comes from the fact that now the other hospitals in the market are less attractive because the physician has been locked into the first.
There's also some evidence, however, that there is an increase in quality caused by these physician/hospital organizations. So, it isn't a slam dunk that these things are anticompetitive, there are two things going on, quality goes up and price goes up.

So what are the conclusions from the academic literature? There's a robust relationship between price and concentration. More concentrated markets have higher prices. That's especially true when there's a lot of managed care penetration.

There's mixed evidence on efficiencies. It may be the case that big hospitals are cheaper, it may not.

I don't want to overplay the last point, but in my view, the balance of the evidence is that not-for-profits are not different from for-profits. Not-for-profit hospitals are not different from for-profits in antitrust relevant ways, but that literature is by no means settled and it could happen that my conclusion would change tomorrow.

I think that is all that we have. No, I don't.

There is also some small evidence of HMO mergers. There's a little bit of evidence of a price concentration relationship among HMOs, not as strong as for hospitals, and there's some evidence both of efficiencies and from price increases from mergers.
There is also some evidence of scale economies, but this is based on a pretty narrow empirical base and I wouldn't want to be too aggressive in conclusions from it.

Finally, based on a very, very weak empirical base, one paper each, there is some evidence that most favored nations, so this is vertical restraints, there's some evidence that most favorite nations clauses increase prices and there is some evidence that tight vertical integration increases prices.

Finally, on monopsony -- well, on monopsony, evidence is especially weak, but there is some evidence that insurance plan market power causes lower prices for providers.

Thank you.

(Applause.)

MR. HYMAN: Thank you, Bill.

I think we're going to try and keep going with the hope that we'll stay on time between now and lunch.

Next up is Cara Lesser from the Center for Studying Health System Change. That takes us from the macro or 10,000 feet perspective to the micro 12-community perspective. Those of you who are like me on the mailing list for the center, every week or so we'll find something new in your mailbox and even more
frequently on their website. We are very lucky to have Cara who is the project director for the 12-city study here to talk about some of the results and recent developments in health care markets, and the policy implications for competition law and policy.

Cara?

MS. LESSER: Thank you.

Well, as David said, I am going to take us down a little bit to a ground level perspective of what's happening in local health care markets across the country based on work we've been doing in the field since 1996.

Let me just start by giving you an overview of the major points I want to make today. First, to provide some further context for today and tomorrow's discussions, I want to highlight what we see as the two major trends shaping health care markets over the past several years, and that is the rapid ascent and subsequent retreat from tightly managed care and then the second is consolidation.

Together, these trends have had really visible effects on local market dynamics and on health care cost trends, and I am going to talk about those effects more specifically. And finally, based on these observations, I want to highlight what we've learned in terms of
competition in local health care markets and leave you
with some thoughts about where we think we're headed in
the near future.

Before launching into this discussion, let me
just step back for a minute and give you some background
on my organization, the Center for Studying Health
System Change. HSC was established by the Robert Wood
Johnson Foundation in 1995, just on the heels of the
demise of the Clinton health reform effort, as it became
really clear that we were embarking on significant
market-based change in the health care system in this
country. The foundation created HSC with the goal of
tracking those changes and their impact on people and
really a focus on highlighting the implications for
policymakers.

Our mission is to provide timely and objective
information to policymakers and decisionmakers in the
industry who are shaping the changes we're observing.
The core of our work is the community tracking study,
which is an independent research effort to track health
system change and its effects. The study is
longitudinal, and as I said in the beginning, it's been
ongoing since 1996.

As the name implies, the study has a community
focus, based on the notion that ultimately all health
care is local. We defined our communities based on MSAs as defined by the Bureau of Economic Analysis, and this allows us to have a consistent measure of a geographic market over time.

Obviously this is somewhat different from how actors in the industry may define their geographic market at different times, but this allows us to have consistency from year to year.

In some cases, the market area is somewhat broader than market actors would describe it, in other cases there are some clear geographic submarkets within our MSA definition of the community.

We have multiple ways that we collect data in these communities. We conduct surveys of households, physicians and employers, and we also conduct site visits every two years. I should back up and say that we have a total of 60 communities that were selected, they were randomly selected to be nationally representative. So, while we do have this local focus, we also have the opportunity to aggregate up our findings and talk about national trends.

Our site visits are conducted in a subset of 12 of the 60 communities that also were randomly selected, and those represent a population of 200,000 or more. In the site visits, we interview anywhere from 50 to over
100 leaders of the local health system, including representatives of the major local health plans, hospitals, physician organizations, representatives of major local employers, state and local policymakers, so it's really getting a broad perspective on the health care market as a whole. We conduct our site visits every two years.

This slide just gives you a map of the 60 study sites, highlighting the 12 where we conduct our site visits. As you can see, the sample is geographically diverse, and the communities vary in size as well as managed care characteristics and general health system characteristics.

We have a number of large metropolitan areas, such as Boston or Miami, Orange County, California, as well as smaller communities that have less experience with managed care like Little Rock and Greenville, South Carolina.

So, unlike other studies that focus on particular communities that are viewed as leaders or the bellwether of change, studies that focus on Minneapolis or Southern California, our work really is able to capture the diversity of change occurring across the country and provide a more balanced view.

As David mentioned, we are very busy at For The Record, Inc.
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disseminating our work. We produce a whole range of research products. We have issued briefs and tracking reports that are our own publications, community reports that highlight the really case studies of the individual communities and how they're changing every two years. We also publish in peer review journals. In order to get our work out more quickly than peer review journals sometimes allow, we have a working paper series to really allow us to disseminate the work there to the policy community more quickly.

We also conduct briefings with policymakers and speak at conferences and meetings like today. All of our work is available on our website, hchange.org, I've also prepared a list that I think is available on the table up front, selective publications that I thought would be of particular interest to this audience. So, that might be worth picking up.

Okay, getting into the meat of the talk, as I said at the beginning, I want to talk about two major trends that have been shaping the health care system since we've been tracking it, since 1996. And of course, the first major trend was the growth of managed care. In the early to mid-1990s, the economy was quite sluggish, and we were in a period of rapidly rising health care costs, and employers become very aggressive
in shifting their employees into managed care options, and there was rapid enrollment growth in HMOs and PPOs. This set off a wave of change in health systems across the country, based on the real or expected growth of tightly managed care arrangements. Throughout the industry, there was the expectation of increased reliance and selective provider networks. That would allow plans to drive business to more efficient providers. In this context, providers proved very willing to accept often steep discounts in exchange for volume. Or promises of volume I should say.

There was increased use of gatekeepers and prior authorization requirements to control utilization, and expected growth of capitated payment to give providers greater financial incentives to managed care. So, the combination of these factors gave health plans tremendous leverage and really put providers on the defensive.

So, take two, not too much farther down the road, by the late 1990s, managed care experienced an abrupt reversal of fortune, as really intense consumer backlash against managed care took hold. This coincided with a time of great economic boom, so a real contrast to the time when managed care was in ascendance, and also incredibly strong tight labor market that made
employers much more amenable to their employees' demands
for open access to care.

During this time, HMO enrollment stagnated, and
plans moved toward more open access products with looser
utilization management, and an emphasis on broader
provider networks that could protect consumer choice.
Both plans and providers moved away from risk
contracting arrangements, in part because these were
more difficult to operationalize in the more loosely
managed health insurance products, and in part because
this environment gave providers more leverage and they
were able to push back in their negotiations with plans
to get out of these risk arrangements that many had come
to view as really a losing proposition.

Meanwhile, a second related trend developed, as
we've been talking about this morning, and that's the
move toward consolidation. There is a great deal of
experimentation with new organizational forms, as
managed care was growing, but the key strategy that's
really had lasting effects on the organization of the
delivery system is horizontal consolidation,
particularly among hospitals.

In contrast, physician markets have changed
relatively little and remain really fragmented. And
while there was some consolidation among health plans,
the focus there was really on more of this cross-market, cross-geographic market concentration or consolidation as opposed to the consolidation within markets that hospitals were experiencing.

So, let me go into each of these in a bit more detail. As we heard about just before, there was extensive merger activity in the early to mid-1990s. In the time period of just 1994 to 1997, there were 700 hospital mergers reported during that three-year period. Although at the time, there was a great deal of attention to the growth of for-profit hospital chains, such as Columbia HCA, really the majority of hospital mergers that occurred during this period involved local, not-for-profit hospitals merging with one another.

Often these mergers involved leading hospitals in the community and hospitals of considerable size, of 400 or 500, sometimes even a 800 or 900 bed hospitals merging with one another. In some cases, the mergers involved one hospital being absorbed by another in a true sort of takeover model. So, for example, that's what we saw in Lansing, one of the communities we track where Sparrow Health System absorbed St. Lawrence Hospital and they became a merged entity.

In many other cases, we saw mergers of equals, where two hospitals were consolidated under a single
system, but really retained their underlying identities. This was a really common strategy for the academic medical centers, in particular.

So, for example, in Boston, this was how Massachusetts General Hospital merged with Brigham & Women's and they performed a partners health care system, but both Massachusetts General and Brigham & Women's remain as independent entities.

The same in Indianapolis, Indiana University Hospital and Methodist Hospitals merged to form the Clarion system, but still remain as two independent entities.

Regardless of those differences, we found that hospital mergers were driven by two primary goals: The first was to streamline operations in order to survive the discounts under managed care, and the second was to improve leverage in negotiations with health plans.

Tracking the hospital mergers in our sites, and we saw mergers in ten of the 12 sites in our first round out, we saw results pretty similar to what you heard described from the literature. There was extensive administrative consolidation in the majority of the mergers that we observed. That really did yield some significant up-front savings, but those savings also were offset to some degree by the added costs associated
with the system-level administration that was required.

So, for example, one system reported $160 million savings in the first three years after their merger, but then have estimated $50 to $60 million costs annually just for the system costs. So, there's a trade-off there.

While there was extensive consolidation of the administrative services, such as purchasing and finance, there really was very little consolidation of clinical services or of capacity. In general, this was a period of downsizing for the hospital sector, but we found it was not common to see greater downsizing as a result of the mergers in these cases. In fact, it was just as common to see expansions of services and expansions of capacity to take advantage of the geographic breadth in the merger partners brought them.

So, despite limited consolidation in terms of clinical services and capacity, there was a clear effect on the markets in terms of increased concentration of ownership. This next slide really captures that. This graph shows hospital concentration as measured by total adjusted in-patient days. It shows how it's increased between 1996 and 2000, so it's really capturing our 12 sites right at the time that merger activity was at its peak and looking at how it's affected the concentration.
of markets today.

The actual level of concentration of these markets is somewhat skewed by the size of the market. Remember, our market definition is the MSA, so this really isn't necessarily how the hospital geographic market lines would be drawn, but what's really important to focus on here is the consistent increase that you see when you look across these bars.

So, Lansing on the right is off the charts really, and that's in part because it's such a small market relative to the other ones that we track. And Boston on the left is very moderately concentrated because it's such a large population. We define the Boston area as the four million plus people who live in Boston itself and the surrounding suburbs.

So, focus less on the actual level than on the change that you see here. There really is a consistent trend across the 12 markets that we track of increasing concentration.

Some markets have seen real sizeable jumps. Cleveland, for example, went from a Herfindahl here of less than 1,000 to just under 2,000 in this four-year period. This was the result of a series of mergers and acquisitions, and the closure of one downtown hospital. Today the local hospital association in Cleveland
estimates that the two major systems there, the Cleveland Clinic and University Hospitals and Health System now account for just under 70 percent of the beds in the total Cleveland area.

While there's been substantial consolidation on the hospital side, as I said, there's really been relatively little consolidation on the part of physicians. Despite expectations about managed care and the need for large physician organizations to manage and coordinate care, there's really been very limited growth of large groups.

Let me just flip to this next slide to give you a graphic here. This slide is based on our physician survey data and it shows the distribution of physician practice size and how it's changed from between 1997 and 2001. As you can see, the bulk of physicians continue to practice in groups with fewer than ten physicians, but at the same time there has been some growth, especially over the past couple of years, in groups with three to nine physicians in particular.

Most of the growth that we're seeing in this three to nine physician category is really attributed to growth in single specialty groups. Primarily procedure-based specialties like cardiology, orthopedics and oncology.
These groups, which we've really been seeing develop across the country, are motivated by two goals: One is to attain the scale necessary to purchase technology and facilities that allow the physicians to supplement their professional fees with profitable revenue from these other sources. The second goal, again, is to increase leverage with health plans. In fact, many groups are finding that they can achieve considerable leverage without that many physicians, especially in a single specialty group. Particularly if those physicians represent a sizeable portion of the market in that area or a sizeable portion of the market for that geographic submarket.

Single specialty groups also avoid the conflict of income distribution within the group that multispecialty groups really struggle with. So, this is a much more attractive option for physicians in the field today.

The other major way that physicians attempted to consolidate during the early managed care year was through PHOs and IPAs and contracting entities of that sort. These organizations really were established to facilitate risk contracting and to help improve physicians' leverage in those negotiations. But as plans move away from risk-based payment, the mechanism

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by which physicians can really rely on these organizations to help them increase their leverage, that mechanism is undercut. So, these organizations, there still are many that exist, but they really have been devalued in the current environment.

Finally, turning to health plans, local health insurance markets were already concentrated in 1996 when we began the community tracking study. In fact, an analysis that was based on our initial round of site visits found that looking across all product types, so I'm including HMO, PPO and indemnity products, that nine of the 12 sites were considered concentrated at that time.

Much of this was due to the historical presence of long-standing dominant plans. Typically the local Blue Cross/Blue Shield plan or a pioneering group or staff model HMO such as Group Health Cooperative in Seattle, or Harbor Pilgrim in Boston.

So, it's really their long-standing dominance in the market that resulted in this concentration, not consolidation. Even though there are a growing number of competitors in markets as managed care was in ascendance, in most communities we track, the market share remained concentrated in that handful of historically dominated plans. It was difficult for new
entrants to really gain a significant foothold.

In some cases, market share became concentrated even further as these plans that attempted entry ultimately exited the market or provider-sponsored plans which some hospitals got into this business exited that market. So, there was some continuing concentration, but really despite some ups and downs, it was those long-standing dominant plans that remained in place and continue today.

Let me flip to the graphic here. This graph shows HMO concentration and how it's changed between 1997 and 2001 using interstudy data. A shortcoming here is that this graph shows only HMO enrollment, which of course is just one segment of the health insurance market and one that may be declining in importance, but the problem is there really is no reliable data on PPO enrollment at the local market level. So, this is the best that we can do in terms of looking at how concentration of managed care products has changed over time.

So, unlike the graph of hospital concentration, you can see that there is no clear direction of change in HMO concentration across markets during this period. Market share became less concentrated or remained essentially unchanged in as many markets as it

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increased.

In general, the smaller markets like Lansing and Little Rock and Greenville have remained highly concentrated, and that's really where the local Blue Cross/Blue Shield plans have long dominated the market. In contrast, larger cities like Miami and Phoenix have continued to be more contested markets with multiple players vying for growing population base and creating an environment that's more conducive to the successful entry and growth of national plans.

What consolidation has occurred among health plans has focused on mergers across geographic markets to gain economies of scale in terms of information systems, administration, to help them expand products and services and a big focus on better serving multistate employers.

Much of this involved national plans in the mid to late 1990s, such as Aetna or United, and more recently the activity is focused on regional or now multiregion Blues Plans like Anthem or WellPoint.

The mergers and acquisitions involving the Blues Plans are particularly interesting since these play to the strengths of what plans can hope to achieve through consolidation; that is, the economies of scale through information systems and administrative services, while
minimizing the problems associated with entering new markets that national plans experience such as the difficulty of establishing local provider networks, the local sales force and things that really remained very local in nature.

By acquiring the often dominant local Blues Plans, the Anthems and the Well Points of the world have found this strategy to skirt the diseconomies of scales associated with entering new markets and have avoided this difficulty of establishing a stronghold in new areas.

So, what have these trends meant for the workings of health care markets? As I said at the beginning, there really have been some very visible effects of these changes on health care market dynamics. First, the concentration from tightly managed care and the effects of increased concentration in the hospital market have increased provider leverage and given rise to this growing phenomenon of contract showdowns between plans and providers, as providers push for increased payment and better contract terms across the country.

Hospitals in particular are adopting the strategy of terminate and then negotiate, and this tactic is really threatening continuity of care for hundreds of thousands of consumers in these communities.
One of the most vivid examples we saw in the communities that we track was in Boston when there was a contract dispute between Partners Health Care System and Tufts Health Plan, and Partners threatened to terminate its contract with Tufts, and this would have affected over 100,000 Tufts members who relied on either one of the hospitals in the Partners Health System or one of the 4,000 physicians that were affiliated with Partners.

So, this created a great deal of consternation in the market, as I'm sure you can imagine. Ultimately local employers and the state attorney general stepped in and the dispute was settled with Tufts giving Partners sizeable rate increases.

The second major effect of these trends that we've seen in markets is the revival of this medical arms race mentality that was mentioned earlier. As hospitals shift back to a retail rather than a wholesale strategy of competing for patients through managed care contracts, they returned to competing for patients by adding attractive services, adding these amenities, and focusing on competing for the revenue-generating services.

This has really led to a proliferation of specialty hospitals, stand-alone surgery centers, centers of excellence and so forth throughout the
country. There's a great deal of mimicking behavior going on in individual communities.

So, for example, in Indianapolis, there are now four new heart hospitals under construction and scheduled to come online within the next couple of years. Some of this activity has been driven by single specialty groups, either on their own or with the backing of national firms such as Med Cath that have sought to establish these niche facilities that specialize in profitable procedures without the drain of the less profitable care like emergency care or uncompensated care.

This leaves traditional acute care hospitals in a real bind. Either they have to compete for these patients and these physicians, or they stand to lose this important source of revenue. So, this phenomenon has really instigated increased joint venture activity around these specialty centers as a way to keep the physicians loyal to the traditional hospitals in the community.

Finally, as was discussed earlier, the market trends that we've seen have had really visible effects on underlying health care costs again today. We actually track health care costs on an annual basis, and our latest report is coming out later this month in

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Health Affairs, but I can preview it for you today just by saying that there have been significant increases in underlying costs again in 2001, and we are reaching levels that's comparable to the pre-managed care era in 1990.

I think the really important point here is that the pharmacy costs continue to play an important role, hospital costs have superseded pharmacy in terms of what's contributing to underlying cost growth today. In the analysis that's coming out in Health Affairs, we really dissect this a bit and show that it's both increases in hospital utilization and increases in hospital prices that are driving this trend.

So, stepping back from the twist and turns we've observed in health care markets over the past several years, there are several key lessons that we've learned about the nature of competition in health care markets as a result of watching this activity. First is that health care markets have a certain level of inherent concentration, in part because health care delivery occurs largely at the local level, and in part because it's dependent upon relationships between hospitals and physicians, providers and plans, and of course patients and providers.

It's difficult to replicate these relationships
across multiple actors, that there are real limits to that. In addition, there are limits to how far we want to go with health care markets, given that health care is ultimately a public good. So, as a result, the degree of competition in health care markets really needs to be assessed within this unique context and it might be quite different, and probably is, quite different from markets in other industries. This doesn't mean that there shouldn't be attention to making health care markets more competitive, but this needs to occur with recognition of the trade-offs that are associated with this goal and with the close examination of the factors that contribute to competition in health care.

So, for example, one of the things that we've observed from our work tracking markets is that ease of entry may actually be changing or may be different from conventional wisdom. On the one hand, the growth of these single specialty hospitals may be a sign that the hospital market actually may have less significant barriers to entry than long believed.

To the extent that these hospitals can come into the market and by virtue of focusing on a narrower set of services, they have the potential to provide higher quality of care at lower costs. And in that respect,
they can create procompetitive pressure for the delivery of these special services.

    But the trade-off is that as traditional acute care hospitals rush to compete with these new entities, it becomes more difficult for them to cross-subsidize other essential yet lower margin services such as emergency care or uncompensated care. So, as a result, competitive pressure for the delivery of these specialty services may yield positive effects, but the health system as a whole experiences stress.

    Some observers suggest that in the longer run, competition over specialty services may result in overcapacity with reduced quality and increased cost. So, that's something that really needs to be monitored over time.

    In terms of ease of entry on the other hand, when we look at the health insurance market, we're seeing that there may be greater barriers to entry than long believed. It's becoming increasingly clear that plans are unlikely to remain in the new market unless they are able to obtain the certain scale. Difficulties establishing a viable provider network is a key barrier to gaining the necessary market share to compete effectively.

    Although theory would lead you to believe that

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there would be procompetitive effects from using plan
entry, it's unclear that this goal is attainable, given
the relationship-dependent nature of health care.

Finally, our work has taught us that
cross-sector competition is subject to significant
change over time as we've seen with these dramatic
swings in plan and provider leverage over the past few
years. Our work has shown that leverage is determined
by more than just firms' market share or the
concentration of the market, but that there really are
multiple internal and external factors at play here.
I'm just going to run through some of those
quickly. On the provider side, this slide shows the
internal factors affecting providers' leverage include
things like reputation and stature in the community.
This is something that's been very important for
academic medical centers in particular. Strength of
relationships with providers, tightness of the hospital
relationships with physicians or for physicians their
relationships with hospitals, the financial stability of
these organizations and so forth. Plus there are a
number of environmental factors: Employer's preference
for broad provider networks has strengthened providers'
leverage, as have emerging market-wide capacity
constraints that make providers less desperate to accept
discounts.

On the plan side, there also are a number of factors that affect leverage that go beyond just market share or market concentration. Individual plans history or standing in the market, the tightness of their relationships with providers also play a role, as does the breadth of their product offerings, which can make them more flexible to respond to changing market conditions. Environmental factors such as the regulatory context in that particular state, employer's product preferences also have an effect.

So, looking across the various factors that contribute to plan and provider leverage, there is reason to believe that even if there are no significant changes in market share or market concentration in the near future, there is the potential for a shift in the relative leverage between plans and providers back in favor of health plans again soon.

Provider leverage may decline, if there's this build-up of capacity that certainly seems that that's the direction that we're heading in, both to respond to current shortages and in response to this medical arms race behavior. This could create real problems for providers, particularly if this recent spike in utilization turns out to be a one-time increase as many
really suggest that it is, really just a one-time  
adjustment to the loosening of managed care again.
  
    Plus plans will shift more financial  
responsibility on to consumers for the increased cost of  
care, the increased copays and coinsurance requirements  
on consumers, as they've really been doing as a strategy  
to manage these year-after-year, double-digit premium  
increases. Analysts are projecting that this will cause  
utilization to slow again soon.
  
    So, providers may be getting themselves into a  
situation of increasing capacity, declining utilization,  
and really being out on the market for volume again.
  
    Plus, as I talked about before, this increased  
pressure from potential substitutes has the potential to  
decrease provider leverage, particularly if these new  
specialty facilities are able to produce lower cost  
services on the market.
  
    But at the same time, providers really remain  
under significant pressure, both from the nursing  
shortage and the shortage of ancillary personnel that  
continues to drive up their input costs. And pressure  
from the continuing squeeze on Medicare payment. So,  
while their leverage may be in decline, they will  
continue to face strong pressure to test the waters with  
health plans and push for higher payment rates on the
Meanwhile, there's some changes on the horizon that have the potential to increase plan leverage. First and foremost is increased employer interest in controlling premium increases, which is giving plans license to develop new strategies to manage care more tightly again. At the same time, the trend to give consumers more skin in the game by increasing their copays and deductibles, this makes consumers a potential ally for health plans in their efforts to control costs. But to date, plans really have had limited success with these new strategies. For example, one strategy that a number of plans across the country are pursuing now is this concept of tiered provider networks in which consumers pay a different amount based on the tier that their provider is in. It's essentially the same concept as a three-tier pharmacy, which plans have had a lot of success with. Three-tier pharmacy is the idea that you pay a lower copay for generic and then increasing amounts for preferred or brand name drugs. This has really helped plans to control pharmacy growth, and as you saw in the earlier slide, we're seeing that cost trend dip down again now. So, the idea is to take the successful strategy and apply it to the provider networks, but plans have been having a harder
time rolling this out in their provider networks and providers have been really resistant to this concept.
So, Boston is one market where we've seen a number of plans propose this, and their tiering was really based on academic medical centers in one tier and community hospitals in another tier. And the academic medical centers have fought that very hard.

In general, there still is also this general unease about restricting access to certain providers or to certain services on the part of both employers and consumers. So, it really makes it questionable how successful this tiered network strategy can be. I think the important context here is that even though the economy has slowed considerably since the hey-day in the late 1990s and the labor market has become somewhat weaker, it still hasn't become as weak as it was in the early 1990s when employers really moved aggressively into managed care and were able to lead off this managed care revolution.

In fact, the labor market is expected to remain relatively tight over the next ten years. So, it is really questionable how much momentum will materialize to lead plans to move towards more restrictive products again.

So, the bottom line is that while there are a
number of forces on the horizon that could increase plans' relative leverage again, there also are a number of mitigating factors, and I think that the lesson that we want to leave you with today is that really monitoring these changes over time will be critical to assessing the degree of competition that exists in health care markets, how that's changing, and what needs to be done about it.

Thank you.

(Applause.)

MR. HYMAN: Thank you, Cara.

We're now going to hear from the heads of three bureaus at the Federal Trade Commission. First will be Joseph Simons from the Bureau of Competition, second will be Howard Beales from the Bureau of Consumer Protection, and finally will be David Scheffman from the Bureau of Economics. Each of them will give you their perspective on health care and competition law and policy, talking a little bit about where the FTC has been and some about where they would like to go. Each has about ten minutes to do so.

MR. SIMONS: Good morning, everyone, and thank you all for coming. Your presence here today, particularly in such large numbers, there is a big overflow in the other rooms as well, really indicates
the increasing importance of health care and the health care industry to our nation's economy.

As Tim said earlier, during the introduction, we really do hope to learn an awful lot during this two-day workshop. To provide some background and context, what I am going to do is just to briefly describe the Bureau of Competition's initiatives over the last year in the health care industry.

First let me say, however, that the Commission has a very long history of activity in health care, and it particularly emphasized health care during Tim's last stint at the Commission. For those of you who haven't noticed, one of the characteristics about Tim, not just in health care, but in other areas as well, his past is very definitely prologue. So, a lot of what we did previously when Tim was here, we're going to be or we are re-emphasizing again.

Moreover, health care has really become a much more important part of our economy over the last few years and thus the Bureau of Competition has really started to dramatically increase the resources that we are devoting to health care.

Our activities have focused primarily on horizontal and vertical restraints and mergers involving hospitals, pharmaceuticals and physicians. Our recent
enforcement activities can be characterized basically in three areas: Price fixing among the health care providers, hospital merger retrospective, and pharmaceuticals. I'll talk briefly about each of those three areas.

So far this year, the Commission has entered into five consent agreements with physicians groups settling what are pretty much price fixing cases. Now, I mentioned past is prologue, and we did this previously, we did this during the '80s, we did this during the '90s, and we were criticized by folks for some of our efforts in the area of going after physician price fixing.

Basically what the criticism involved was that we were picking a doctor here, a couple of doctors there, generally in rural areas, and why were we wasting our resources doing that? Well, whatever you think of that old criticism, it really doesn't apply to what we're doing now.

The cases that we've brought in the last year have been in large metropolitan areas and involved fairly large numbers of doctors, especially the recent case in Dallas which involved over 1,200 doctors engaged in price fixing.

Just last month, the Commission provisionally accepted a consent agreement with System Health

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Providers, which is a multispecialty physician group with about 1,250 doctors practicing in the eastern part of the Dallas metropolitan area.

The second, third and fourth cases that we brought involve orders issued against or orders provisionally accepted by the Commission for comment, three physician groups in Denver, Colorado. The first one, P-I-S-D, affectionately known as PISD, is a group of 41 primary care doctors practicing in the southern part of Denver; AAPCP had about 45 primary care doctors located in the suburb of Aurora; and PIWC involves a group of more than 80 Denver obstetrician/gynecologists.

In each of these matters, the non-physician agent who organized the group or who acted as the agent in dealing with the payers was also named in the complaint and is also bound by the order.

The fifth doctor case involved Napa County, California. That case involved a group of almost all of the obstetrician/gynecologists in Napa County. As a result of the doctors' actions, at least according to our complaint, some health plans actually stopped providing HMO coverage in that county entirely. The order requires the group to dissolve.

Finally, as it relates to physician matters, we issued an advisory opinion to MedSouth, which is a
Denver IPA. As that letter indicates, we are very receptive to innovative forms of health care provider integration where it stands to benefit consumers by either reducing costs, or by improving quality.

Let me just be clear, in terms of the cases that we've brought this year, the five cases that I mentioned, those were really price fixing cases, none of those cases involved any form of serious integrated activity. One of the things that Tim's been emphasizing since he got here is efficiencies. He's emphasized that in mergers, and in non-mergers as well, and that's really critical to what we're doing in the health care area. We are very sympathetic to efficiency claims and to quality concerns, and we are committed to looking very seriously any time those arguments are in play.

Let me talk a little bit about the hospital merger retrospective. You had a presentation a little bit earlier today which kind of put the line-up on the board of the government's success or really its failure in the area of hospital merger enforcement. In fact, I think we're zero for our last seven.

Coming into this, we had a couple of choices. Basically we could just say, ah, let's fold our tents, there's nothing we can do, or we could try something significantly different than what we had been
doing. So, we picked the latter.

What we thought we might do is, a lot of us had a suspicion that even though we lost all of those cases, that we were really right, at least in some substantial part of them, and that prices were really affected. So, what we have committed to do is going back and actually looking to see in a variety of contexts whether the mergers, after the fact, can be shown to have increased price.

We're doing this for two reasons: The first one is if we find a transaction where we can show a price effect and a remedy is available, we'll fix it, and we would do that through the administrative process. Then two is if by studying these consummated transactions we can actually show there was, in fact, an effect when the court said, oh, no, there wouldn't be, well then we can use that to inform the cases going forward and re-institute the challenges to mergers prior to consummation. So, we're looking at that from those two perspectives.

The final area that we're involved with that I want to talk about today is pharmaceuticals. Everyone who pays any attention to the news sees the concerns about rapidly increasing costs of prescription drugs on behalf of virtually everybody, patients, employers, the
government. Consequently, the Commission over the last several years has been devoting an increasing amount of resources to the pharmaceutical industry. We are now to the point where we focus more than 20 percent of all competition resources on the pharmaceutical business.

There were three very significant non-merger matters this year in the pharmaceutical industry that were brought by the Commission. The first one involves Biovail. This was a landmark case for us involving a wrongful listing in the FDA's Orange Book. Biovail is basically a two-fer for us. It's our first wrongful listing case in the Orange Book, and it also involved a vertical acquisition, in this case of a patent.

Biovail manufactures a drug known as Tiazac. It's a product used to treat high blood pressure and chronic chest pain. Another company had filed an application with the FDA for approval to provide a generic of Tiazac, and certified that it did not infringe any of Biovail's patents that were listed in the Orange Book.

Biovail sued them for infringement anyway and the generic prevailed at trial, but before the generic could get to the market, Biovail acquired an exclusive license to another patent that was not required to
manufacture Tiazac, but which Biovail claimed the
generic would infringe anyway in making the generic for
Tiazac. Biovail then listed that patent in the Orange
Book, sued the generic and the 30-month stay under the
Hatch-Waxman Act was triggered.

The complaint that the Commission filed charged
both that the acquisition of the license and the
wrongful listing in the Orange Book unlawfully
maintained Biovail's monopoly in violation of both
Section 7 of the Clayton Act and Section 5 of the FTC
Act. The consent order required Biovail to divest part
of the exclusive license that was preventing the generic
entrant from entering, the order prohibits the company
from taking any action to cause any additional delay
under the Hatch-Waxman Act, and the order also prohibits
Biovail from wrongfully listing any patents in the
Orange Book relating to any products that Biovail
produces.

The second case also involves Biovail. It was a
big year for them. Biovail and Elan were the only two
manufacturers that had FDA approval to produce a generic
version of branded Adalat, which is an antihypertensive
drug. What the parties basically did was they agreed
that only Biovail would have the control of the
distribution and Biovail would share in all of the

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profits whether the product was Elan's products being
sold or whether it was Biovail's product being sold.

The order that we obtained there terminates the
agreement between the two companies and it prohibits
them from entering into similar agreements in the
future.

The third case in this area is the Schering
case, and that case is currently in part III litigation.
This is the first case that the Commission is litigating
that involves a patent settlement with what we call a
reverse payment where the brand pays the generic, the
alleged infringer, to stay off the market. The
complaint alleged that Schering-Plough paid Upsher-Smith
$60 million and American Home Products at least $15
million in exchange for those companies' agreements to
stay off the market with respect to their generic
potassium chloride supplements, the generic for what
Schering was selling, which was its K-Dur 20 product.

The staff has appealed the decision of the ALJ
dismissing the complaint and the case is now on appeal.
In addition, AHP had settled that case before the trial
began. So, that's on appeal to the Commission, and I'm
very hopeful that the Commission will reverse the ALJ,
and in any event I think the Commission is going to have
an excellent opportunity to write a highly interesting

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opinion.

The other area in pharmaceuticals that we're focusing on is mergers. We have been extremely active there as well. There's one quite large investigation that's ongoing, and in addition a very good example of our activity there is a recent transaction involving Amgen and Immunex which was a deal involving a big deal in the biotech sector.

All right, what lies ahead? Well, what lies ahead depends in part on what we learn here in these two days and then what comes about as a follow-up from these two days of hearings. The Commission really over the last few years has been quite active in holding these types of hearings and workshops and they've been highly informative. So, we're really optimistic about getting some excellent input from the folks at these two hearings, the two days of hearings, and then what follows.

But in any case, we're certainly going to continue to devote a very substantial portion of the bureau's resources to the health care industry. We are very much committed to trying to revitalize hospital merger enforcement, and we have many cases in the pharmaceutical industry in our pipeline and of course we'll be very active with respect to mergers in the
That concludes my remarks for this afternoon. Thank you so much for your attention. I'm sure that the rest of the workshop will be extremely interesting and very thought-provoking. Thanks again.

(Applause.)

MR. BEALES: I may or may not be a speaker that needs no introduction, but I get no introduction. I'm Howard Beales, I'm Director of the Bureau of Consumer Protection.

The Bureau of Consumer Protection shares the Bureau of Competition's goal of ensuring that the consumers enjoy the full benefits of a competitive marketplace. However, we come at it from a somewhat different perspective. In particular, we focus on the crucial role that the free flow of truthful advertising plays in competitive markets. Truthful advertising enables consumers to make well-informed decisions about their health care options, including, their choices or health care goods and services.

As George Stigler once wrote, "Advertising is an immensely powerful instrument for the elimination of ignorance." Unfortunately, there's a good deal of information in the marketplace that's not truthful, and not even close in many cases.

A key part of our mission is to target...
advertisers that deceive consumers, particularly
vulnerable consumers who are desperate to find a cure
for their cancer, guard their family from bioterrorism,
or shed a few unwanted pounds to improve their health.

We commit substantial resources to keeping abreast of new health care developments to prevent deceptive advertising. In doing so, we coordinate our efforts with other federal and state agencies, in order to leverage the resources that we have available.

Let me give you a few examples: One long-standing priority of our program is to combat health fraud by marketers who sell unproven cures to desperate consumers suffering from cancer, AIDS, arthritis, or other serious diseases.

Unfortunately, the advent of the Internet has made it inexpensive to reach a large, potentially world-wide audience, with claims that are plainly false or unsubstantiated. The FTC, in cooperation with other federal and state agencies, has cracked down on companies that use the Internet to deceptively market products for the treatment of a wide range of serious health conditions.

Most recently, we settled charges with BioPulse International, which advertised its alternative cancer treatments at a clinic in Tijuana. The company claimed that its therapy would cure cancer by inducing a coma with insulin. To
this audience, that's probably all that needs to be said about the substantiation for that claim.

In addition to bringing actions against these types of marketers, we use Operation Cure-all as an educational tool to alert consumers to health care fraud online and offline.

Another major project has involves bioterrorism. Consumer fraud is by definition an opportunistic endeavor. Last fall, just after the nation-wide anthrax scare, we learned that unscrupulous marketers were preying on consumers' fears and marketing products to detect biological agents or prevent or treat anthrax, smallpox, and other biohazards.

We launched, together with the FDA and 30 state enforcement agencies, an Internet surf to identify sites making suspicious claims. We sent out more than 100 warning letters to marketers, demanding that they immediately discontinue their claims. We followed up the warning letters, and ultimately we brought enforcement actions against several companies, including Vital Living Products.

Vital Living Products advertised a do-it-yourself home anthrax testing kit.

Unfortunately, when we tested the kit against anthrax, it said there was none: when we tested it
against common household bacteria, it said we had anthrax. Fortunately, we stopped them before any test kits were actually sold. In this area, prompt federal and coordinated federal and state enforcement efforts were successful in preventing the emergence of more widespread frauds involving bioterrorism-related products.

Of course, not everything we do is fraud. In some cases, marketers of legitimate products will stray over the line in an effort to obtain a competitive advantage. When they do, it's our job to pull them back. In March, for example, we announced a settlement of allegations that the makers of Wonder Bread and its advertising agency made the deceptive claim that added calcium in Wonder Bread could improve children's brain function and memory.

Now, calcium is wonderful stuff, and if you don't have any calcium, then probably your brain won't function very well, but to go from there to a claim that adding calcium to your diet will improve memory and brain function, is more of a stretch than the evidence will support.

Although ordinarily our actions are effective in bringing advertisers into line, there are some intractable problems out there. One has been in the area of weight loss, where marketers continue to take advantage of consumers' desperation to lose those pounds.
or change the shape of their bodies. There seem to be countless new ploys to separate overweight consumers from their money with a new one emerging every few months.

In May, we filed federal court complaints challenging claims made by three widely advertised abdominal exercise belts. You probably saw the ads. The companies claim that you could wear the belts for a few minutes a day and have washboard abs with no effort whatsoever. Unfortunately, it wasn't true.

This action follows a series of FTC actions against other products with names that also say it all, like Exercise in a Bottle, and Fat Trapper Plus. If only it were true! Our actions were often accompanied by orders that required the payment of millions of dollars in consumer redress. There will be more of these enforcement actions.

What probably interests us most about this workshop is the session on prescription drug advertising to consumers. This is something that the Commission has in the past defended as consistent with the benefits of truthful advertising in competitive markets, and it's something that really has the potential to revolutionize the way consumers find out about important new treatments.

Because such advertising has such significant potential benefits, it's also especially important that it be truthful. Now, the FDA has primary jurisdiction over
prescription drug advertising. But this is one area where we also have jurisdiction and one area where we can work closely with the FDA, as we do in other areas. We're looking at ways to do that in order to ensure that prescription drug advertising directly to consumers remains truthful and fulfills the potential benefits that it can offer.

Prescription drug advertising raises a variety of issues, from its effect on prices to its effect on physician/patient relationships, and we look forward to the discussions in the panel tomorrow on that issue. Thank you very much for your attention, and we look forward to your input during the workshop.

(Applause.)

MR. SCHEFFMAN: Hi, I'm David Scheffman, I'm the head of the Bureau of Economics, we're the brains behind all these lawyers, we like to think.

Economics is important to what we're doing in health care. I'm going to talk very briefly about what we're doing. Tim Muris has long believed in and been a very strong proponent of enforcement. In the '80s he came in with a very aggressive enforcement program, with health care being one of the targets. He has also always believed that having research to supplement our efforts is important. As he indicated in his remarks today, the Bureau of Economics has a long history of producing research in the health care area. He talked about the Greenberg Conference and Monica Noether's report from the early '80s which was for a while successful in
Let me talk a little bit about some of the areas where the Bureau of Economics is currently active. First, as a number of people have already said, we're looking at consummated hospital mergers. This is part of a broader program of looking at mergers in lots of industries where enforcement decisions were unsuccessful. We are trying to determine whether we had the analysis right. What's involved is looking at data and trying to determine as a matter of economic analysis whether prices appear to have gone up more than they should have as a result of anticompetitive behavior.

It's fundamentally an empirical issue. We don't have any answers yet, and we're analyzing a lot of data. It is going to be interesting, in my view, as many of us have watched the unsuccessful jurisprudence on hospital mergers. The courts probably haven't gotten the market definition right in terms of geographic market. This is a bit disappointing because the court's decision must have been based on economic testimony, and based on patient migration data.

Many people have said for some time, including a Greg Werden article, that patient migration data may not tell you a lot about market definition in a situation where you have networks and bargaining power and where the sales are made to third party payers and not directly to patients. I think that if we find evidence in our empirical analysis...
that demonstrates that some of these mergers that were not successfully
challenged were anticompetitive, it's going to
fundamentally change the way we do market definition. I
think appropriately so, but it's an empirical issue and
we don't know the answer yet.

In addition, the analysis of competitive effects in hospital
mergers is going to have to be rethought. There's nothing better than
having actual examples of post merger activity to use to analyze how
hospital competition really
works, as opposed to how we usually analyze mergers prospectively

We're also doing a lot of thinking about health-care providers.
As Joe indicated, we have a lot of investigations
of essentially naked price fixing arrangements among doctors. An
important issue for economic analysis to address in these
investigations is the competitive impact of provider group integration.
The question is if the provider groups get big enough, and sufficiently
integrated, will there come a point where is big enough becomes too
big, and where we might foresee an anticompetitive effect. We're
analyzing this issue.

On the enforcement side we also continue to be very busy with
Hatch-Waxman related pharmaceutical matters. BE also has an active
research agenda. We've brought in Bill Vogt to help spearhead our
research efforts, and we're delighted with that. We have some
outstanding health care researchers in the Bureau like Mike Vita and
Lou Silvia and other folks who have been actively working on health
care issues for some time. We have also made contact with some of the leading health care economists in the country and are working with them.

We understand that quality is the most important issue in health care. For an enforcement agency is critical to be able to demonstrate that enforcement actions don't have an adverse effect on quality.

In the rest of antitrust, we generally don't think there is a "quality competition trade-off." However, for years we've actively enforced in the pharmaceutical area, where our cases are often based on reductions in quality and variety, and that's noncontroversial. We're sponsoring a lot of research with leading researchers on the quality issue. So far, we have contracted with four researchers to examine the relationship between health care competition and quality. The issues they are investigating include the relationship between hospital surgical volume and quality, and the relationship between physician practice organizations market structure and quality.

So, those are things we're doing as part of this, as the other speakers have talked about, these hearings are very important because we're bringing some of the leading people in the area to come and talk and we'll be listening. If you have more to tell us, more than in the conference in terms of papers, data, economic analysis, of any sort, we would be delighted to

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hear from you.

Thank you very much for coming.

(Applause.)

MR. HYMAN: We're now going to hear from representatives of two of the entities that are partners of the Commission in enforcing the nation's antitrust laws, first representing the Department of Justice is Deborah Majoras, who is Deputy Assistant Attorney General for Civil Enforcement in the Antitrust Division.

MS. MAJORAS: Thank you, David.

I'm pleased to have the opportunity today to tell you about some of the Antitrust Division's initiatives and enforcement actions recently in the health care industry. I thank Chairman Muris and the Federal Trade Commission for sponsoring this workshop and for inviting our participation.

Strong antitrust enforcement plays a significant role in encouraging and facilitating competition in the health care industry, and in the few minutes I have, I am going to give you a brief overview of what we are doing in this area, identify some areas of concern and interest for us, and tell you where I think our efforts will be directed in the future.

I first want to address a matter that I think has been the subject of some misunderstanding by some...
observers, and that is the absorption of the responsibilities and most of the resources of our Health Care Task Force into our newly created Litigation I Section earlier this year. That action did not signal and has not resulted in the Division’s exit from a significant enforcement role in the health care sector. Rather, it was part of a Congressionally-approved and Division-wide modernization effort to concentrate industry expertise in six civil litigating sections of roughly equal size, each having broad merger and non-merger responsibility in particular industries and each with sufficient staff to perform those responsibilities efficiently and effectively.

Now, in the case of the Health Care Task Force, the staff, and of course their expertise, was not dissipated in this reorganization; rather, that staff was essentially transferred wholesale into the new Litigation I Section. Led by Mark Botti and John Reed, our Chief and Assistant Chief, respectively, those staff members continue to investigate health care matters within the context of that full-fledged section. In accordance with the philosophy that underlies our modernization effort, we expect that Section to engage in "community policing" in this important industry.

Now, one area of primary concern for Litigation I, I will be the evaluation of mergers and of unilateral or coordinated conduct by health insurers. For consumers
to benefit from competition in health care markets, sufficient competition must be maintained not only among providers, but also among the health plans that purchase the providers' services on behalf of the plan members.

Our competitive interest in this regard has been heightened by the generally increased level of consolidation of health insurance markets in the past few years. Given these ongoing market changes, we will pay close attention to whether any particular merger would give the merged insurer sufficient market power to increase prices or reduce quality in the sale of managed care plans in specific geographic areas or to acquire monopsony power over providers. We will make close scrutiny of health insurance plan mergers a priority.

Likewise, we will continue to focus on collective or unilateral activity by insurers that may raise competitive concerns, depending, of course, on the insured's market power and other relevant market conditions. To cite some examples, we recently scrutinized a health insurance market in a major metropolitan area for possible evidence of coordination or collusion among managed care plans operating there.

In addition, within the past several months, we investigated a complaint by providers that a form of "all products clause" instituted by an insurer with

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substantial market power -- that is, a clause that gives
providers more favorable reimbursement rates if they opt
to participate in all of an insurer's plan offerings -- was
anticompetitive.

Furthermore, we continue to receive and evaluate
complaints about managed care plans' use of "most favored
nations" clauses to determine whether they merit more
complete investigation or ultimately enforcement action.
These types of clauses generally operate to protect insurers against
other plans getting better reimbursement rates, and so they often
provide a disincentive to providers to lower their rates. In this
regard, we have, for example, investigated the use of an MFN clause by
a Blue Cross plan in Alabama, an investigation we closed only upon
confirming through our investigation that the plan abandoned the MFN
policy. Similarly, in Western Pennsylvania, Highmark, an insurer with
significant
market share, recently proposed to the Pennsylvania
Department of Insurance the inclusion of an MFN clause
in their contracts with hospitals. Now, in the mid-1990s, the Division
had advised the Pennsylvania Insurance Department that Highmark's then-
proposal to institute an MFN policy had serious
competitive concerns. While we were evaluating the MFN
this time, Highmark abandoned it.

Another area of the health care sector that we
are currently focusing on and that has absorbed an increasing
amount of our resources is the rather broad category referred to as "ancillary health care products and services." The Dentsply case is a recent example. That lawsuit, which we filed in federal district court in Delaware, challenges the use by Dentsply, the dominant manufacturer of artificial teeth in the United States, of restrictive dealing arrangements with dental laboratory distributors. The trial of that case this spring lasted three weeks, and we have closing arguments scheduled for September 20.

In that case, we're challenging two exclusive dealing practices by Dentsply, which has an 80 percent share of the artificial tooth market in the U.S. and sells all of its teeth to dealers. Under Dentsply's Dealer Criterion No. 6, if a dealer selling Dentsply teeth begins selling a competitive brand, Dentsply pulls its teeth from that dealer. (I'm sorry, I couldn't resist!) In addition, Dentsply has a practice of requiring new dealers to drop some or all competitive brands in order to take on Dentsply's teeth in the first place.

Now, there are several important legal issues presented by this case and I will just highlight two for you: One issue is whether exclusive dealing arrangements that are, as a technical matter, terminable-at-will can nevertheless cause anticompetitive effects in the market. Dentsply
sells its teeth to dealers on a purchase order basis, and there is no express duration to their agreements. Yet, as a practical matter, these agreements have been perpetual in length because no dealer has been willing to give up substantial Dentsply tooth business to add a rival tooth brand. Dentsply's policy, then, presents dealers with an all-or-nothing proposition: if you add competitive brands, you will lose all of your Dentsply business. Given the 80 percent market share, that choice has been an easy one for dealers in the last 15 years. During that time, while some had expressed an interest in adding rival tooth brands, none has done so.

Another issue in this case relates to the importance of a traditional proxy used by courts in assessing exclusive dealing arrangements. Traditionally, courts have examined such factors as the duration of the agreement and amount of foreclosure and we believe we have strong evidence to support that these factors in our case support a violation. But we also have direct evidence, from a variety of sources, of the actual anticompetitive effects of these practices, that is evidence that the practices have substantially reduced competition and consumer choice, deterred entry, and increased prices. And that evidence we are arguing, ought to be enough for us to prevail in this case. We are optimistic that the evidence we presented will result in a finding of liability, enabling us to restore competition in this market for the benefit of
consumers.

Now, our significant attention to the areas of health insurance and health care products should not be taken as an indication that the Division will in any way ignore issues in provider markets. While we believe our focus on health insurance is complementary to the FTC's increased commitment to enforcement in provider markets, we will continue to use our expertise regarding providers to open investigations and take action where appropriate. Currently the Division is pursuing a number of health care matters focused on provider conduct, including a number that we have opened in recent months. Litigation I will continue to focus heavily on horizontal activity. For example, in *United States versus Federation of Physicians and Dentists*, we are in the process of securing entry of a stringent consent decree that would put an end to illegal collective action under taken by orthopedic surgeons in private practice through their membership in a professional union operating nationwide.

In that case, we have alleged that the Federation had recruited nearly all of the private practice orthopedic surgeons in Delaware as members, who then agreed to designate the Federation's executive director as their agent to negotiate the fee levels they would accept from Blue Cross/Blue Shield of Delaware. When Blue Cross declined to negotiate with the doctors

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through the Federation, the Federation and others persuaded the doctors
to deal with Blue Cross only through the
Federation and ultimately organized nearly all of its
member orthopedists to terminate their contracts with
Blue Cross in the belief that the action would force
Blue Cross to accede to their fee demands.

The proposed consent decree is nationwide in
scope and prohibits the Federation from participating
in, encouraging, or facilitating any agreement or
understanding between competing physicians or from
negotiating on behalf of competing physicians about any
payer contract or contract term -- activities that if
undertaken would force health plans to pay increased
fees.

We continue to investigate other allegations
that professionals in various markets are using
seemingly legitimate joint conduct as a pretext for
collusion. Over the past several months, we've been
conducting an investigation into a physician-owned joint
venture that provides a multipractice network of
physicians to health care payers in a substantial urban
area. The network began operating in 1995 and now has
several hundred physician members representing over 90
percent of the physicians practicing in this market.

We have also opened an inquiry into a hospital network, and
we are reviewing a hospital joint operating agreement in another instance of physician collective bargaining, just to give you the flavor of some of the things we have before us.

It must be recognized that if, in our scrutiny of horizontal conduct, we discover health care businesses that cross the line to engage in explicit collusive arrangements regarding fees or market allocation, we will consider prosecuting criminally. In this regard, we have strengthened our liaison relationship with the Federal Trade Commission recently so that FTC staff who uncover evidence of such explicit agreements when they are doing their own investigations can quickly bring the evidence to the attention of our staff in the National Criminal Enforcement Section here in Washington.

I would just like to say a few words on the procedural front and highlight our merger review process for a moment. Assistant Attorney General Charles James has made it a top priority to make our merger review process more efficient and manageable for the Division and for all parties in all industries, including the health care sector. The effort began with the announcement of our Merger Process Review Initiative in which we established a number of methods for making initial waiting periods more productive, as well as
streamlining both the Second Requests that are issued and the staff's assembling and analysis of information. The procedures outlined in this Initiative are designed to encourage our staff and the merging parties to move more quickly to identify critical legal and economic issues regarding proposed mergers, to facilitate a more efficient and more focused investigative process, and to provide for a more effective process for reaching conclusions based on an evaluation of evidence. While the dearth of merger activity has led to only limited experimentation with this Initiative, the early feedback both from staff and from parties has been quite positive, and I encourage all parties to continue working cooperatively with us through this initiative.

In closing, I want to emphasize that the Division intends to closely monitoring and, where appropriate, take enforcement action in this vitally important health care sector of the economy. In doing so, we expect to give greater attention than we traditionally have given to the area of health care insurance. At the same time, though, we will maintain flexibility to enable us to adapt our enforcement focus to any significant anticompetitive activities that arise in this industry. Using our strong expertise, and in partnership with the FTC, we intend to work to ensure a competitive health care marketplace for consumers.

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Thank you very much.

(Applause.)

MR. HYMAN: A couple of logistical announcements and then I'll introduce the last speaker before lunch. First, all of the materials that were referenced by the heads of various bureaus are included in the photocopied tan-colored book of which there are copies outside of each of the rooms in which this workshop is being held. We are also going to put together a relatively easily accessible set of all of those things on our website. So, if you're interested in getting more details on any of those enforcement actions, or any of the papers, those will be easy to find on the workshop website.

Second is there will be a transcript of this entire session that will be posted on the website as well.

Third, for those who prefer moving pictures, you can purchase a video, once that gets processed. The slides that people have been showing will also be posted on the website after the workshop is completely over. If you check in about a week, all of them should be up.

Fourth, lunch lasts from 12:35 until about 2:00. We are planning to start promptly again at 2:00 and we will begin panel discussions, the subjects of which are

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outlined in the agenda.

Finally, the FTC respect property rights, but in order to have your property rights in your seat maintained, you need to leave something there that indicates what the boundaries are to avoid adverse possession problems. I don't teach property.

Let me introduce our last speaker of the morning. In addition to the Department of Justice, the 50 Attorneys General of the various states have their own distinct role in enforcing the nation's antitrust laws and also usually have their own state-specific antitrust laws.

Now, we figured it would tax the patience of a saint to bring in all 50 of the State Attorneys General or at least representatives and so we instead picked one who will offer a broader perspective. We're very lucky to have Ellen Cooper, who is an Assistant Attorney General and the Chief of the Maryland Antitrust Division. She's also the Chair of the Health Care Working Group of the Multistate Antitrust Task Force of the National Association of Attorneys General, so she will be able to, in one ten-minute session, give you a 50-state perspective on health care and competition policy.

MS. COOPER: As you can imagine, from that introduction, I'll be speaking very, very quickly.

It's an honor to be here today representing the
State Attorneys General in this very important and timely workshop. Before I get started, I have to say that the views that I express are my own and not those of any state attorney general or the Attorney General of Maryland.

I would also like to thank my colleagues, Bob Hubbard from New York, Kevin O'Connor from Wisconsin and Meredith Andrus from Maryland in their help for my preparation for these remarks.

First, let me give you some context before describing some recent state health care antitrust initiatives. State attorneys general tend to concentrate their antitrust enforcement resources on problems that profoundly affect consumers within the state or that disproportionately impact the state's general social and economic welfare. Providing affordable health care to citizens in both urban and rural areas is a problem that meet both criteria.

Also, the activities of health care providers like hospitals, physicians, home health agencies and ambulance companies are often local in nature, affecting only a single region of the state, or a single metropolitan area. For this reason, federal agencies may not wish to devote resources to the matter.

The attorneys general, in contrast, may be
particularly competent to analyze competitive conditions in local markets, and also particularly motivated to do so. Many state attorneys general have expressly articulated health care issues as an antitrust enforcement priority. However, attorneys general have responsibilities, and this is the context part, that are much broader than antitrust enforcement.

They may represent their state departments of health, they may participate in certificate of public advantage proceedings, they may participate in certificate of need proceedings, representing state regulators. They may prosecute health care professionals for violating state licensing regulations. They may have both statutory and equitable powers to protect the integrity of charitable trusts that run hospitals. They may even represent large university teaching and research hospitals.

In addition, attorneys general prosecute health care fraud and abuse cases. They may represent state insurance commissioners whose analysis of health insurance providers may focus more on solvency issues than on competition issues.

Despite these often conflicting roles, the attorneys general of the majority of states have antitrust divisions more and more often headed by career
antitrust enforcers that approach antitrust investigations in a systematic, professional and highly confident way.

Currently, the primary focus of the states is the pharmaceutical industry. In a series of multistate cases, some prosecuted in cooperation with the FTC, and some litigated with private class action counsel, the states have sued both brand name and generic drug manufacturers.

In Mylan Laboratories, the states and the FTC sued a generic drug manufacturer for tying up the supply of chemicals of two antianxiety drugs needed by other generic manufacturers to compete by entering into exclusive contracts with these suppliers.

In a $100 million settlement negotiated by the states and the FTC, jointly, encompassing all 50 states and the FTC, the FTC obtained disgorgement. The states were able to ensure, by working with chain pharmacies, that an unusually high number of affected consumers were able to recover monetary relief, ranging from $200 to $2,000, depending upon the length of time that they purchased the two drugs.

At the present time, various combinations of states are challenging the practices of major pharmaceutical companies related to extensions of their
patents on the following drugs: Cardizem CD, Hytrin, K-Dur 20, Taxol and Buspar. The specific acts complained of vary.

In some cases, like Cardizem CD, the states challenged the settlement of a patent infringement case brought pursuant to the Hatch-Waxman Act. In other cases, like Taxol, the states have claimed fraud on the patent office. Each case is unique, but I would like to use Taxol as an example of a current state initiative.

Taxol, as you may know, is a chemotherapy drug developed by the National Cancer Institute of the National Institutes of Health. NIH entered into a statutory research and development agreement with Bristol-Meyers Squibb which allowed Bristol to market Taxol exclusively for five years without patent protection, after which time generic entry was expected. According to the states' complaint, notwithstanding this arrangement, Bristol applied for and obtained a method of use patent failing to disclose several material publications to the PTO.

The states contend that this fraudulently obtained patent maintained Bristol's monopoly and precluded generic entry. Most of the patents' claims have subsequently been declared invalid and unenforceable. Two claims are still in litigation.
Bristol also agreed to list in the FDA Orange Book a patent owned by a competing generic company, American Bioscience, Inc., ABI, which further delayed generic entry into the market for packs of Taxol. ABI's patent was later declared invalid. The Taxol case is now entering the discovery phase.

More than simply looking at pricing problems in the pharmaceutical industry in antitrust terms, the attorneys general through the National Association of Attorneys General, have created a pharmaceutical pricing task force to address issues of cost and access as well as how to redress collusion, fraud, and misinformation through litigation, legislation, and education.

Most antitrust violations affecting health care are local, though, and they are not amenable to multistate litigation. A number of states have stayed extremely active in protecting competition in local health care markets. Just looking at matters over the past few years, I found continued interest by state attorneys general in continuing to review the consolidation of hospitals and other kinds of providers through merger and joint venture.

For example, in Connecticut versus American Medical Response, the state settled with an ambulance company by requiring it to divest ambulance licenses to
competitors, to sell ambulances at market prices and to give up rights to certain primary service areas to rectify concentration in the market caused by a series of acquisitions. California challenged Sutter Health System's acquisition of Summit Medical Center after the FTC investigated and decided not to challenge the transaction. Unfortunately, California was ultimately unsuccessful, failing to prove a relevant geographic market to the judge's satisfaction.

Other states that have actively reviewed hospital physician and clinic mergers in the past few years include Pennsylvania and Wisconsin, both of which have crafted consent agreements that allow the transaction to proceed, but placed restrictions on the merged entity's future conduct. Such restrictions usually characterized as regulatory by detractors and creative by proponents typically require the new entry to pass along to consumers cost savings from efficiencies claimed from the merger and to maintain an open hospital staff and finally to refrain from tying certain services or acting in a discriminatory way.

Attorneys general generally appear more amenable to reaching resolutions that they perceive to be in the public interest. It may be for this same reason that many offices resolve health care issues informally.
Instead or in addition to taking a litigation route, the attorneys general may analyze market conditions and report to the legislature or to an administrative or executive agency.

In 2002, the Massachusetts Attorney General issued a report to the legislature on the Springfield health care market and the Arizona Attorney General issued a report on prescription drug prices, for example. However, price fixing remains a core concern of the attorneys general.

In New York versus St. Francis Hospital, New York successfully challenged the joint negotiations of managed care contracts and allocation of services by two hospitals in Poughkeepsie. The court ruled that the hospital's joint negotiations were per se price fixing agreements and the allocation of services were horizontal market allocation agreements also per se illegal. Interestingly, the hospitals tried to claim the state action defense, which the court found was not valid because state supervision was missing.

In addition to litigating cases, attorneys general issue opinions. My own office in Maryland has a board review program which advocates that licensing board regulations be as procompetitive as possible, commensurate with the board's mission to protect
consumers.

And since I'm out of time, I'm going to say, finally, looking to the future, I believe that the State Attorneys General will continue to focus on pharmaceutical pricing issues, bringing cases under antitrust, consumer protection, and fraud statutes. Indeed, additional states may join Texas, Nevada, Minnesota, and California in bringing or joining AWP lawsuits based on various state statutory and common law theories. However, continued consolidation in the health care industry is certain to remain a concern, and traditional core concerns about price fixing and other, per se, antitrust violations are unlikely to diminish.

Thank you.

(Applause.)

MR. HYMAN: We'll continue commencing at 2:00.

(Whereupon, at 12:40 p.m., a lunch recess was taken.)
the Federal Trade Commission who will have some brief
remarks.

    COMMISSIONER ANTHONY: Thank you, David, and
thank you for all of your hard work in organizing this
very important workshop. Throughout my five years as
FTC Commissioner, I've often predicted that tackling
health related competition and consumer protection
issues would be the Commission's greatest accomplishment
during my tenure.

    As my term comes to a close, I think that
prediction has come true. I'm extremely proud of our
enforcement efforts, although we've had some disappointments in the
hospital merger area. We have really done our best, I think, for the
American public, especially in pharmaceutical cases relating to generic
drug competition. These cases have saved American consumers literally
millions of dollars.

    As you've heard from our Chairman and our three
bureau directors this morning, we certainly aren't
resting on our laurels. Our health care agenda remains
full and varied. Given the Commission's broad
jurisdiction over many sectors of our economy, sometimes
our enforcement actions involve products and services
that seem esoteric or irrelevant to the average
American. In contrast, health care is something that
affects all of our lives and those of our loved ones.
When I talk to my family and friends about their greatest economic concerns, you can bet that health care is always at the top or near the top of their list, Budgeting for increasingly expensive drug products, securing a timely appointment with an over-booked specialist, getting enough of a doctor's time to really discuss a diagnosis or a proposed treatment, dealing with the endless, health insurance paperwork -- well, you and your parents have been there, and you know what I'm talking about.

I'm assuming that we, in this room, are among the lucky ones. We take for granted our access to quality health care, our very ability to participate in the health care system. For those uninsured Americans who can barely afford basic care for themselves and their families, and whose savings could be wiped out by a major illness, the roster of concerns is even more fundamental and frightening.

In short, while the American health care system is, in many respects, the envy of the world, it is, by far, not perfect. The many problems are too complex for one discipline to solve alone.

In this building, the relevant question is, how can the Commission encourage the use of competition principles to improve the delivery of health care and
keep the health care market itself healthy? I'm quite hopeful that this
workshop will help focus the discussion and encourage a dialogue among
all interested parties.

As our work progresses, perhaps we'll be able to
find some answers. However, some relevant topics are
beyond the Commission's authority and beyond the scope
of this workshop.

For example, a doctor friend of mine, whom I
asked to review our proposed agenda, expressed regret
that the Commission couldn't do something about
Medicare, which accounts for a huge percentage of all
health care expenditures. Well, I have to admit, I'm relieved that we
can leave the Medicare reform to other parties. Personally, I do
remain very interested in consumer protection issues relating to
dietary supplements, weight loss products
and over-the-counter remedies, and I hope the Commission
will remain vigilant in those areas.

Having said that, the most critical health care
issues will be covered over the next day and a half, and
I look forward to a tremendous learning opportunity for
us all.

And now I turn the microphone over to the moderator
of this afternoon's panel, John Wiegand. John's a
senior antitrust attorney in the FTC's San Francisco
office. In his 14 years with the Commission he's

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handled a variety of health care matters, including mergers of hospitals, health plans and physician practices. In addition, he's led investigations into horizontal collusion among hospitals and among physicians.

John?
MR. WIEGAND: Thank you, Commissioner Anthony. The first panel will address the subject of provider integration, and our first member of the panel is Ellen Burkett from MedSouth in the Denver area. Ellen?

MS. BURKETT: Thank you. Just so you know, I'm a little outnumbered here. I'm not an economist. I'm not an attorney. I'm actually a practicing physician. I'm the clinical director and vice president of MedSouth, which is a physician group in the Denver area. You've already heard about Denver.

Three of the five decisions this year were about Denver, and I would reassure you that our group has been working on our project for about three years. Antecedent to some of these decisions, we've been working very hard to find a way to do it the right way. Our physician group has been in existence about
six years and reinvented itself about three years ago
with the idea that capitation was not the right way to do business for
physicians. So we looked for another way to do business, and I think
there are several ways that have been mentioned today.

We grasped the one that was probably the brass ring,
which is clinical integration. We are, as somebody described us in
their handout, the unicorn. I've also been described as Joan of Arc.
You know how both of these people ended up.

So we are still working on our project and
wanted to tell you a little about what we've done. We
have currently 315 physicians. About a third of those
are primary care physicians. We are physicians that are
in the south end of Denver, which strangely enough all
of the other FTC decisions that were done were in that
similar area or nearby. So we have been kind of under
the microscope, as everyone else has been in the south
area of Denver.

We have two competing hospital systems in Denver, that
currently have three hospitals. Sometime in the next two to three
years, they'll be five hospitals but two systems. We've undergone many
of the things that have been described here this morning, the hospital
consolidation, the health plan consolidation.

We have had a massive physician exodus from the
Denver area. It's very hard to recruit physicians in
to the Denver area because of the situation. We've
also had specialty groups forming and building separate facilities. We've had all of those issues sort of going on at the same time that we've been working on this project.

We've had two partners, Quest Labs, which is a national lab company, and MedPlus, which is a software company. Those companies came to us to be their beta site for this project and gave us the ability, I think, to accomplish what we've done so far.

We have actually created a plan that does, we think, the best job so far, which is the only job so far presented to the FTC, in doing both clinical and technology integration for our group. The clinical arm uses clinical guidelines. These have been taken from national guidelines, and they've been truncated and measures added and benchmarks added, and those are electronically available to the physicians, and the physicians have signed physician agreements, which they are accountable for the guidelines which pertain to them in their specialty.

They've had to sign off of them, and they all know they're responsible and accountable for how those guidelines are going to be measured.

The technology arm is a large data repository
that's been created for our physician group, and data's already been going in for about a year and a half now. It's going to be ongoing historical data. It currently shares labs and radiology, and we're working on adding prescription information, hospital information and some of the other pieces that go into the system.

We are not contracting as of yet. I'm sure lots of people have questions about how we're doing. We're not contracting yet. It's like a mine field. The FTC reviewed our proposal in June of 2001, and we got the answer back in 2002, and it was basically a yellow light, and I think that was an appropriate response.

I think they made a thoughtful review of our game plan, and to be real honest, those of you who haven't seen it, it's very ambitious. I think it encompasses a lot of things that we intend to do, but we need to be fully and completely implemented before we begin to contract.

I will say that we've met with some of the health plans in the Denver area and have been met with a very positive response. I think the health plans in our area are interested in the physicians taking back some of the responsibility for taking care of patients, and I think that's one of the things that this health plan or

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our clinical integration program does.
We see that there's benefits for the patients,
for the health plans and for the providers, all for
different reasons, but much of it revolves around the
ability to share the information that we use for patient
care.

I think what brought 315 physicians with us,
despite the fact that this was an extensive amount of
money, time and energy on our part, was that this was a
program that was patient-centric. It's not health plan
centric. It really revolves around how to better take
care of patients, and that's sort of the basis of why we
practice medicine.

We want to take better care of patients, and the
ability to do that has been hampered a bit by our lack
of technology. Most physicians, as we found out three
years ago, either didn't have a computer in their office
or only had a computer for electronic billing.

Part of this program is that every physician has
the link. Every physician has a computer. Everybody
has an Internet connection. We all are linked, and we
have the ability to communicate with each other and
share information.

The health plans really like this idea. We are

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giving them a group of physicians who agreed, across the board, to follow national guidelines, follow an excellence of care pattern that we've established for our community, and we are able to communicate amongst each other about how we're doing, report back. We're accountable, and so I think the health plans are in favor of us doing this, at least in our area.

I think one of the concerns we have is we have not yet gone out to contract because we want to be fully implemented to do that. What we met with when we talked and what we meet with when we go to contract may be two different things. We hope not, but we will have to wait to see.

Another concern of ours is we have a very ambitious, complex plan. Our concern is that other groups nationally may try to say, Well, we can Email each other, therefore we're clinically integrated or something not quite as ambitious, and that this could sort of taint the atmosphere in the national community for what clinical integration could do for physicians.

I think another issue that I would have is that the burden of proof for us as a group on whether or not we're improving quality is one that's going to be difficult, and I think we can show some efficiencies,
but much of what we're doing to improve quality are long-term issues. At least in the Denver area, the turnover for patients is about every two years, they change health plans.

For me to sell a health plan, I need to be able to show that we're going to give some long-term benefits to their patients for their diabetes, for their prevention of cancer, those kind of things, so I think that's an issue. That burden of proof that rests on us for quality oftentimes will be long-term issues rather than short-term, Are we going to do one less blood test or one less x-ray.

I think probably the most basic, and I'll end with this, is that this has been a very costly and time consuming project for our physicians. We've worked on this for three years. Basically we were told by the FTC, and I'm sure there's people here looking for their other IPAs to sort of start this road, during that period we were asked not to do any contracting.

So for three years we've sat on some relatively dismal contracts for physicians, and I think what has been the best -- I mean, we went with 400 physicians, and we've ended up with 315 physicians when the dust has cleared, is that the physicians see that this is a
patient-centric program.

It really will improve the quality, and the information sharing amongst physicians, which will benefit patients and I think secondarily benefit the health plans, but it was very costly and time consuming. This was a pretty long haul for us all.

So when other groups are looking at this, whether they approach the FTC or not, I think the point is that if they have a game plan that's as complex and ambitious as ours, it will take them some time and energy and money to do this.

MR. WIEGAND: Thank you. Our next speaker is Henry Desmarais from the Health Insurance Association of America. Henry?

MR. DESMARAI S: Thank you very much. I'm pleased to be here on behalf of HIAA. Our members provide the full range of health insurance products to over a hundred million Americans.

I would like to, in the interest of full disclosure given the topic, to say that I am a physician by training, although for the last 24 years, my specialty has been health policy, and I've been working in both the public and private sectors.

I would like to start by stating that HIAA has
been generally supportive of the statements of antitrust enforcement policy in health care that were issued by the Department of Justice and the Federal Trade Commission.

However, we still remain somewhat concerned about the implications of the MedSouth decision. Clearly, the FTC staff broke new ground in issuing the advisory opinion because MedSouth is going to be clinically integrated and not a risk sharing joint venture.

Now, both the FTC staff and individual commissioners have certainly indicated that they recognize the uncertainties and difficulties that exist in determining if this new model is going to function as its proposed.

We think there's three major challenges that are faced in making that determination. First, in terms of changing practice patterns, it does clearly require an ongoing commitment of time, effort and expertise, and it's going to be difficult to accomplish.

Whether the expected clinical efficiencies are achieved is going to be difficult to determine in evaluating the patient population. As you just heard, they have a variety of specialties, and they're going to
be dealing with a whole range of health conditions.

Secondly, the efficiency enhancing integration does establish goals that are important and make sense, but Commissioner Thomas Leary himself said: "Those who provide the best product are able to charge more for it. They can charge a quality premium, so in the case of MedSouth, if rates go up, how will we know if that's the quality premium or a result of anti-competitive practices?"

It really is not clear exactly how the Commission is going to be able to determine whether efficiencies have indeed been achieved that allowed them to issue the advisory opinion in the sense of balancing likely anti-competitive effects.

Thirdly, in terms of antitrust law, the issue is going to rest on whether the arrangement, the network, remains nonexclusive. Again the FTC staff has already anticipated that in the advisory opinion, to quote from it, "health plans appear to be vulnerable to a threat by the group's members not to contract outside the group unless the plans pay higher than prevailing fees."

So again the issue is going to be with the large number of physicians in MedSouth to be able to determine whether it truly is a nonexclusive kind of situation,
and certainly as we've heard earlier today, there have been now three consent agreements in the Denver area itself, so the fact that we have a heightened sensitivity about the potential implications of this I think is certainly warranted.

Throughout the advisory opinion, the Commission staff states that at this early point in time and based on the information, they weren't going to make any enforcement action recommendations, but they did imply that they were planning to reevaluate based on the Rule of Reason after MedSouth was operational.

Now, what we're hoping is that, in fact, there will be a rigorous review and not simply waiting for complaints to emerge. Again, Commissioner Leary has himself said that complaints shouldn't be the only vehicle here for monitoring the situation as it continues to evolve.

What we're hoping is given the degree of information systems that they're obviously putting into place in MedSouth that they will be easily in a position to provide information that the Commission staff might find useful in continuing to monitor the situation.

A greater concern of ours is that while the Commission's opinion, the advisory opinion, is the problem that this could, in fact, cause other groups
simply to attempt to put in place an identical or a very similar undertaking without the need to seek any kind of review here at the Federal Trade Commission or any kind of advance approval. We believe ideally there would be more of a notification and some upfront scrutiny if, in fact, other groups are going to allege that they are now using the MedSouth model to put in place their own systems.

Now, this may require new legislative authority, but I think it is again an issue that before too long we could find a number of what I would call copycat groups that again might not, in fact, satisfy the level of integration that MedSouth is clearly trying to accomplish.

Let me close by saying that we appreciate the opportunity to participate in this workshop, and we look forward to working with the Commission and the Department of Justice, and we may, in fact, wish to submit some additional written comments by the September 30th deadline. Thank you very much.

MR. WIEGAND: Thank you. Our next panelist is Stuart Fine from Grand View Hospital in suburban Philadelphia, Pennsylvania.

MR. FINE: Thank you. I'm located about 45 miles north of Philadelphia, due south of the Allentown...
market, and just to give you a feel for the market within which we operate, we have approximately 100 hospitals located within 60 minutes driving time of our facility, so when we start talking about market power, the impact of mergers, we have to look at many, many things that come into play in a given market.

Again in our market, which is the one with which I'm certainly most familiar, although I'm here today representing the hospital community in the American Hospital Association, we have the Thomas Jefferson University Health System, which has nine member institutions. We have the University of Pennsylvania with its five affiliates. Tenet came into the market following the demise of the Allegheny Health System. I believe Tenet is now operating five institutions.

Five years ago there were no for-profit institutions in our market operating general hospitals. We now have approximately 11 percent for-profit market share in Philadelphia, so things are very dynamic where we're located and again very unique. If you look at one hospital market, you've seen one hospital market.

We also have an unusual situation when it comes to the third-party payors, in that we have what I, as a non economist, would consider to be at least a duopsony, if not a monopsony, with Aetna and an independent
BlueCross being the predominant payors outside of the
government.

At my hospital, we have approximately 50 percent
Medicare/Medical assistance market share. We have 67
percent of the remaining market share with BlueCross.
We have a situation where when you want to integrate
with another payor, or excuse me, with another provider,
we also have to contend with the Stark Rules. We have
Medicare fraud and abuse implications that actually need
to be looked at first and probably in most cases more
critically than some of the antitrust regulations.

They're harder for us to contend with at the
hospital level. We are severely and strictly limited as
to what we can do in cooperating and doing joint
ventures with other physicians and other providers in
our community. We have had some experience and some
success with integration. We've also had some failures
at Grand View Hospital.

On the success side, we have joined with 11
other hospitals to form a professional liability
insurance captive that has allowed us to continue to
access the professional liability insurance markets
where many of the hospitals and a very large number of
physicians in our market are not having that same level
of success.

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Although our costs for professional liability insurance went up 50 percent last year from $2 million to $3 million, and although in the 89 year history of our hospital we've never had a court judgment against it, hospitals around us are seeing even greater increases in their costs for professional liability insurance. Those are costs that generally need to be absorbed by the hospital since we have multi year provider contracts with the different payors.

When we look at other more clinically oriented things we were part of something called Penn Care. Twelve hospitals that came together to accept risk with one of the large payors that was trying to break in to the Allentown market and had not been able to do so in order to get a contract with some of the hospitals in that area agreed to a risk sharing agreement where we assumed risk for, at its peak, 110,000 covered lives.

We relied on the payor to provide us with certain back office functions, and according to that payor, we were doing tremendously well and operating very profitably until they discovered a $13 million accounting error that put us $11 million into the red.

We are now trying to figure how to unravel Penn Care and how we can approach our medical staff members from our hospitals in the future to talk about clinical
integration or integrating for business reasons and have them not shy away, given the terrible result of the Penn Care experiment.

We do partner with specialty hospitals in the city of Philadelphia. We have the Children's Hospital of Philadelphia at Grand View where they operate our inpatient pediatric unit in a partnership with us, and we have pediatric hospitals available in our community now 24 hours a day.

We lose money on that type of a venture, but qualitatively, it's something that we felt was called for and certainly benefits our community. We do not receive the same payment rates that a Children's Hospital would receive in Philadelphia, but we do, as I say, help to fulfill our mission, especially given the fact that in the suburbs, we're ten miles away from the closest public transportation depot.

So out in our area, if you can't get your health care locally, it's quite an inconvenience, although as I said we have a hundred hospitals within 60 minutes driving time, but you have to have a car.

Speaking about mergers generally, in the Philadelphia market, mergers can be very beneficial. Qualitatively there are tremendous improvements and enhancements to be realized. I would hope that the FTC
will look not only at the cost savings issues but the qualitative issues and work with health care providers and academics to try to determine what those measures should be.

Again in closing, the fraud and abuse Stark regulations are the things with which hospitals have the most difficulty contending. It is not at least currently the antitrust provisions with which we're asked to deal.

MR. WIEGAND: Thank you. Our next speaker is Warren Greenberg from George Washington University School of Public Health.

MR. GREENBERG: Let's look outside the health care sector. It is 86 percent of the GDP, and for a long time, the subject of this panel now is integration. For a long time outside of the health care sector, we've had a long history of vertical integration, a linking of buyer and supplier relationships such as in the petroleum industry where large refineries such as Mobil and Exxon bought their own retail gas stations and were subject, as a matter of fact, with six refineries to a major suit brought by the FTC in 1973.

Firms have also had, outside of the health care industry Per Se, and perhaps in the pharmaceutical
industry, firms have also had a long history of horizontal integration. Mergers of basically the same product such as in the pharmaceuticals, way before the attention being paid today, were firms such as Warner Lambert and Park Davis had merged and been subject to FTC investigation.

My subject today, of course, is on health services, and I would like to focus on vertical integration in health services. I would like to say that vertical integration, although we have a couple panelists talking about physician involvement with hospitals, that would also be included, but also hospitals and HMOs, physicians and hospitals and HMOs or any combination thereof, including long-term care facilities.

These arrangements have mostly occurred over the last 25 years, in large part because the more competitive health care sector has forced firms to be more efficient or look for alternative ways to achieve greater revenues such as through monopoly power arrangements.

Thus, the reasons for integration in the health care sector are the same as outside the health care sector, to realize lower costs, to realize higher profits or prices or some combination of the two. Improvements in
quality care may also be a motive.

In a recently published paper the determinants of hospital and HMO vertically integrated systems, we found, using American Hospital Association data, that hospitals integrated with HMOs when they had a higher market share and a greater bargaining power to purchase HMOs much more cheaply.

The modus for integration could be to reduce transaction costs of hospitals attracting patients from a large number of HMOs in order to primarily transact with one HMO or fewer HMOs in order to achieve a more dependable flow of patients, a lower average cost and to reduce uncertainty.

We also found that hospitals, which have lower occupancy rates also tended to merge, to increase the number of occupied beds and achieve some economies of scale from contracting with a single HMO or integrating with a single HMO.

We also found that vertically integrated systems, as we heard before, do not always work as hospitals would want them to, and for example in 1997, there were 353 hospital mergers with HMOs, yet 330 vertically integrated systems dissolved. There's been a slight decline in vertical integration. In 1994, there were 748 hospital HMO integrated systems compared to

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353 in our 1997 data.

Getting back to antitrust and vertical integration, BlueCross/BlueShield versus Marshfield Clinic in 1994, there was ample evidence to suggest that the vertical integration between the physician group, the Marshfield Clinic, 500 physicians, the St. Joseph's tertiary care hospital, a monopoly teaching hospital in the relevant market and Marshfield Clinics HMO called Security HMO created significant barriers to entry for independent physicians and led to monopoly power of Marshfield Clinic physicians.

Hospital staff privileges were not provided to non Marshfield clinic physicians at the St. Joseph's teaching hospital and its three smaller affiliated hospitals. Marshfield Clinic physicians refused to cover for non Marshfield physicians when the latter physicians were unavailable due to vacations or professional business meetings.

Security Health Plan HMO physicians would send their patients needing specialty or tertiary care to Marshfield Clinic physicians only. Security Health Plan HMO only employed primary care physicians of the Marshfield Clinic. Marshfield Clinic physicians refused to participate with BlueCross/BlueShield indemnity plan.
The Marshfield clinic physicians also agreed not to affiliate with Comp Care BlueCross's HMO. The Marshfield Clinic HMO Security Health Plan also agreed to segment the relevant geographic market with North Central Health Protection Plan eliminating any price or non price competition between them.

High monopoly prices by Marshfield Clinic was the outcome of the integration and anti-competitive conduct by Marshfield, in addition to reduction in choice of physician, reduction in choice of the health plan.

The District Court agreed with BlueCross and BlueShield in this case, finding that Marshfield Clinic violated Section 1 and Section 2 of the Sherman Act, but the decision was overturned by the Court of Appeals when they appropriately defined relevant market to third-party payors. The Section 1 charge, that's the price fixing charge, that Security and North Central HMO divided the HMO markets in northwest Wisconsin was upheld.

Judge Posner sitting on the Court of Appeals suggested the high market shares of the Marshfield Clinic physicians also may be due to their higher quality, but he could provide no evidence of this.

Thus, for the Federal Trade Commission, I would
suggest investigate the vertical integrations, examine
the sources of any monopoly power, if any, such as
monopoly hospitals denying staff privileges to
independent physicians, and be prepared to trade-off the
potential of lower cost against monopoly prices.

To all this, investigate the possibility of
increases or decreases in the quality of physician care,
hospital care or health care plans due to integration.
Volume of surgeries and case mix adjusting the mortality
rates have often been used as proxies for quality of
health care.

The costs or benefits of changes in quality,
therefore, must be weighed against the possibility of
lower costs or monopoly power or vertical integration in
order to arrive at the optimum degree of efficiency in
these health care markets.

That's it.

MR. WIEGAND: Thank you. Next speaker is
Catherine Hanson from the California Medical
Association.

MS. HANSON: Good afternoon. I am vice
president and general counsel of the California Medical
Association and am pleased to be here today to offer the
perspective of the American Medical Association and
practicing physicians on the application of the

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antitrust laws to physician conduct.

We, who represent physicians, support efforts to promote competition in the health care system. Competition often leads to quality improvements, innovation and enhanced access to medical services.

However, we believe it's time to take a fresh look at some of the core principles that have guided antitrust enforcement in the health care sector. In our view, some of these principles simply don't hold up to close examination. They are simply assumptions which have never been proven and in which, in our view, have outlived any purpose they once may have served and are now counterproductive.

Today, I will identify some of these assumptions and explain why we believe the Commission should revisit them. Our central message boils down to this. When physicians create a network to market their services jointly to payors, the Rule of Reason rather than the Per Se Rule should generally apply. The physician network should not be required to do risk contracting, to clinically integrate or to use the so-called messenger model in order to avoid charges of price fixing.

We believe the Rule of Reason is up to the task of distinguishing between physician networks that are
truly harmful to competition and those which are benign, and at the same time will allow greater flexibility, more innovation and ultimately a better health care system.

The first assumption I want to address is the agency's position that capitation and other forms of risk contracting are more efficient than fee for service medicine. Both risk contracts and fee for service contracts are regularly used by payors. The agency's posit that capitation and withholdst promote efficiency by giving physicians an incentive to contain costs.

By contrast, the agencies believe that joint contracting on a fee for service basis creates no efficiencies and is illegal Per Se.

As a factual matter, it's far from clear whether risk contracting is really more efficient than fee for service. To the extent this question has been studied, the results have been inconclusive. To determine this question of efficiency, it would be necessary to gather and compare data on the overall costs in quality of care of both types of physician network. This would be a daunting task. A number of factors would need to be considered, such as the administrative costs of risk contracting, including the cost of legal and regulatory compliance. In addition, the effects of risk

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contracting on quality would have to be considered.
This alone is a highly controversial and unsettled
question.

An additional cost that is all too familiar to
those of us in California is the numerous physician
bankruptcies that have resulted from inadequate
capitation rates. In California where capitation has
been the norm rather than the exception, dozens of
medical groups and IPAs have declared bankruptcy since
1999, and dozen more are on the brink. These
bankruptcies have caused enormous disruptions in care,
jeopardizing the continuity and quality of care for
millions of patients.

Every time a medical group or IPA goes under,
patients lose access to their treating physicians and
must scramble to get their medical records. Patients
are forced again to establish a new therapeutic
relationship with a physician they hope they will
retain, assuming they can find any physician who can see
them.

Even if it were demonstrated that one form of
contracting is more efficient than another, there's a
more fundamental question to address, Is it the proper
role of antitrust officials to state a preference for
risk contracting versus fee for service?
Competition policy ordinarily does not take sides on this sort of question. It usually lets the market decide. To quote Clark Havighurst, "Antitrust enforcers should not, without good reason, deny physician designed arrangements a fair chance to compete against lay controlled entities in finding efficient ways to cope with disease at reasonable cost."

Havighurst went on to say that "the fact that physicians are able to rely on professionalism, collegiality and consensus rather than exclusively on rules imposed from the corporate top down should give them a competitive advantage."

Another assumption that the AMA disagrees with is that joint contracting by physicians on a fee for service basis offers no potential for transactional or other efficiencies.

We believe that joint contracting by physician sponsored networks offer transactional efficiencies that can result in significant cost savings for both the payor and for the physicians. For payors, efficiencies can be achieved as a result of contracting with networks that have already been developed by physicians.

Because physicians still practice predominantly in solo practice or in small groups, creating a physician panel can be a very time consuming and
expensive task for a payor seeking to enter or to expand its place in a market.

For physicians, a network would enable them to pool their resources to afford the necessary expertise to evaluate contract proposals, just as large health plans do now. This would lower costs and rationalize pricing without restraining competition.

To illustrate, I'll describe a fairly typical physician sponsored network. It includes a large number of physicians in the community. All of the physicians' credentials have been pre-approved by the network's credentials community. The network is also truly nonexclusive.

Payors thus have an option. They can build their own network by approaching physicians individually or they can approach the physician sponsored network and obtain ready access to a panel of qualified physicians.

Assume too that payors have the additional option of acquiring a physician panel by going to a national or regional PPO that is not sponsored by physicians but that has contracts with many of those physicians that are in the physician sponsored network.

No threat to competition is posed by this physician network. Because it is nonexclusive, the physicians actively and independently consider contracts
presented to them outside of the network. A payor who
is unable to reach a package deal with the network can
go directly to its physicians or to the competing PPO.
Rather than restraining trade, the physicians have
created an additional option for purchasers, which is
pro-competitive.

In this sense, these types of networks can be viewed as a new product under the Supreme Court's
decisions in BMI and Maricopa. Although some view
Maricopa as creating a strict Per Se prohibition for fee
for service contracting by a physician sponsored
network, the four to three decision in that case should
not be read so broadly, particularly since, because of
its procedural posture, there was no factual record
before the Court on the potential efficiencies of joint
contracting.

Ironically, while enforcement policy continues
to favor risk contracting, the market appears to be
shifting away from it and to discounted fee for service
networks. Many employers and patients want to eliminate
financial incentives for physicians to withhold care.

Should antitrust policy stand in the way of
physicians responding to this consumer demand? Should
our hypothetical physician network be prohibited from
competing on an even keel with the national or regional
PPO? The next assumption worth addressing is that physician networks that want the flexibility to contract on a fee for service basis can simply become clinically integrated.

Although the MedSouth letter represents a thoughtful attempt by the Commission to deal with an innovative effort by physicians to provide new services within the confines of antitrust restrictions, it demonstrates how high the bar has been set. For most physician groups, the level of investment called for in MedSouth is simply not an option.

The letter is also laced with caveats that seem to indicate the IPA will continue to be exposed to significant antitrust risk. After years of work, a very substantial investment, lots of physician and consultant time, the IPA walked away with a luke warm conditional go ahead. This leaves us with another assumption.

The messenger model represents a viable alternative for physician networks that do not want to become financially or clinically integrated. The messenger model, although creative, is an invention worthy of Rube Goldberg. It is purely a device for maintaining antitrust compliance with no independent business justification, and it is cumbersome and difficult to administer.

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Moreover, the messenger model leaves physicians exposed to charges of boycott whenever a large number of physicians in the network independently view a payor's offer as inadequate. Consider the following scenario. A payor offers a contract to the network messenger. The messenger takes the contract to the individual physicians, many of whom reject it as unacceptable. The payor, who views its offer as eminently reasonable, concludes that the physicians must have colluded and so contacted the FTC.

In the end the machinations of the messenger model provide little in the way of antitrust protection for physicians while imposing significant administrative costs on all parties.

Finally, we question the assumption that as long as health care markets remain price competitive, quality will take care of itself. When it comes to antitrust enforcement in health care, quality is too often viewed as a secondary consideration, or worse, a code word for collusion.

The need to ensure quality is part of what distinguishes medicine from other professions and other industries. Subtle differences in approach may make a life or death difference. Quality is the driving consideration which guides medical decision making of

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We are encouraged to hear that the Commission is committed to researching the quality competition trade off. We suggest that the role of quality health care competition is an issue that requires significant additional study. The study must reflect the ongoing work in this area by recognized medical experts.

In conclusion, I would like to thank you for the opportunity to present AMA's views to the Commission. We look forward to a continuing dialogue with the Commission on these and other important issues.

MR. WIEGAND: Thank you. The final member of this panel is Stephanie Kanwit of the American Association of Health Plans.

MS. KANWIT: Thank you, John. I'm Stephanie Kanwit. I'm general counsel and senior vice president for the American Association of Health Plans, better known as AAHP. AAHP is the principal national organization representing HMOs, PPOs and other network based health plans.

Our member organizations provide health care coverage to approximately 170 million individuals nationwide. AAHP member plans contract with large and small employers, state and local governments as well as with Medicare, Medicaid, the Federal Employee Health
Benefits Plan and the State Children's Health Insurance Program, the SCHIP program, so it's both the public side and the private side.

We most appreciate this opportunity to participate in this important dialogue on provider integration and important trends in the health care system.

In an environment of rising health care costs, it's important to take a step back and examine the key factors shaping today's health care market. I would like to talk a little bit about the trends in that market.

According to the U.S. Department of Health and Human Services, HHS, overall health care spending rose 6.9 percent in the year 2000, and that was the largest increase since 1993. A number of factors, of course, are contributing to this increase, but both HHS and the non-partisan Center for Studying Health Systems Change which you heard from this morning in Cara Lesser's presentation, cited increases in hospital costs as the largest single factor.

Moreover, a study commissioned by us at AAHP and conducted by Pricewaterhouse Coopers just this past spring, April 2002, found that rising provider expenses, which is a category including hospitals, physicians and

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others, accounted for fully 18 percent of the increase in health care premiums from the year 2000 to 2001, in that one year. All three studies identify hospital consolidation as one of the prominent drivers of rising health care cost.

Now, while it's clear that consolidation among health care organizations has the potential to benefit consumers by adding efficiency and affordability to the market, in evaluating the impact of any consolidation from an antitrust standpoint, the key question that needs to be answered, and this was addressed by Commission personnel this morning, is whether the test is met. The test is, what is the impact on consumers? Unfortunately, the evidence published to date suggests that some consolidations may have had unintended negative consequences.

I want to briefly review now five types of market activity that we believe should be evaluated closely. Number 1, increases in charges. In site visits to 12 nationally representative communities in 2001, the Center for Studying Health Systems Change found that consolidation has given hospitals significantly more leverage in contract negotiations, making it possible for them to gain substantially higher payments from health plans.
An article in The New York Times from last year, 2001, reported that as a growing number of hospitals gained market power through mergers and acquisition, they demanded rate increases as high as 40 to 60 percent for some services. These rate increases, of course, are ultimately passed on to employers, consumers and governments in the form of higher health care costs.

Number 2, spill over effects. In some instances, provider charges not only increased for the largest player in a given market but also for all hospitals in that particular region. This is because once the largest player obtains a large increase, there's significant upward cost pressure throughout the same geographic area.

Number 3, the issue of all or nothing contracts. In some markets, hospital systems force health plans to contract with every facility affiliated with their system, even if some of those facilities fill no real need in the health plans network.

Number 4, termination instead of negotiation. Some hospital systems are using a strategy of sending termination letters to health plans as part of their efforts to obtain higher rates. While termination used to be the last resort in negotiations, in some highly
consolidated markets, it would appear that termination notices are now being used as the first strategy. The disruption in service this causes and the concern and uncertainty these tactics pose for consumers should be cause for concern.

Last but not least, number 5, increased leverage through joint arrangements with physicians. In some instances, hospitals are forming joint arrangements with physician groups that have increased their market power substantially and resulted in major rate increases for provider services.

In a number of metropolitan areas, for example, large hospital systems own or are affiliated with physician practices. When large hospital systems also own physician groups that represent the majority of physicians in the market, the limits on consumer choice as well as on the impact of consumer affordability are of equal concern.

Now, increases in hospital and physician charges have a ripple effect throughout the health care system in both private and public sectors. As costs rise, it becomes more difficult for both government and private employers, particularly small businesses, to offer health care coverage to their workers.

Consumers ultimately pay the price in the form

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of increased health premiums, higher cost sharing and in extreme cases loss of access to employer sponsored health care coverage. To promote policies and practices that benefit consumers, it is critical that enforcement agencies monitor the market closely and take steps to address anti-competitive practices.

Finally, I would like to go over three recommendations. In light of these developments in the market, we need a renewed focus on ensuring appropriate enforcement of the antitrust laws to ensure that consolidation benefits consumers. Such an approach could include the following three things.

Number 1, given recent press reports about how consolidation is impacting health care negotiations, we believe it is prudent for the agency, the Federal Trade Commission, to proceed with its plans to evaluate the impact of already consummated mergers as Chairman Muris discussed this morning.

Such an analysis is critical to determine whether existing mergers meet the test of benefitting consumers by promoting efficiencies and affordability in health care markets rather than adding another administrative layer simply for negotiating purposes.

Number 2, in the past we believe that the federal courts reviewing hospital mergers have defined

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markets for acute care services as geographic areas that are much too broad. We believe that the initial steps in the agency's analysis should be to reevaluate the definition of hospital markets and to assemble a more appropriate definition that accurately reflects patterns of utilization in the particular geographic area.

Third, we encourage the agency to continue its important efforts in coordination with state and other federal enforcement agencies to gather the facts necessary to evaluate existing mergers and to analyze proposed mergers through the prism of whether the impact is positive or negative for health care consumers.

In the next panel, we will be addressing the important issue of antitrust enforcement and how it impacts quality of care. We believe that maintaining competition in the health care market is critical to create an environment in which policy makers, payors and providers in both the public and private sectors can develop effective strategies to bring health care costs under control and provide consumers choice of affordable health care options.

Thank you very much.

MR. WIEGAND: Thank you, and beginning with your last point about quality of care issues, I would like to raise that issue. I know that Warren Greenberg
expressed some skepticism about quality of care being a
motivation for integration, and I would like, if you
would, for him to expand on that a little bit, and then
I would like to invite Ellen Burkett to respond to that
because she emphasized MedSouth's emphasis on quality of
care. Then I will open it up to any of the other members of
the panel to discuss that particular point.

Warren?

MR. GREENBERG: Okay. This is an unrehearsed
question and unrehearsed answers, but I will give it a
shot.

I think everyone in the health care area has
good will to bring about as much quality as they can.
However, there are constraints on the incentives to
provide quality of care, mostly by health care plans,
and even perhaps on our providers such as hospitals and
physicians. Why do I say that?

The health care plan that advertises, we have
the best quality in the city, we treat HMO, we treat
cancer patients immediately and we'll send them to Sloan
Kettering if they have cancer at our expense or we'll
treat an AIDS patient and open up the doors with an 800
number, if you have AIDS, come in here, we'll treat you
with an infectious disease doctor in five minutes, the
next enrollment period that HMO will be flooded with
high risk individuals. What are the incentives of the health care plans to provide quality under those sorts of arrangements?

There's a problem with risk selection in the health care market. It goes right up and down the line from HMOs to physicians to hospitals. What incentives do the hospitals have to be known as good quality hospitals, maybe again being flooded with high risk individuals?

The incentives are I think people at hospitals want to do a good job. They're professionals. I think physicians want to do a good job. They're professionals. I think health plans want to do a good job. They're run by human beings.

On the other hand, we have to be careful of the incentives in the marketplace. When we talk about quality, we have to really couple it with changes in the incentives. I would ask Stephanie if she knows of any health care plan in the country that will advertise, this is our 800 number and if you're sick with heart disease, we open up our doors to you tomorrow and we'll fly you to the Cleveland Clinic.

MR. WIEGAND: Let's go to Ellen Burkett first, and then we'll let Stephanie respond and any members of the panel that would like to weigh in on this.

MS. BURKETT: She can go first, that's okay.
I think this quality issue is one that I raised as well. I think it's going to be very difficult to measure, and I think it really changes the paradigm for physicians in our community to define what quality is.

I don't think health plans have actually done a great job of that. I think probably the best measure of quality in our community has been how well the health plans achieve their HEDIS requirements, and they're measured, and that's reported in this paper, and that's sort of reported as quality.

I think the physicians in the past have been incentivized, as Warren has said, on cost only. I think it's much more difficult to define quality, particularly in our community where it's a short-term goal of what can you do for me in the next year that I can define as quality? Did your 45 year old female get her mammogram is defined as quality. I think it behooves the physicians to show we're looking at a community of patients over whom we're taking care of over maybe a 20 or 30 year career.

There isn't a lot of turnover physicians to patients. I think there's a lot of turnover with patients to health plans, so I think our definition of quality is a longer term one, and one that I think as
physicians, it's really on our backs to define that.
That's what I said, I think it's on us to define what
that quality is, and I think that's just a different
take on it.

I think we have to define what that quality is
as a physician group rather than waiting for the health
plans to define that for us and not to have it be an
economic decision.

MR. WIEGAND: Stephanie Kanwit.

MS. KANWIT: Quality is an extraordinarily
important issue to health care plans, and I think we're
being a little bit too negative here, and we've made
great strides in the last five or six years, the last
decade, in quality issues. Just this morning, the
National Academy of Sciences Institute of Medicine
report was raised and went into all the quality issues
that are going into health care.

We're also underestimating employers with the
information out, that employers when they buy group
health care for their employees or arrange for group
health care are, in fact, very, very savvy consumers who
are working with HEDIS, JCAHO data, NCQA data about where
the best care is being given and the cost of that data.
Our health plans, on the quality area, are working with
disease management programs, proactive screening
programs, collecting and sharing medical information.

I think one of the things that we're proudest
of, John, is that we're partnering with the providers,
the hospitals and the doctors in terms of these disease
management programs and screening programs and using new
technology under HIPAA as well as just little things like
Palm Pilots and the technology that's out there, making
consumers more knowledgeable and savvy, making employers
as buyers of health care more savvy and in general
getting a healthier population as a result. I'm very,
very optimistic in this score.

MR. WIEGAND: Stuart.

MR. FINE: At least in the Commonwealth of
Pennsylvania we have an entity called the Pennsylvania
Health Care Cost Containment Council that publishes
mortality and morbidity information on each and every
hospital in the state. This is an annual report that
comes out. It also publishes information concerning
charges, not cost to reimbursement but charges that
pertain to each DRG category that's analyzed in the
report.

The report is far from perfect, but it's the
best thing that's out there right now. The frustration
that hospitals like my own have is that we'll have a
report that shows that we have superior outcomes, lower
than expected morbidity and mortality statistics. Yet again the health plans don't modify the way in which they contract based on that, and we've seen very little public response, very little in the way of people changing, how they shop for care based on the release of this information.

MR. WIEGAND: Any other members want to say anything on the subject of quality? Let me pursue the point one step further. Suppose hypothetically that MedSouth were to increase price over time and proceed to contract with payors and proceed to increase price. Let's suppose further that they claim that the increase in price is due to the fact that they've achieved a lot of the clinical integration that they hoped and planned to achieve. How are we going to measure whether that price increase is a result of market power or is it really just a reflection of a better product?

I will let Ellen take a stab at this and then anyone who has any other ideas about how enforcement agencies might address such a question.

MS. BURKETT: I think that's a very difficult question. I think we haven't yet achieved what we said we were going to achieve. I think it may take us a year to have any proof of that know, any reporting.
capabilities back, but I do think with the health plans in consideration in contracting that we can give them something that we have not been able to give them before.

So I do think that we offer a better product, and in terms of one of our physicians who is not here today, we built a better mousetrap, and I think that's worth something to our community of physicians, and it's also worth something I think to our patients, and that makes it valuable to the health plans.

I think we do offer something, and I think you said which is it going to be. Is it going to be power in the marketplace? We see a lot of the leverage techniques in our marketplace. I think our group is walking the mine field here. We're not really out to leverage anybody and pound anybody over the head with a strike.

I think what we're really working towards is a better product from the physicians, and I think there's been this triangle between the health plans and the hospitals and the doctors, and particularly in Denver it's been kind of a vicious triangle, and we've been sort of on the back burner for awhile, and I think the physicians feel like we can provide a better product, and I think that's sort of the hope, that we will in
turn give someone a health plan that may save them some money, and in return some of that may come back to the physicians as well.

MR. WIEGAND: Henry?

MR. DESMARVAIS: Certainly it's possible that MedSouth would be able to -- for example, they could increase fees for physician services, but because of the nature of the systems they've put in place, they're actually saving money by reduced hospitalization or other kinds of services, so there's certainly a lot of theory here to support what they're trying to do.

I don't mean to suggest that we're throwing cold water on the whole concept. However, I think the question you asked, the whole Rule of Reason and how these judgments will be made and the tools, what tools does the Commission and others have to do that kind of analysis and in particular, if there's thousands of MedSouths that occur overnight.

I think there's some real significant issues here to wrestle with, and I think we're anxious to see as MedSouth continues to develop and become operational, the kinds of information it is able to produce, both for the plans that are involved there but also for the Commission and others who are trying to learn really from what is a very good experience.
MR. WIEGAND: Catherine?

MS. HANSON: If I could just add, I think one thing that gets lost a little bit in the MedSouth opinion, at least as I read it, was that they are a nonexclusive network, so it seems to me that the market is going to tell us whether the additional benefit they're providing is worth more money because either people will contract with them, and if they are paying a premium, they'll be paying a premium.

If the premium is too high, then no one is going to contract with them, and since it's nonexclusive, they'll go around them and otherwise contract with the doctors, so I think the MedSouth case actually provides almost no or no potential for anti-competitive problems.

I think the better concern with MedSouth is, as I said, the bar is so high that there's a significant concern about whether they're going to be able to survive, whether they're going to be able to get past three years of development without being able to generate any revenue to support it, and I think that's a very serious question for the Commission to consider is, What are you doing to new entrants here and people who are trying to do things that at least a lot of people think theoretically may be a good thing to do?
The second point is that I do think there is a lag time issue in these things. It costs a lot of money to put together the kinds of information systems that everybody is telling us are going to ultimately provide tremendous efficiencies, and I personally believe that those systems will provide tremendous efficiencies, but somewhere there's got to be money to get those systems in place.

So I think it's very possible that you could have a MedSouth situation where the initial years, there was a higher premium for that, and then potentially over time, maybe there's still a higher premium for that, but in terms of the overall cost of that network providing care to the patient population, it's actually lower from the standpoint of the system.

MR. WIEGAND: Warren?

MR. GREENBERG: I just wanted to hit the quality point again. I think we've come a long way with this quality question in antitrust. 20 and 25 years ago, we never heard this word at the Commission. We only talked about costs and monopoly prices.

Moving along, now there's been talk even by the Commissioner himself this morning about quality in health care. We never had rankings of hospitals in Pennsylvania or New York state before. In the last ten
years we've begun to have these kind of rankings, and I say that once we change these incentives, once we change these rankings, I would also suggest this, that we'll be able to measure quality.

It won't be easy. It will be tough, but compare it with other industries of which there are differences of opinion. Talk about the latest movie that you saw or the last theater performance. You may have liked it. Your friend didn't like it. Somehow we kind of agree that this movie was better than another.

So again that's perhaps why I started off looking at outside the health care box. There are other things that we're buying all the time where quality can be differentially rated among individuals, and yet we've come up with market mechanisms, with government mechanisms, with quasi government mechanisms to try and evaluate quality. I believe this conference will mark the start of exploring changing incentives to look for other ways to measure quality in the health care sector.

MR. WIEGAND: Henry Desmarais.

MR. DESMARAI S: Briefly just to avoid a danger here. We don't have to have a MedSouth to work on quality. Quality's being worked on today. We saw I think it was Cara Lesser this morning showed us a chart
that spoke to the issue of appropriate drug management after a heart attack, and the drugs we were talking about were aspirin and generic drugs propranolol and so on.

So it's not an insurmountable thing. There's a lot of things that can get done. Clearly MedSouth presents an opportunity, a more sophisticated opportunity, but they're doing it in part because they're also looking for the benefit of collective negotiating, so I think that's another balancing act that the Commission clearly has to consider.

MR. WIEGAND: I would like to follow up, if I could, on a point that Catherine Hanson made about the nonexclusivity provision and the MedSouth approach that the Commission took in that letter and ask, I guess I'll direct this first to representatives of payors, Stephanie Kanwit and Henry Desmarais, if you would, how do you find the concept of nonexclusivity to work in practice?

Do we find that to be a real outlet for seeking providers to participate in a network, or is it sometimes more of an advertised portion of a venture's planning but doesn't really exist in real life? How can we at the FTC measure and examine the degree to which a network is not exclusive?
MR. DESMARAIS: Obviously this is another issue of where is the bright line. That's going to be difficult, and obviously it's an issue of, Is it truly nonexclusive or is it just in name nonexclusive, and we were talking earlier today about the various forms of coercion that may go on, refusing to cover for somebody and so on, that can all be brought to bear to say, Oh, yeah, you're free to do something, but subtly don't do it or don't do it very often.

So I think one of the issues is going to be, Well, is it 1 percent, is that enough to be nonexclusive or should we be looking at some other tests, and I think there will be some serious difficulties there.

MS. KANWIT: I agree with Henry. We're going to have to look at this from a de novo standpoint because MedSouth is such an unusual opinion from the Commission. On the other hand we are encouraged by MedSouth because of the Commission's flexibility in that in terms of the doctors there I believe used good faith in developing a novel method of delivering health care, and I think the Commission's opinion is very well balanced.

MR. WIEGAND: Ellen Burkett, how would we know the degree to which the physician members of MedSouth are contracting independently from MedSouth?
going to be anyway that that information is going to be monitored or collected, or are we going to have to go to every doctor and say, How many contracts have you signed, how many patients do you see pursuant to those contracts?

MS. BURKETT: I think the administration of MedSouth knows which of those physicians have contracted outside. If we can't reach agreement with a health plan, we probably will know who is or who isn't, but one thing I would just like to add to this exclusivity/nonexclusivity that is sort of the physician's perspective, sort of not as a MedSouth person but as a physician, is that it's not all about price. I think that's sort of been one of the basic tenets here is if we can't agree on a price, and I think in our group we've actually had some groups of specialists join our group with the anticipation that the price would actually be lower for them than it would be if they contracted individually for two reasons. One is the clinical integration program offers them some benefits with the referring physicians and clinically communicating with the other physicians. The other is that as a group, we have a little more say in contracting negotiations as far as wording of contracts, and in Denver, that's been a huge problem is timely

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payment, hassle factor and things like that.

When we get down to nuts and bolts, it's not all going to be about price, so this exclusivity issue, it's clear that the group is going to be nonexclusive, and physicians will be sign outside of the contract. We've already had that happen in the past, so I have no concerns about that happening in the future, but I think the physicians are motivated to do something beyond just price.

I think we have a group of physicians that's ready to sort of sit at the table with the health plan and express some concerns over a lot of the hassle factors which have driven a lot of our friends and compatriots out of Denver, so I think we're actually talking about something beyond just, how much are you going to pay us for this service.

It's really about having a healthy dialogue as a group with health plans in town.

MR. WIEGAND: Catherine.

MS. HANSON: If I can add a point, I think certainly the practical reality for most physicians at least in California is that nonexclusivity is the rule. People are contracted with multiple networks, and in fact that's part of the problem on the administrative efficiency side is that they can't reconcile their
payments because they've got so many different contracts
with so many different terms with so many different
payment rates, even within one health plan which is
paying them this price for this company and that price
for that company.

It becomes an absolute nightmare, but I think
reality is that nonexclusivity has been the rule.

MR. DESMAR AIS: To make a little point too, to
me it's not just MedSouth's responsibility to even be
tracking this. They certainly shouldn't be precluding
physicians to negotiate outside the MedSouth
arrangement, but I don't think they're supposed to be
sitting there and saying, Hey, you're too linked to us
so you better go out and get some business.

That's really not their responsibility, and
that's another issue I think just in monitoring this.
I'm not sure whether it's MedSouth that is supposed to
be collecting the data how frequently their physicians
are, in fact, entering into agreements with other
plans.

MR. WIEGAND: So would you say there would even
be some danger in MedSouth collecting such data?

MR. DESMAR AIS: I think there could be, yes,
depending on exactly how it's used and what the
implications might be. So again, it's a challenge, and it
does put them in a difficult position because the advisory opinion clearly was conditioned on seeing that this truly was nonexclusive.

MR. WIEGAND: Any other comments on the value to consumers through nonexclusivity of the provider network?

I would like to follow up next on a point that Catherine Hanson raised in her initial presentation, really questioning the value of Per Se Rules, and I would like, if you would, Catherine, to address whether you would advocate eliminating Per Se Rules to all industries or just to physicians, and if just to physicians, if you have a kind of neutral objective basis for advocating such position.

MS. HANSON: I protest no expertise with respect to all industries, so I'll stay away from that one. I think the concern in the health care arena is that what we have seen, and again I speak primarily from California since that's been my experience, is that the FTC rules and guidelines have led the industry in a particular direction which has proven not to be ideal, to use somebody's wording here today.

I think it's not so certain that risk integration, for example, is absolutely the best way to go, and one of the things we found in California is that
in order for a physician group to take capitation, they really have to become a little insurance company, and that takes a huge amount of money and a huge amount of expertise, which is not within the normal training of a physician.

A number of physicians in California got into capitation without knowing really what it meant and without, in our view, getting adequate information from the health plans about what kind of risk they were going to be taking in any event, but the net result of all of it was a huge amount of fall-out and disruption in the community.

Under those circumstances, it seems to me that it's time to say, we really don't know where things should go. We need to provide some more flexibility. Obviously I fully understand if a doctor group is getting together not to be nonexclusive and simply to boycott various arrangements, that's a whole different kettle of fish, and clearly under the Rule of Reason, that would be a violation.

I think the concern is when the Commission starts setting rules and starts setting the bar high, as it has in the MedSouth case, that you're both shutting out a lot of innovation that may be beneficial and you're potentially not even allowing an organization
like MedSouth to ever get anywhere because they simply

  can't afford to get through all the hoops to get clearance.

MR. WIEGAND: What do our other panelists think about possibly eliminating Per Se Rules as they would apply to physician networks?

MS. KANWIT: Not much. Basically as I understand Catherine's proposal here, what this would be would be a back door way to physician collective bargaining. One of the issues in the recent Conyers/Barr bill that came up before Congress this spring was exactly that, was treating health care in a physician bargaining in a different way and carving out physicians out as an exception to the antitrust laws. This A, raises prices for consumers in both the public and private sector, and B, isn't necessary because they already, under the health care guidelines, can talk to each other about quality and treatment, et cetera.

So this is kind of a back door way to do that.

I think we also need to remember what Per Se Rules apply to. They apply to price fixing, boycotts and market allocations. I just cannot see the benefit to consumers, again I harp on this, in a time of raising health care costs of having the DOJ or the FTC spend three years looking at a physician group to determine
under the Rule of Reason whether a certain arrangement is or is not violative of the antitrust laws. That is not going to benefit consumers.

MR. WIEGAND: How do our other panelists see it?

MR. DESMARAIS: I agree with what Stephanie just said. I'm not an attorney.

MR. FINE: Again from the hospital perspective the issue becomes much more the Stark Medicare fraud and abuse implications than the antitrust implications.

If we have a Per Se illegal situation, if we want to joint venture with physicians, we want to invite physicians to participate in our MRI unit, but if they do that, that will constitute an inducement for them to refer. Instead, they can own their own MRI. They can put one in an office and own it outright, but they can't joint venture with us, so we are disadvantaged competitively.

So I know that that's not where you were taking this, John, but we have the concern on the Medicare side.

MR. GREENBERG: You can have an example of 20 physicians or a number of physicians sitting together in perhaps a non smoke filled room fixing prices or attempting to fix prices because there are so many of them that they feel they
have to sit in a non smoke filled room to attempt to fix prices. That's going to fail. Physicians' behaviors are different. Physicians are practicing differently. FTC or Department of Justice can brings a case. There's no way that these 20 physicians are going to be able to fix prices with different types of practices and different types of locations and so forth. If that case is brought, perhaps it would be a waste of Commission resources.

On the other hand, three physicians, not sitting in a non smoke filled room, kind of following the leader, following each other carefully, not violative of Section 1 of Sherman Act, that may go right by the FTC and where that may, in fact, become a scenario of higher prices.

Given that, I think it's a tough good question that you asked. I think there's such things as transactions costs, as Stephanie pointed out, and there's such a thing as length of trial, as Stephanie pointed out, and I think on balance I think we ought to look at Per Se and keep that Per Se approach, but with the cognizance, let's be smart about which cases we bring about in the Per Se area.

MR. FINE: John, I will add one other thing, and that's not on the physician side but on the hospital side.
If we can't work with hospitals with which we're not integrated or merged to rationalize services in a way that makes sense from a public health perspective, then we are left with no option but to seek the merger alternative. We're sometimes forced, due to failing concern issues or other complicated issues, to look at alternatives that we might prefer not to pursue but then we're forced in the direction that I believe FTC would rather not see us go.

MR. WIEGAND: So you're really saying that there's situations in which you would like to do a joint venture collaboratively with competing hospitals, but you feel constrained due to the fact that you might be caught into the Per Se dragnet.

MR. FINE: Exactly.

MR. WIEGAND: Catherine.

MS. HANSON: Just to follow up, I think there are other places where the Commission and certainly the courts have looked at joint sales agencies and have found pro-competitive justifications that allowed them to go forward, and I think what we're saying is that when you look at certainly networks, physician networks, they are out there.

They're being developed by for-profit
entrepreneurs because there are employers particularly that are very interested in being able to access a physician network, and they don't want to have to go through the cost of developing that network.

It clearly is a product. It's clearly out there, and yet because of, in our view, the weird way that the Maricopa case came up, none of those issues really were in front of the Court, and so the Court suggests that all physician network activity is inherently Per Se illegal.

So I'm not saying that you have a number of doctors who sit down and do something that has no pro-competitive justification, that ultimately you might conclude that that's totally illegal, you probably would, but the question becomes in this area of physician networks where you have purchasers for that product, i.e., they want something more than just access to a single physician, that there are clear pro-competitive values in that. At a minimum, the Commission ought to hold hearings on that question and reassess whether every one of those is inherently anti-competitive or ones that have some level of clinical integration that doesn't meet close to what MedSouth has done but are moving in that direction given limited financial resources, that there ought to be a

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second look at what's happening out there and what might be ultimately in the benefit of consumers.

MR. WIEGAND: Anyone else on this point?

Let's talk for a moment about the legal form of the network. I don't think this issue has been raised, but it occasionally appears in real life. If the network is itself a corporation composed of all the physicians or partnership composed of all the physicians, should it be immune from antitrust scrutiny?

Say an organization like MedSouth was created not as an umbrella entity but as a merger of all the physician practices into a single partnership or a single shell corporation, should such an entity be granted immunity just because it's a single entity?

Warren, do you want to speak to that first?

MR. GREENBERG: No, but I'll leave it to my colleagues to expand on that. I don't quite see the reasoning why it should be granted immunity. I would say no. I think they should be investigated.

MS. HANSON: I don't think I understand or I'm not sure I understand your hypothetical.

MR. GREENBERG: Just say no.

MS. HANSON: Are they integrated, or just it's an IPA that's set up as a professional corporation.
MR. WIEGAND: It's the latter.

MS. HANSON: Well, that's the current situation. If they're not a single entity, then they're going to be, now in our view, too strictly under the Per Se Rule, whereas they should be viewed under the Rule of Reason depending on whether what they're doing has pro-competitive justifications that outweigh the anti-competitive effects.

MR. WIEGAND: Sure. The concern is when they are legally, from a legal point of structure, a single entity and arguing that they're incapable of conspiring with one another because they're in a single partnership or a single corporation, but economically they're not integrated in any way at all, and whether that kind of arrangement is a problem to payors, whether it's something that's commonplace in the industry.

MR. GREENBERG: I think payor would have a problem with that, wouldn't they? A single entity combined together, wouldn't you have a problem with that, Stephanie?

MS. KANWIT: It's hypothetical.

MR. WIEGAND: Sure.

MS. KANWIT: I really can't answer that. I'm trying to remember, John, if we're talking about are they risk bearing? Is it clinically integrated in any
way? What is the network?

MR. WIEGAND: No. There is no clinical or economic integration. The member physicians have put all their practices into a common partnership, haven't changed anything else as to what they do, except they might change their prices, but they haven't changed anything about what they're doing as far as financial risk sharing or clinical integration.

They've just created either a shell corporation or a shell partnership that covers all of their practices and created a single legal entity, and my question is: Is that an entity that ought to be exempt from application of the antitrust laws generally or the Per Se Rule specifically?

MS. HANSON: Yes, it should be exempt from the Per Se Rule, and it should be reviewed under the Rule of Reason.

MR. WIEGAND: Anyone else?

MS. KANWIT: Let me just add payors, are not always in the best position to know exactly how an entity like that, John, is constituted so you're asking a payor representative a difficult question here.

MR. WIEGAND: Okay. Are there any other questions, the panelists would like to raise?

MR. DESMARAI: One of the things I wondered
about, MedSouth clearly has come forward and dealt with
the Commission staff and received an advisory opinion,
but to the extent other groups begin or think they can
rely on that opinion to set up similar entities and then
they in turn begin to negotiate collectively with plans.
I'm beginning to wonder, absent some notification of
what's going on, that we are clinically integrated and
so on, whether plans are going to begin to report to the
FTC some suspicious activity believing that, well, these
aren't risks, they are not a risk sharing arrangement,
and so they really shouldn't be doing what they're
doing.

So I think it could potentially cause some
confusion out in the market.

MR. GREENBERG: John, may I ask a question of
you, and that is, let us say the FTC does the right
thing, as it usually does work in the public interest.
What does the FTC expect to see, a drop in the increase
in rising health care costs, a one-time drop in health
care costs, a continual curve of rising health care
costs?

MR. WIEGAND: I can only speak for myself. I'll
give a standard disclaimer.

MR. GREENBERG: You asked me a question.

MR. WIEGAND: I can't speak for the Commission
or Commissioners or Bureau Directors or anybody else. I think that from either financial integration or clinical integration, what we hope to see from it is ongoing efficiencies being achieved, and ongoing improvements in the delivery of care.

Over time, as those benefits are achieved, there's also going to be affecting the marketplace cost increases, so if you're just looking at price, I think what you'll see is an initial benefit, and you might even see prices go down or the rate of increase take a dramatic hit.

I don't think anyone's suggesting that an improvement in efficiency is going to be a cure all to price increases over the long haul because as technology advances and medical science, people want access to that. It's a story about everyone wanting 1970 prices for 2002 medicine. Well, that's not going to happen, and I don't think anyone at our agency is suggesting it will.

We're going to take about a five-minute break.

MS. MATHIAS: Actually the next panel is set to start about 3:50, so if we could just make it 3:45, give you all a little bit more than a five-minute break, about a ten-minute break. We'll start on time at 3:45.

Just two quick reminders. If you didn't see the MedSouth opinion, it is in the brown handout under the...
Bureau of Competition section in the handout. If anybody wants to review that, it's in the handout. Also if you go out and use our cell phones, please turn them off when you come back in. Thanks.

MR. WIEGAND: I would like to thank all of our panelists.

(Applause.)

(Break in the proceedings.)

MS. MATHIAS: Let's go ahead and get this started again. Please turn off your cell phones. They do interfere with the sound system. Let's get this rolling so everyone hopefully can get out of here.

I would like to take this opportunity to introduce Mark Botti. Mark is the chief of Litigation I in the Department of Justice which handles all health related antitrust measures at the Department of Justice. I'll hand this over to Mark.
Panel 2, Health Insurance, Payor/provider Issues

Panel Members
Helen Darling, Washington Business Group on Health
Henry R. Desmarais, Health Insurance Association of America
Stuart Fine, Grand View Hospital
Stephanie Foreman, Pennsylvania Medical Society
Donald J. Palmisiano, American Medical Association
Lawrence Wu, NERA
Mark Botti, Department Of Justice, Moderator.

MR. BOTTI: Good afternoon, everyone. I think the best way to do this, since we've been here awhile today, is to launch into our panel. We're going to use the same objective criterion of the alphabet in deciding which order we'll go.

Helen Darling from the Washington Business Group, can I ask you to start us off with your remarks.

MR. DARLING: I will, thank you. Thank you very much. I come from the Washington Business Group on Health which is the national voice for large employers dedicated to finding innovative and forward solutions to health care problems.
Our membership includes 175 mostly large employers, Fortune 100, Fortune 500, representing about 40 million retired and active employees and their families.

As employers we would, of course, not surprisingly like to see a health care marketplace that competes on the basis of quality, innovation, service and price as other goods and services do.

Unfortunately, as I'm sure everyone in this room knows, the health care marketplace doesn't function very well, and it falls far too short on many of those, in fact I would say virtually all of them.

Employers and consumers, which you also know, it's in the paper almost daily, have been facing double digit health care cost increases. Over a five-year period we had 50 percent increases. This year, meaning 2002, are looking at 13 to 14 percent on top of the 50 percent. It's estimated that 2003 will be another 13 or 14 percent depending on whose numbers you use.

In effect, health care has indeed become more unaffordable than ever, and of greater concern is there's absolutely no end in sight. All of the underlying forces currently driving health care costs are there, and there's no reason to believe that they're
going to change any time soon.

Unfortunately, overall the growth in health care cost, the spending has been associated in the last couple of years with hospital costs. Up until 2000, the main driver of health care cost increases were prescription drugs. That changed in 2000. It will change again in 2001, and given what we've seen in some of the markets around the country and some of what you all have heard, and you heard this morning from Cara Lesser from the Center for Health Systems Change, we have no reason to think that is going to change at all.

Provider consolidation, particularly hospital consolidation, is we believe strongly aggravating these cost increases. In a growing number of geographic areas, urban and rural, northern California, Long Island, other places, consolidation has left us with either a single hospital or a few dominant systems, and they have in turn chosen, for whatever complicated set of reasons, in some instances to demand and essentially receive payment increases of up to 40 percent in a single contract year.

We've also seen that there are hospital systems, we've put that in quotes, that join together for cost price negotiation purposes with no apparent evidence of any other integration of services, resources or
referrals or anything else that might directly benefit
patient care.

We believe, not surprisingly, that these actions
hurt consumers and make it more difficult to institute
programs that improve quality and moderate cost.

We have had a number of highly public so-called
contract showdowns, again you heard about that this
morning, between hospitals in some communities and
payors reflecting the increase in the market power of
hospitals. Some of the most dramatic ones of course
were in Boston. I know we have someone here from the
Boston area.

I can tell you that I have many members who are
directly affected by what happened in Boston. It was
pretty amazing, really nothing like anything we've seen
in this country at least in my entire career. So things
have really changed rather dramatically.

We also know that consolidation which at least
in theory might provide some benefits for volume
referrals and some other things that we might value in
quality, what we have seen is no evidence that that
happens, and we could talk about some of the
trade-offs. The reality is we're not seeing any
trade-offs of any kind, other than increased cost and
virtually no changes in quality and certainly no changes

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or no ability for health plans or employers to have any ability to negotiate or frankly to even get some kind of flexibility to talk about quality matters.

Also we know that hospital consolidation may actively harm quality and certainly purchasers' and consumers' ability to reward hospitals that compete on quality and innovation and transparency in the health system essentially is impossible if there's only one hospital or one dominant hospital system.

So we don't even have the ability to do some of the really important innovations, such as tiered networks where we begin to change the dynamics of the health system by empowering consumers with money, their own money or the belief it's their own money because they have choice. When choice goes away, all of our ability to try to drive the system towards quality innovation essentially goes away.

On prescription drugs, just to shift subjects, employers support fair market rules that promote access to affordable medicine as well as promote the development of tomorrow's innovative therapies. We believe that playing by the rules stimulates innovation and promotes robust and fair competition that benefits consumers.
Anti-competitive abuses and unwarranted delays to market entry harm employers, employees and all consumers, and we find that pretty unacceptable at this point. Employers would also be very concerned about efforts to ease or waive health care antitrust regulations in general and for any specific segment of the health care industry. Such a change is likely to reduce access and competition and lead to higher costs, particularly for some services or in some geographic areas.

We urge you to carefully assess any proposal to ease health care antitrust regulations to determine who will really benefit. In an increasingly consumer driven health care world, which is what we're already in, will be more so as consumers pay an increased share of their own health care costs, there must be clear benefit to the consumer.

Employers applaud recent efforts by the FTC to step up antitrust enforcement efforts in health care and increase staffing in this area. We cannot say that strongly enough. We are very pleased by what the FTC is doing and feel that it's extremely important at this time that they continue with that very impressive effort.
In addition, employers believe that post merger follow up and continuing oversight is essential to determine whether hospital mergers have actually benefitted consumers or simply allowed hospitals to charge more and importantly resist efforts to improve quality and patient safety.

And if I may, I would just like to make one quote from an article in Health Affairs by Spange, Bazolli and Arno, they concluded "The position that hospital mergers should be presumed beneficial for consumers, unless they pose severe threats to competition, is not well supported." And we certainly agree with that.

Finally, our point on information is that transparency in the health system is an essential ingredient for a truly competitive health care marketplace and is essential if consumers are going to be able to navigate and negotiate the system, which they will have to do whether we do anything else or not.

Providers should be making information on quality, utilization and performance easily available to all consumers. In many cases a lot of information, very valuable information is already publicly reported and is not proprietary and does not risk any confidentiality.
We believe that all hospitals should pose all publicly reportable information in a user friendly way on their web sites so that consumers can use it to select on quality, efficiency and service.

Thank you.

MR. BOTTI: Thank you, Helen. Let's just move it along. Henry Desmarais from the Health Insurance Association of America.

MR. DESMARAIS: Thank you. This panel obviously addresses some issues that are at great dispute between providers and health plans, and because of my own personal concern that this could become too easily overly adversarial and unproductive as a dialogue, I wanted to begin by emphasizing that HIAA is committed to working with the physician community in the hope of addressing problems before they become the subject of bitterly divisive legislative proposals or lawsuits.

Obviously we have a long way to go in recognizing this hope, but our current president, Don Young is a physician. Last November our board approved a resolution strongly supporting open communication and collaborative working relationships between HIAA and organizations representing physicians and other health
care professionals. In approving this resolution, the board heard that such relationships are necessary to establish trust and to further the shared goals of strengthening the physician and patient relationship and encouraging high quality affordable health care.

Obviously we all recognize here that the Federal Trade Commission is ultimately there to protect and benefit the consumer, and if relationships between physicians, health insurance plans and employers are not functioning appropriately, consumers will be the ones affected the most. If access to needed physician services is compromised or if health insurance coverage becomes unaffordable for employers, individual consumers are the ones that are affected.

The issue of affordability is certainly an important one, especially at the time of rising health care cost. We've heard quoted earlier today recent studies showing that employer based health insurance costs rose 12.7 percent from spring 2001 to spring 2002.

I think quoting further from that study, they said that this high rate of growth appears to have been driven primarily by rapid inflation and spending for health care services. Some people like to think that
it's rising premiums and with the assumption somehow
that insurers are the only ones that are involved or
explain the increase in costs, but again it's the
services and the cost both in terms of increased price
and increased utilization that are key here.

The report also, by the way, went on to say that
monthly employee contributions for health insurance rose
from $30 to $38 for single coverage, and from 150 to 174
for family coverage, and finally the study found that
employers responded to the rising cost by increasing
employee deductibles and copayments, reducing covered
benefits and even in some instances dropping health care
insurance coverage all together.

So in this context it's important to
consideration the implications of potential changes in
public policies on access, cost and quality.

The issue of whether consumers benefit when
providers combine to form what they call a
countervailing balance is one that is brought to the
forefront by physicians seeking to bypass antitrust law
and form cartels to collectively bargain with health
plans on fees.

HIAA, it's not secret, is strongly opposed to
any federal or state effort by physicians to gain this
kind of an exemption. A recent study by Charles River Associates show that enacting physician antitrust regulation would increase health care costs by 5 to 7 percent.

A more recent study by Charles River Associates also states, "There are no economic principles that support the argument that bargaining between two parties that both possess market power leads to a superior outcome for ultimate consumers, in this case patients, than bargaining between one party with market power and one without."

In our view physicians and providers currently have significant market power and the ability to legally negotiate with health plans. In addition, employers have expressed the desire for less restrictive managed care plan designs and access to large provider networks through their employees, so this is another factor that puts physicians and other providers in the position of power in negotiations with health insurance plans that need to contract with large numbers of physicians or even with specific must have physicians in order to satisfy consumer did he hands.

Testimony by Paul Ginsburg, the President of the Center for Studying Health System Change, shows that one

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likely factor resulting in an increase in the cost of health insurance is hospital consolidation.

Physicians argue that health insurers that have a significant health insurance market share possess monopsony power or the power to suppress the purchase of physician services and therefore suppress physician fees.

While the insurance and physician service markets are interrelated, they are not identical, and the competitive characteristics of each market must be analyzed separately. There is a great deal of competition among health insurers in purchasing physician services. As noted in one recent report "any attempt by a single plan to decrease the rates it pays providers below the competitive level would be offset by its competitors taking the opportunity to augment their provider panels and thereby grow their businesses at the expense of the plan attempting to reduce its fees paid to providers. Even if health insurers possess significant market power, they might not have market power in purchasing physician services."

Physician groups can use consolidation to increase their bargaining power. Physicians can capitalize on their good reputations or powerful presence in local
geographic areas to achieve leverage with insurers. In addition physicians have other sources of income, including Medicare, Medicaid, federal and state employee plans and also obviously a big presence in the market, the self-insured plans.

As Catherine Hanson reminded us earlier today, the average physician has contractual or other business arrangements with multiple private plans, and has she told us, even if they contract in the case of a single payor, then they have multiple payment arrangements with different payment schedules.

It's also I think important to recognize that insurers are subject to intense governmental scrutiny of their business practices. Some examples of regulatory oversight include the following: Regulation of insurer's financial statements, regulation of insurer's investments, financial examinations, review and approval of premium rates and policy forms, regulation of form and substance of disclosures, regulation of discontinuance and replacement of policies, investigation of consumer complaints, performance of market conduct examinations, investigation and prosecution of insurance fraud, and finally regulation of trade and claim payment practices.

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Indeed, there are few business activities an insurer can undertake without having to consider compliance with an existing law or regulation. This includes issues relating to mergers, acquisitions and antitrust. While actions taken by federal authorities, both the Department of Justice and FTC, against insurers for antitrust concerns are not common, this lack of activity is not attributable to a lack of scrutiny. Certainly this morning Deborah Majoras from the Department of Justice told us a great deal of how they were looking at the issue of consolidation and also collective activity by insurers.

In addition to the national antitrust enforcement agencies, State Attorneys General are also very active, and we heard Ellen Cooper echo that early today.

I would like to emphasize that the insurance business is extremely competitive. There are multiple pressures on insurers from purchasers of the product, both individuals, and remember there are 16 million individuals in this country who purchase their own health insurance, as well the remainder of the population that's covered obtains their coverage through their employers.
There's also obviously pressure from providers and also individual consumers. It's a difficult business. It's a business where risk has to be managed, and this is not easy, and you've heard about the physicians in California who entered into risk arrangements and who had difficulty.

Well, it's not easy to manage risk, and with the cloud of bioterrorism hanging over us, it makes it even more difficult, so once again, I would like to close by thanking the Commission for providing HIAA this opportunity to participate in this important forum.

Thank you very much.

MR. BOTTI: Thank you, Henry. And Stuart Fine, Grand View Hospital.

MR. FINE: I'll just pick up where we left off with the prior discussion. In the Philadelphia market, we have a rather unique situation in that we have a particularly concentrated payor market that creates formidable barriers to entry to any insurance company that might want to try to break in.

I've already described our situation at Grand View Hospital where we have one insurer who has 67 percent of the non Medicare, non Medicaid market. I can only imagine what it would be like, the deep pockets it would take for an insurance company to come in and try
to position themselves to do business in such an
environment.

We heard comments in the previous panel having
to do with hospitals and hospital networks demanding
that people take or, excuse me, that insurance companies
accept all or nothing contracting, that each of those
networks must be taken as a network in full rather than
as individual facilities, should that group want to
contract with the insurance payor.

In Philadelphia we have the converse of that.
We have a situation where the predominant payor requires
all products be accepted. We have no option to say,
well, we would prefer not to participate in your
Medicare HMO product.

In our county, the only non government Medicare
product is provided by one entity that has 99.7 percent
market share. That is not something someone else can
come in and easily contend with.

We've heard from a couple different people
earlier today about hospitals involved in contract
showdowns where, rather than try to negotiate renewals
or changes to contracts, it's been made to sound like
there would be unilateral termination on the side of the
hospital. What wasn't stated was that the hospital
contracts all contain within them Evergreen provisions,
automatic renewal provisions, that if cancellation or
termination is not effected within 60 or 90 days prior
to the expiration date, that contract automatically
rolls over for another three to five year term.

My hospital was one of the hospitals that was
involved in such a situation in the Philadelphia market,
and for a period of five months, we worked to try to set
up meetings, face-to-face meetings, and we were denied
for five months. So we had no option but to submit a
notice of contract termination, and then it was made to
sound as if we had acted in a very Machiavellian way.

We have a situation with the health insurers
where we have market segmentation. In the situation
with BlueCross, we have county lines that BlueCross
plans won't cross, so we happen to sit in the very
northern end of Bucks County, Pennsylvania. We're
within the Independence Blue Cross territory, where if
we were just a few miles up in the world we would be in
the Capital Blue Cross territory.

We are not allowed to negotiate with Capital, to
have a contract with Capital. We have to do our
contracting through IBC, so there's market segmentation
that works one way but again can't work another.

What we're looking for is a road that runs both
ways, a level playing field, and we're very frustrated
that from the perspective of the hospital, we don't have
that.

When it comes to the issue of cost, in our contracts, the standard in the Philadelphia area is an inflation index tied to the Mcgraw Hill DRI. If we have increased costs, for example, the professional liability insurance costs that I mentioned a little while back that went up a million dollars, we can't pass that through. We get the DRI, and if you're lucky you get the DRI plus a fraction of a percentage point, but you do not get to pass through things like Zygroous, the new drug that costs over 8,000 dollars per course of treatment, the coated stents that we've heard mentioned earlier today, the labor costs with which we're all confronted, given the nursing shortage and the shortage of pharmacists and radiation techs and things like that. This is very, very frustrating.

We have an average age of plant that requires attention. I know at my facility we're looking at a 30 million dollar enhancement to plant. Hospitals have deferred and deferred acting on plant, but now we have a situation with the baby boomers coming through where demand for services far outstrips our ability to meet that demand.

Nationwide, hospital spending has grown at a slower rate than health care spending overall. We've
heard some inconsistent data here on this morning, and I find that confusing myself, but I can only tell you that the data that I've been reviewing and that I reviewed even just this past Friday showed that up until at least the year 2000, spending on health care increased 6.9 percent overall, but on hospitals it was 5.1 percent. Hospitals account for 33 percent of the total health care spending, but only 25 percent of the growth in health care spending.

We have unfunded mandates with which we need to contend, HIPAA, the Privacy Act is expected to cost hospitals 22 billion dollars over the next five years; disaster readiness, another 11 billion dollars over the next two to three years.

We are working to improve quality and patient safety. Those are not things for which we receive direct compensation. We have Medicare and Medicaid payment shortfalls.

Since the implementation of the Perspective Payment System back in 1987, Medicare has passed through less than their calculations concerning cost to increases by a cumulative 21 percent. That's a very, very hefty gap when in our case, as I've already stated, Medicare and Medicaid provide 54 percent of our

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revenues.

We have demands from private payors, employers and consumers such as the Leapfrog Group saying that hospitals should have hospitalists operating their intensive care units 24 hours a day. At the same time at my institution the Solucient Group named us as operating one of the top 100 Intensive Care Units in the country based on effectiveness and patient outcomes, but we don't have hospitalists.

So do we put the money out for the hospitalists, although our outcomes appear to place us in the very top tier, or is that not a necessary expenditure?

Access to capital, is very very problematic. In 2001, bond downgrades for hospitals exceeded upgrades by six fold. We are an A 2 credit by Moodies, and we have been told that if we go to the bond market this year, it is unlikely that we'll be able to get bond insurance because we happen to be situated in the Philadelphia market. It has nothing to do with our balance sheet, nothing to do with our credit rating. It has to do with our geographic location.

Wrapping up, we have increased competition from other providers. The merger activity around us has actually slowed over the past five years, at least in
the market with which I'm familiar, but we still have
issues in some states with Certificate Of Need laws
being barriers to entry. In Pennsylvania, CON has gone
away, and we've seen a proliferation of things like open
heart surgery programs. We've seen 16 new programs
developed in the five county Philadelphia area in the
past two years, but the number of surgeries being
performed has not increased.

So we're seeing that segmented more and more.

We have the difficulties with Stark that I've made
mention of previously relative to inducements to refer.
We have specialty or niche providers such as cardiac
hospitals, heart hospitals, bariatric hospitals being
developed around us.

In the nation, we have one-third of our
hospitals operating with a negative operating margin.
In the Commonwealth of Pennsylvania that number is
two-thirds, so that's pretty much our situation. It's
pretty ugly.

As I say, what we would hope to see from FTC
activity is a leveling of the playing field, a situation
that not only looks at hospital alignment but one that
looks at the market power of insurers as well.

Thank you.

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MR. BOTTI: Thank you, Stuart. Steve Foreman of the Pennsylvania Medical Society. PowerPoint?

MR. FOREMAN: PowerPoint. Good afternoon. I'm Steve Foreman. I'm director of Health Services Research for the Pennsylvania Medical Society. I'm here to present a bit of a different view than you may have heard earlier today.

Many of our constituents see, at least think they see a gradually disintegrating health care market in the State of Pennsylvania. In fact, there's some of us who are concerned that one or two random events might cause that disintegration to accelerate rapidly, a disintegrating screen, too. We're concerned about a rapid disintegration in these markets and a total unwinding to be totally blunt.

I'm just a poor North Carolina lawyer, so I brought some pictures. We have four markets as defined by BlueCross firms in Pennsylvania. I'm going to present some figures from one of them, but we believe they generalize. We conduct our analysis, we've been doing this for about six years now, in what I will call a comparative context.

We don't think that you can look at any one segment of the market and reach conclusions about
competition or market power. We look at the relative position of all the players in the market, so what I mean very specifically is that in the market for health insurance, that part of the segment, we look at the relative power of insurers compared to employers, who are the major purchasers here, and then in the other segment, the market for medical care, we evaluate the market power of providers like hospitals and physicians compared with health insurers. We think this is the best way to look at these markets.

Obviously we're using a structure conduct performance analysis in doing this. We have actually built some demand curves in, and we have found a number of downward slopping demand curves, and we think that in terms of ongoing research, that's an area where the Commission might make some strides.

Our first picture in terms of the structure, I said we're going to do this in a comparative context. It's unnamed, I took the names out so we're not talking about specific times, an unnamed market in Pennsylvania with an insurance HHI of 6139, a 77 percent competitor competing mostly with a 19 percent competitor. This is all private commercial products, and we try to use this in its broadest sense.
Employers, by contrast, are almost all smaller than 250 employers. Employers do not bargain on an equal level playing field in terms of the bargaining between employers and insurance companies, at least in terms of size.

In terms of hospital shares, we've seen rapid consolidation in the last ten years. The HHI for hospitals is 1464. I didn't have a number for employers, by the way. It's 50. So hospitals have an HHI here of 1464, and physicians, by and large, half of the physicians in this market -- this goes back to 1980, and I heard some facts and figures earlier today.

In 1980, about 45 percent of physicians were engaged in practice, 16.4 in group practices. Take a look at the change in the last 20 years. We're at 32.7 for physicians, 29.6 for group practice. In other words, there's a structural change undergoing with physicians. One of the things that we really believe is that we can deal with the countervailing power issues through the market. The market will evolve and one of the concerns we have is what's going to happen when all physicians are employed.

How does structure translate into conduct? We look at conduct in three realms. One is operating
results. The other is process, do people negotiate or
do they dictate. The third part of that is what's in the contracts,
I'm going to focus on some of the results.

The contracts are highly illuminating. I used to
use them for my health law class. This is the dominant
insurer premiums per member per month going back to
1990. On average the increases have been at double
digit rates. That ties in with our question about the
relative power of employers and the dominant insurers
here.

This is the profits of the dominant insurer
going back to 1990, the blue line tied back to the blue
on that other chart, the red to the red. We think this
situation is not long-term sustainable.

Something that's not been talked about today are
reserves and unpaid claims, although it's been mumbled
about. In Pennsylvania, our insurance firms have rather
substantial reserves. These are well run companies.
These are actually good firms, most of them nonprofit,
but here's the reserves.

And one of the questions we have to ask in a
full market analysis is, how are reserves being used?
Why do we care about large reserves? Well, various
barriers to entry comes to mind immediately, also
efficiencies in terms of operation. Then unpaid

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claims. Between reserves and unpaid claims, that's a rather large sum of money that firms can use to invest, and they can use it in terms of entry barriers.

What about hospitals? We saw the comparative market power of hospitals. This is the same market. That red arrow is the profits of system hospitals. System hospitals made more in profits than the health insurers in that market. The health insurer made a little over 200 million dollars before tax. The hospitals in that market made 280 million dollars. So countervailing power may make a difference here.

What about physicians? Well, those two light blue lines at the top -- this is seven selected specialties. We didn't do a weighted average. We just weighted all codes for these specialties. The light blue lines at the top are the national averages, the national means for these specialties.

Medicare is there in red and Medicaid in orange. Medicare pays less than half, sometimes even a third of national averages. Medicaid pays less than that in Pennsylvania. In fact I go into these meetings and I even mention Medicaid, and I have some physicians get up and yell and scream, and I can't finish.

The dominant payor that I talked about there
pays less than Medicare in this market. That is not
market power.

So what are we saying here? First of all, the
structure and conduct of these markets has some obvious
impact on the industry. You've heard reports about
diminished coverage, as employers respond to increasing
health care premiums and even some employers that are
dropping coverage all together. We wonder whether
that's evidence of an unwinding market.

In addition, we see substantially increasing
concentration in markets across the state, even across
the country, unrelated to economies of scale.

Physicians, physicians really would like to work
well with everybody in the system. I will tell you in
my travels about the State of Pennsylvania, the biggest
physician concerns these days are departures, early
retirements, unwillingness to come to practices in the
State of Pennsylvania. We see situations where
residencies aren't filled. Medical school applications
are down, and out just in Claring, Pennsylvania, last
week, these situations are hitting hardest and fastest
in rural areas of Pennsylvania. Again we wonder about a
market unraveling.

What do we do? I think that our constituents
would be first in line yelling and cheering if we were to restore full competition to health insurance in medical care markets. That would be a first best solution that everyone I think would really go along with. In every area, it would not necessarily mean physician fee increases, mark that.

In fact in some ways, as I said, I had a doctor explain to me, this is a tragedy of the medical commons in a way. We have a number of entities in this system playing out self interests in a way that is unhealthy for the whole system. Everybody needs to make some contributions to dealing with it, and I think everybody means everybody.

If we can't restore full competition to these markets and given where we've evolved, that might be a tall order. If we think Microsoft was difficult, this might be of a magnitude bigger. Then we need to think about some countervailing power responses to it.

As I said earlier, we can either that do by regulation or by legislation, or we can let the market do it. You will see employer buying cooperatives and you will see employee physicians coming out of this if there's a really countervailing power imbalance.

Third, I suppose the state menu, the menu of

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state action, could come to play here, although we heard
this morning about the enforcement problems that come
along with that.

Get ready for a single payor system. I think
we'll see another national campaign waged on this issue
if we don't deal with market breakdown in health care.

Finally, and near and dear to my heart, I think
we need a whole range of much better research on where
we are and where we're headed in this industry, simple
things like optimal sizes of firms, providers, more
complicated issues like countervailing power.

Let's really research countervailing power, get
the vitriol out of all this and take a look at where
this all heads. Other items like tracking state action
doctrines where they're implemented. I'm talking about
a whole research agenda, although I must say I'm not
sure we have a big window of opportunity here.

I'm quoting Fran Swoisman who runs Health
America in Pennsylvania. I was on a panel with him a
couple weeks ago. He said, This system is broke. This

system is very broke, and if we don't, insurance
industry providers, employers, find a way to craft a
solution to this, we will have the solution imposed
on us.
Thank you much.

MR. BOTTI: Thank you, Stephen. Stephanie Kanwit of the American Association of Health Plans.

MS. KANWIT: Thanks very much, Mark. Well, on that downer note, Stephen Foreman, I won't introduce myself again since this is a reprise.

In terms of the payor-provider issues that are the subject of this panel, AAHP and its member plans strongly support both competition and cooperation among all participants in the health care delivery system. Competition creates incentives for health care providers to increase their efficiency, lower their cost and improve quality.

Competition among health plans spurs them to be innovative and efficient and assures that the savings they obtain through their negotiations with health care providers will be passed on to consumers through lower prices to employers which pay for the bulk of the premiums and ultimately to all of us, the employees.

Cooperation between health plans and providers promotes payments for services that are timely and appropriate for properly submitted claims as well as a better system wide integration of evidence-based standards into the practice of medicine, very important,
evidence-based standards.

Simply put, competition and cooperation are necessary ingredients for a health care system that ultimately puts consumers first so that as many as possible have access to affordable health care that is of the highest quality.

When standards for competition are loosened or when cooperative efforts are hindered, consumers lose. Their health care costs rise. Ability to afford access to the system declines, and quality and safety improvement efforts are undermined.

Any consideration of altering existing antitrust laws or the statement of antitrust enforcement policies in health care should start with one key question, one fundamental question, Does this proposed change help consumers or does it hurt consumers?

As Helen Darling noted on this panel, health care costs are rising at the fastest rate in a decade. Consumers today view affordability as the single most important problem in health care today.

The second most important problem, and this is according to consumer polling, is the high number of uninsured, which tends to rise, of course, with the cost of health care. In fact, one recent study suggests that
with every 1 percent rise in health care costs 300,000 more Americans lose access to health insurance.

All of us, whether representing providers or payors, have a crucial task to accomplish in the immediate future, to work together to address these very serious concerns while continuing our best efforts to integrate the latest and best medical science into the practice of medicine.

In terms of that best medical science, I would remind you of recent information regarding Hormone Replacement Therapy, HRT, and arthritic surgery. These are two examples of areas where assumptions about medical efficacy were simply proven wrong, to the detriment of patients and the health care system as a whole.

Preserving standards for healthy market competition among all members of the health care community is an indispensable part of these efforts.

Now, health care antitrust guidelines, you have asked for our views on the current statements of antitrust enforcement policy issued by the Commission and the Department of Justice. First, we reject the contention that the guidelines need to be amended to allow providers to collectively negotiate regarding price.

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The current guidelines, as we discussed somewhat in the last panel, provide sufficient flexibility for providers to create new and alternative ways of creating delivery networks to provide patients quality care.

At the same time, the guidelines unfortunately may have had the unintended consequence of giving providers more opportunity to form cartels. Several years ago when changes were made to the guidelines we raised this concern, 1996.

Unfortunately, the activities we are beginning to see in certain parts of the country now suggest that these concerns were warranted. The FTC's MedSouth advisory opinion, which again we discussed extensively in the last panel, we believe allows flexibility to create new alternatives that can lead to improved quality of care.

Notwithstanding MedSouth, some physicians have continued to argue that the guidelines and current antitrust laws prevent them from communicating about such issues as quality, utilization management or contract terms. The rhetoric doesn't match the reality, and moreover, it continues to be used as a device to justify a long standing effort to seek changes to the antitrust laws in the form of exemptions or other
special treatment for providers. Were the FTC to provide this type of special treatment, consumers would certainly pay the price.

The antitrust laws have always permitted, always permitted health care providers to join together to provide more efficient health care and negotiate with health plans. For example, by forming group practices, which can often include groups of a hundred or even a thousand or more, physicians can create substantial economies of scale. These arrangements provide a lawful means by which physicians can achieve efficiencies and negotiate collectively with health plans.

While providers have argued that alternatives to these arrangements are needed to create a "more level playing field for competition," in fact their proposals would do just the opposite. They would create large powerful provider cartels which would both restrict consumer choice and hinder the ability of health plans and employers to manage escalating health care cost.

In 2000 the consulting firm LECG estimated for us at AAHP that enactment of physician collective bargaining legislation would increase health care expenditures by 141 billion dollars over a five-year period, 141 billion, or 8.6 percent private health care costs during its peak year.

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According to a separate LECG study, that would result in almost 17 million people losing insurance over the next five years and 855,000 people losing their jobs. For consumers, that is simply too high a price.

Now, there have been several recent settlements between provider groups and the FTC that highlight these concerns regarding collective bargaining and the harm that befalls consumers when providers are allowed to negotiate the terms that include price fixing.

One example, which many of you are probably familiar with, is the recent Dallas Fort Worth Physician Groups settlement. In that case, the FTC determined that the physician groups management company's actions restrained price and other forms of competition. As a result physician fees rose significantly and health care costs for consumers, employer and payors in the public and private sector increased.

These activities by providers reveal the significant problems that anti-competitive activities cause for consumers. We commend the FTC and the Department of Justice for their consistent opposition to any special exemption for physicians or other health care professionals, and we continue to believe that providers should be allowed to negotiate as permitted under the existing laws and guidelines.
Penultimately here, I want to talk about the uniform model contracting and class action litigation. Very briefly these are two additional strategies that providers currently are using to advance their arguments regarding the need for a more level playing field, number one, advocating for a uniform contract with all payors. Number 2, joining with plaintiffs' attorneys in filing class action lawsuits to force disclosure of health plan fee schedules and rate payment information.

In fact, we believe that disclosure of contract terms and payment rates to all players in a market would eliminate the opportunity for negotiating to keep prices affordable for consumers.

Essentially such disclosure would lead to a rate setting process in which providers have the opportunity collectively to drive rates to the highest possible level. As a result competition in the market would be eliminated.

Lastly some recommendations. We've all been talking this afternoon and this morning as well about the purpose of the antitrust laws, in a nutshell, to promote and preserve competition for the benefit of consumers, not individual competitors.

To that end, we believe that the FTC and the Department of Justice can make a positive contribution

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by, number 1, continuing their work in an active
enforcement of the existing antitrust laws; number 2,
working with the state and local levels in a unified
collaborative approach to antitrust enforcement
throughout the health care system; and number 3,
facilitating an open dialogue about what are and what
are not permissible negotiating parameters under the
existing statements of antitrust enforcement policy in
health care.

In sum, we believe it's a time to build bridges,
not fences, and to work together in addressing the
problems facing our health care system.

Thank you.

MR. BOTTI: Thank you. Donald Palmisiano of the
American Medical Association.

MR. PALMISIANO: Thank you. Good afternoon. My
name is Donald Palmisiano. I'm a surgeon from New
Orleans, Louisiana, and I'm president elect of the
American Medical Association. It's a pleasure to be
here today on behalf of the AMA to address the Federal
Trade Commission regarding antitrust issues involving
physicians and third-party payors.

We approach the topic of antitrust enforcement
before this Commission with great respect and serious
concerns. To put it bluntly, we believe that federal
antitrust agencies have placed physicians under far
greater scrutiny than is warranted by our comparative
economic strength in today's health care system.

In recent years, physicians and physician
organizations have been the subject of approximately 50
enforcement actions. Virtually all of the physician
organizations in these actions have been small in
economic and practical terms. It is no wonder that
every one of these organizations settled with the
Commission rather than commit to a time consuming
struggle which likely would have depleted the
organization's resources before reaching decision.

By contrast, we know of no single FTC action
against a third party payor ever. We are very
encouraged to hear today by the Department of Justice's
Deborah Majoras that the Department of Justice will give
close scrutiny to the competitiveness of payor markets.
The absence of enforcement activity on the payor side to
date is puzzling because there are plenty of reasons to
be concerned about the competitiveness of payor
markets.

In the latter half of the 1990s, managed care
organizations consolidated at a record pace. Today
we're seeing double digit increases in health premiums
and in health plan profits. At the same time consumers
have expressed deep dissatisfaction with managed care, and physicians have found themselves vastly over powered in their dealings with payors.

In any other industry, a merger wave followed by an abrupt rise in prices would cry out for an investigation, but so far these conditions have only led to renewed calls by the Commission "to get tough against physicians and other health care providers." Something is amiss.

Our suggestion today is that the time is right for the Commission to consider a fundamental shift in how it deploys its resources within the health care field. As I just indicated, in the latter 1990s, it was a period of unprecedented consolidation among health insurers. Between 1995 and 2000, there were over 350 mergers.

Today, the ten largest health plans control over half of the commercially insured persons. The effects of consolidation are most clearly seen at the local and regional levels. Last year, the AMA conducted the most comprehensive study ever undertaken of competition in health insurance.

What we found was staggering. Out of the 40 large metropolitan statistical areas or MSAs across the country, approximately 70 percent of HMO markets were
highly concentrated. 87.5 percent of PPO markets were highly concentrated, and nearly half of the combined HMO PPO markets were highly concentrated.

Moreover, in roughly half of these highly concentrated MSA market, a single payor had a market share in excess of 40 percent, and in a quarter of these markets a single payor had a market share in excess of 50 percent. The study confirmed what patients, physicians and employers already knew. In many parts of the country, health insurance markets are dominated by a few companies that have significant power.

We also looked beyond market concentration at other characteristics of payor markets. In doing so, we found further cause for concern. Payor markets are characterized by significant regulatory barriers to entry. To enter a market, a payor most invest millions of dollars to comply with state regulations governing insurance companies. The payor must also invest time, labor and money to establish relationships with physicians and other providers in the market.

These costs and regulatory hurdles facing a new entrant make it possible for an existing dominant payor to increase premiums without concern that it will lose its market share. Even worse large payors often use contractual devices to lock in physicians and keep out
new rivals. The large companies are clearly in the driver's seat.

On the supply side, physicians face unique legal and ethical responsibilities that enhance the ability of payors to exercise market power. Unlike suppliers in most areas of the economy, physicians can't rapidly switch customers in response to changes in price. Physician's decisions are driven by their relationships with their patients.

The combined effect of these conditions is to enable an insurer with a large market share to increase its premiums while also reducing physician payments. Dominant plans can wield enormous bargaining power, often driving payment rates well below the level needed to provide medically necessary care, and in some cases forcing medical groups into bankruptcy. From the consumers' perspective the result has been chaos, higher out of pocket expense, longer waiting times and reduced access to physicians.

If the late 1990s were a period of mergers and acquisitions in managed care, the years since have been characterized by increasing health plan premiums and profits. Again let's take a look at the facts. From 2000 to 2001, premiums increased by 11 percent, the fifth consecutive year of increases, outpacing overall
inflation by a wide margin. Preliminary results of a recent survey indicate that HMOs expect to implement double digit premium increases in 2003.

These recent increases have not been primarily driven by increases in medical costs. Data also indicate that premiums have been rising at a faster rate than administrative costs and claims expenses. Further, recent reports on payor profits refute any notion that claims expenses are driving premium increases. Profit margins of the major national payors have been steadily rising, despite a slow down in the general economy.

In 2001, health insurers reported a 25 percent increase in profits. In the second quarter of 2000, most national insurers posted increased profits and in one case an increase of more than ten fold. To the extent that premium increases are attributable to rising costs of health care, physicians costs have not been one of the major drivers.

The federal government's own data shows growth in spending for physician services decreased from 1991 to 1996. Then after a few years of slight increases, payments leveled off in 2000. However you cut the pie, physician costs today are simply not a significant factor driving growth in overall health care costs.

Why is it then that the Commission continues to
focus on physicians rather than payors? Is there
something about physician markets that justifies the
Commission's extraordinary vigilance in policing them?
Alternatively, is there something about payor markets
that justifies a hands off attitude?

One perspective is that payors are simply
purchasers of health care services whose interests are
closely aligned with consumers. Under this view, when
payors prevail in fee negotiations, the ultimate winner
is the patient. This view is terribly naive. Patients
don't buy the idea that their interests are aligned with
their health plan, witness the "managed care backlash"
of recent years.

Patients do share an interest in avoiding
unnecessary expenses, but they also have an intense
interest in receiving high quality medical care, an
interest that health plans do not necessarily share.

Furthermore, payors are not merely purchasers.
They're also sellers. Employers who negotiate premiums
with health insurers know this fact all too well.
Payors don't simply pass through expenses. Premiums
reflect administrative expenses in profits, not just
claims expenses, so competition in the health insurance
sector really matters.

When health premiums rise due to lack of
competition, some employers providing coverage or reduce
the scope of benefits provided. Lack of coverage places
enormous pressures on other segments of the health care
system. It also leads to increase expenditures for
emergency treatment.

Further, as the Justice Department recognized in
the Aetna matter, a lack of competition among health
insurers may also open the door for health plans to
exercise monopsony power, often leading to physicians
leaving the market and reducing access to care for
patients. These are precisely the effects that are
being currently observed in a number of markets that are
dominated by large payors.

In short, the Commission should care about
competition in the health insurance sector. There is
simply no justification for a one sided enforcement
policy that puts the sole burden of compliance on
physicians.

In closing, we respectfully ask the Commission
to reconsider its approach and take a serious look at
competition on the payor side. In our written
testimony, we offer numerous issues that we think merit
particular attention.

Thank you for the opportunity to participate in
these proceedings. The American Medical Association

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hopes to continue a dialogue with the Commission regarding these important issue.

Thank you.

MR. BOTTI: Thank you very much. Lawrence Wu with NERA.

MR. WU: Thank you. I want to thank the FTC for hosting and organizing this workshop and for inviting me to speak.

I am encouraged to see the FTC's continuing interest in fostering competition in health care markets. Competition is not just an antitrust issue. I believe competition can help us control the rise in health care cost, which has long been an important public policy goal.

My perspective is a little bit different from the others on this panel. As an antitrust economist, I am interested in understanding the sources of market power in an industry and in measuring its effects.

As a health economist, I'm interested in the public policy questions related to health care cost containment, and as an empirical economist, I have a natural interest in numbers, and when it comes to health care, there are some pretty big numbers that caught my interest and the interest of others on this panel as well.
So let me start there. A recent survey found that employers' health insurance premiums increased almost 13 percent from 2001 to 2002, the largest increase since 1990. This is higher than the inflation rate, which was 1.6 percent. Increases in premiums for small employers are even higher, and experts believe that the average premium will rise anywhere from 12 to 15 percent from 2002 to 2003.

Spending on health care services and prescription drugs has increased around 7 percent per year recently. Sound small? Not compared to the 2 percent growth rates that we had in the mid 1990s. To give you a little more perspective, spending on hospital in-patient care actually declined from 1994 to 1998, and that's not the case anymore.

By most accounts we are headed for significant increases in health care spending, and as a result the demand for cost containment will be stronger than ever. So what can we do to control cost?

In broad terms, we have three strategies. One, we can reduce prices paid to providers; two, we can manage health care utilization better; and/or three, we can accept a lower quality of care.

I want to talk a little bit about each of these cost containment tools, but more importantly, I want to...
talk about the role that competition can play and has played in developing innovative ways to control the rise in costs. Because competition is so important, I will include a few observations on the vital role that the FTC has and will continue to have in preserving competition in this industry.

What can health plans do to control cost? First, health plans could continue to try to reduce the prices that are paid to providers. In the past, this has come about through HMOs, who use selective contracting with providers as a way to negotiate lower provider reimbursement rates.

Will this continue to work? Not without some major change because the HMOs have lost quite a bit of bargaining power in recent years. If the past five years is any indication, employers have shown that they prefer PPOs and health plans that do not limit coverage to certain hospitals and physicians. But, limiting coverage is the backbone of selective contracting.

Health plans also could reduce cost by managing health care utilization better or by reducing the quality of care that is provided or covered by a plan. Again, if the past five years are any indication, it isn't clear that employers and employees will embrace...
more controls that will restrict the amount of medical care that is provided and paid for. Consumer concerns about the quality of care provided to HMO enrollees have already made HMOs reluctant to further manage access and use of health care services.

Now, if we can't count on the traditional tools of managed care and if consumers are not willing to accept a lower quality of care, are we destined for double digit inflation? I don't think so, but we have to allow competition to take its course.

Here's what I mean. If you go back to the basics, it's pretty clear that managed care was able to reduce the rise in health care spending by doing two things, encouraging competition among providers and encouraging consumers to shop for a health plan on the basis of price.

What happened? The market evolved. Using selective contracting, HMOs proceeded to negotiate low reimbursement rates with providers, with lower cost. The HMOs went to the marketplace and sold low price insurance. Employees and employers loved the low premiums and enrolled by the millions, and this only served to give HMOs even more leverage to negotiate even lower prices with providers.

In this way, managed care changed the nature of
competition so that market forces could be used to control costs. Managed care wasn't perfect, but it worked. Total health care spending stabilized as a percent of the gross domestic product, and the rise in premiums and provider cost slowed.

Then consumers started to express their dissatisfaction with some of the restrictions that came with managed care. We wanted more freedom of choice, and we didn't want to have to get a referral before we were allowed to see a specialist. What happened?

The market evolved, and we saw the introduction and proliferation of numerous types of health plans that varied in terms of copayment rates, benefits coverage and access to care. By the mid 1990s, enrollment in HMOs started to fall, and HMOs began to lose their ability to negotiate low rates with providers. Not surprisingly, provider costs and premiums are again raising at levels not seen since 1990.

Where will it end? I don't know, but the market is evolving. For example, more and more health plans are starting to introduce triple tiered pricing, which is a fancy word for charging consumers different copayment rates depending on their choice of provider. The hope is that by charging different copayment rates for say different hospitals, consumers will pay more
attention to price.

Just as important, the expectation is that tiered pricing to consumers will lead to tiered pricing to providers, which should help stimulate price competition among providers for contracts for health plans.

This sounds like old-fashioned competition, and it is, but as the financial incentives become more complicated, it is likely that the contracting and reimbursement arrangements between payors and providers also will become much more complicated.

Providers have not and won't be standing still to make themselves attractive to health plans. Providers have found, with varying degrees of success, new ways to reduce and control the rise in cost. MedSouth, an IPA of south Denver that was the subject of a recent FTC staff advisory opinion, is a great example of a physician group that is trying to find innovative solutions that will help patients and lower costs.

Will tiered pricing and providing integration eliminate concerns about cost containment? Again I don't know, but what I do know is that the market will evolve. The solutions that will survive will not be driven by the health plans, and they will not be driven by the providers.
The solutions that will survive will be driven by what employers and employees want and by the tools that consumers want to put in the hands of the health plans.

What does this mean for the FTC? First the Federal Trade Commission will probably have an important role in commenting on physician collective bargaining laws and legislation such as the Patient's Bill of Rights. Many, if not all, of the proposals for collective bargaining have included provisions that would allow some physicians to price jointly without integration.

And second, the FTC will continue to play an important role in evaluating the competitive effects of mergers, contracts and other changes in ownership and organizational form. These organizational changes, especially if they involve complex contracts, will likely affect the way contracts between payors and providers are written, which will change the way health care is delivered, priced and paid for.

The task facing the FTC will not be easy, one, because it is likely that the responses of health plans and providers to consumer demands for cost containment could have pro-competitive as well as potentially anti-competitive consequences.
For example, in evaluating the buyer power of a health plan, we will need to be careful to distinguish sensible and pro-competitive cost controls from the exercise of market power that also lowers the amount that is paid to providers. It is not always easy to separate the two theories but we must try.

The dynamics of competition also complicates matters by making it harder to conduct a forward looking antitrust analysis. In this context, I like the FTC's recent initiative to take a retrospective look at consummated hospital mergers because this approach to merger analysis is premised in the belief that in the first instance, the market is capable of sorting things out.

Post merger reviews, if they can be done well, and if we have the patience to let the market sort things out, lessens the pressure to forecast the future. This is probably helpful in this industry, which is complicated and needs extra understanding and flexibility in times of change.

So in summary, competition is an important part of the cost containment process. It is the dynamic that encourages providers to find new ways to develop high quality cost effective medicine. It is also the dynamic that's encouraged payors to find ways to slow the rise.
in health care costs of employers and employees.

The challenge for the FTC will be to protect and preserve competition without discouraging the marketplace incentives that are helping payors, employers and employees control the rise in health care cost.

MR. BOTTI: Thank you. Let me start off by thanking each and every one of you for some very thoughtful and provocative comments to get this panel started. There's a lot of diversity of opinion that's just been expressed, but there is some uniformity, and I think one of the uniform themes is we're seeing increasing health insurance premiums, increasing costs in this system, and questions of what's the cause of that are dividing some of you.

If I can comment briefly, I've sort of heard three different things come out as primary themes. One is that the payors are consolidating or somehow exercising market power.

Two is the principal focus on the hospital segment of the industry. The third is Lawrence's comments, that there's evolving consumer preferences that are perhaps affecting the way in which the system is operating and allowing some increase in the prices.

I want to focus for a moment on one factual

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issue, and that is payor consolidation, and I would like to turn to our payor representatives and get your comments on that. Henry, if I could start with you, you've had a chance to rest for awhile since you started first, and ask your views, has there been a consolidation among payors? Is it a healthy thing? Is it counterproductive in some areas? Can you comment on that, please?

MR. DESMARAIS: Sure. There has been consolidation. We heard this morning actually that a lot of it was not at the local level but was across geographic regions, so if a payor in California chooses to purchase a payor in Maryland, that's consolidation, but I would be hard pressed to show how that's anti-competitive and could produce problems.

There's certainly been consolidation with companies, and we know that the federal and state officials, there is oversight. In fact when two payors tried to merge, they were told they needed to divest themselves of certain issues in the State of Texas, so people were looking to see what the impact would be of the merger.

So again I think people are watching. There is some consolidation going on, but not always at the local level which I think is significant here. I think too we
hear a lot that the single payors in a state have a huge market share of at least a small part of the market we want to look at, so I think that's another issue.

We also have to ask ourselves, What's the denominator before we look at what the numerator is, but a lot of that is honestly the Blues Plans, and there's historic reasons for that, how they came about, how they were formed involving both hospitals and physicians and their initial formation, how many of them remain not for profit, how many of them have certain obligations placed upon them by state government in terms of insurer of last resort.

So there's a lot of complex issues I think that as we look at the market -- I don't know if Stephanie wants to add anything.

MR. BOTTI: Stephanie if you would like to pick up on it, and let me ask you in particular, accepting Henry's point that some consolidation may be across localized geographic areas, has there been consolidation on a local level, the type concentration that may or may not be anti-competitive, but is the type of thing we look at in antitrust?

MS. KANWIT: I'm not aware, Mark, of any competitive consolidations by health plans, and I think the Department of Justice has made statements to that

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effect, certainly the former chief Joel Klein, et
cetera. I mean, there's really two questions. One is
do health plans after consolidation have monopsony
power, and are we looking at, as Henry says, the right
denominator.

I think one of the many factors that goes in the
mix that people forget is that the bulk of health care
dollars in the United States are spent for Champus,
Medicare Medicaid, FEHBP, the other health plans and
they're not the commercial insurance market, so we have
to be careful.

But the other really big point, and Helen made
this just a little while ago, is consumer choice. You
saw some slides this morning that I thought were
excellent, I think they were Cara Lesser's slides, where
she pointed out that the majority of employees, health
care consumers in the United States have a choice of two
or three health plans right now. 60 percent of them
have a choice of two or more, and 40 percent have a
choice of three or more, so that's really the bottom
line.

When we start talking about consolidation in the
abstract, again we have to come back to what is the
impact on consumers, and I certainly am not seeing any
competitive impact out there.
MR. BOTTI: Stephen. Please, go ahead.

MR. FINE: I'm sorry. Part of this may be an issue of definition when we talk about consolidation. Again in the Philadelphia market, most consumers do have a choice between multiple plans. They could, for example, have independence BlueCross Keystone, independence BlueCross PPO, BlueCross Commercial, Independence BlueCross I believe it's Blair Mill Administrators. There are five or six different products.

The parent BlueCross is a not-for-profit entity. Most, if not all, of the other health plans that are subsidiaries are for profit entities. So we need to look again at each market individually, but make sure that we don't focus on, Was there a merger of two existing plans or did one plan create alternatives but in an effort to potentially dominate that market.

MR. BOTTI: Fair enough point, that we need to get underneath the statistics and see what's meant by that. Stephen, you've taken a pretty close look at Pennsylvania markets, it sounds like, and gave us some statistics on market share of health plans.

Can you address whether that's the result of some type of consolidation? Is that a historical number that's been consistent over the years? Has it grown,
and if there's been growth, what's the source of it?

MR. FOREMAN: In Pennsylvania we've had two factors that have contributed to this. One is, as Henry mentioned, the historical role that the BlueCross firms have played in the state, and at one point in time back in the 40s and early 50s before other entry, they were the only plans.

More recently there's been a merger of BlueCross of Western Pennsylvania and Pennsylvania BlueShield. As part of that merger, Independence BlueCross gained sole control of Keystone East Health Plan so merger and acquisition activities played a role here.

One thing I would like to sort of point out as an overview on this is that, number 1, it should be the concentration that we look at in the market that exists, not necessarily what's historically gone before, and then number 2, if there is a concentrated market, what do we do with it? In other words, how is that concentration been used?

Just sort of as an overview so we don't get side tracked, it's pretty clear that in a lot of these concentrated markets, the health plans are not price takers. In other words, the touchstone of competition that we're arguing about here would be price taking behavior. We have price making firms, and we have

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prices that are being set by negotiation. That's not competitive either. That's a game theoretic, and we haven't really studied the application of game theoretic to what's going on here, but I think it has a lot of applicability.

MR. BOTTI: Helen, in terms of this concentration if it is occurring on a local level and it's to a significant degree, it would seem like employers would have concern over that vis-a-vis whether they're getting competition among health insurers. Do you have a concern? Can you address this?

MS. DARLING: Yes, and I'll do it from two perspectives, from my current job and my prior job where I used to buy health care for Xerox Corporation around the country, so I got to know 240 markets real well in that process.

I would say first a couple things. First, I think it's very important, it's the way you all operate, but it's the way we have to think about it, you cannot answer most of our questions one way. You have to say, What's the market and what's the year you're talking about.

For example, we had about four or five years where underlying medical costs were actually higher than what was being charged by some insurance companies, not
much to be sure, and you had other years where the underlying medical costs, which is where we are right now, was considerably below what's being charged in premiums where there's a premium. So looking every year at every market is extremely important to answer those questions.

Our concern and some of my concerns at Xerox was that you're going to have problems in lots of markets much of the time, and you're going to have to deal with them market by market. There was a time period I guess, I have to think a second about what the years were, when a number of the large health plans were buying each other, and in fact we had a chaotic time in places like Texas where you had companies like (inaudible) being bought by -- I'll probably get the names wrong because you lose track of it, but you had sort of a mess going on because at the local level you had problems, service problems, delays, physicians weren't being paid and that kind of thing. In other markets it was working perfectly well so it varies enormously around the country both by time and by location.

I think in terms of whether or not the consolidation, now I just said don't make a generalization and I'm going to make one, but right now there's still in most markets sufficient competition and
choices for employers, but we certainly think everything ought to be watched.

I mean, nothing should be left untouched in terms of analysis and information, and what's so important about I think what you all are talking about doing now and a number of organizations like the Center are doing is watching these things very closely, so we have an empirical basis. We knows what's happening at every time and as quickly as possible, and we also know what's happening market by market, and you all can act accordingly.

MR. BOTTI: Your comments earlier, I believe you told us you were concerned about rising premiums, and if I'm interpreting what you just said properly, you're not attributing that to consolidation among payors.

MS. DARLING: No, and actually most of our employers don't even pay premiums. Most of our employers are self funded, so right frankly they're worried to death about claims. What's driving their costs right now are claims. There's some concern sometimes when there's consolidation, the companies are able to charge more or try to charge more for the services they provide.

MR. BOTTI: Is one of the services they provide negotiating better rates for you among the hospitals?
MS. DARLING: Absolutely.

MR. BOTTI: Let me ask how you view the competition among payors to provide you that service. Do you have enough payors trying to do that? Are they trying to do it hard enough, and are they being successful or not?

MS. DARLING: A couple things I would say. Up until recently they were trying at the level they try, but for the most part there was plenty of competition to encourage them to do as well as they could and always to do better.

More recently, however, meaning in the last couple years what's happened with these so-called contract showdowns is no matter who's out there trying to negotiate what we would consider a reasonable price, and we can debate one I'm sure endlessly, and by the way, we're talking about cost too. We believe that it's reasonable to have a reasonable number of costs and also perhaps some payment for additional services.

There's a huge debate, as you might know right now, in the hospitals feeling that they are underpaid because their full costs are not paid, so that's a whole other debate, which we could probably have another workshop on and might be worth doing because that's a major problem.
Some of the markets where the worst contract showdowns have occurred are the markets with very large numbers of teaching hospitals, academic medical centers, medical schools, sometimes five or seven in a given geographic area.

So they feel they must have their cost reimbursed for a very expensive system, so that's one of our big concerns.

MR. BOTTI: Thank you. Lawrence, do you want to say something?

MR. WU: I think Helen is right that in many cities employers and employees do have choice, and I want to tie this back to some of the charts that we've seen that describe payor concentration in various marketplaces.

There's one dynamic that falls out of employer and employee choice, and that is employer and employee choice facilitates the entry and exit of health plans, and that is one dynamic that isn't easy to show on a PowerPoint slide, and that is over time, there is a lot of entry of new health plans, and at the same time there's a lot of exodus of health plans, and it does make sense because if you look at the profits of health plans, health plans are not doing as well as you might think they're doing.
So there is this dynamic of entry and exit, and it makes a difference because if one were to do a study of says 50 or 60 top MSAs, that is Metropolitan Statistical Areas in the U.S., and look at who the leading health plan was say in 1994, and then ask the question four years later, Will the leading plan in 1994 still be the leading plan in 1998? If you do that study, you will find that the leading health plan in 1994 in general was no longer the leading plan in 1998.

And that is a dynamic in the health insurance industry that I think it's easy to forget, but a very important one in evaluating the market power of the health plan.

MR. BOTTI: Okay, Don, let me ask you to give us some comments somewhat picking up on what Helen said, and that is she had expressed a concern over hospital costs, and I think most of us in this room know that physicians and hospitals interact quite a bit, and physicians should have a good sense of what's been going on in the hospital sector, whether that's driving the cost of these premiums or not.

One thing that has struck me, that is, if we've had consolidation of hospitals, and we have vigorous competition in health plans, and I'm not purporting to say any of this is right or not, but let's just work on
that proposition, we should have seen reduced costs in
hospitals and costs being passed through to employers
and consumers, and maybe you can give us the physician's
perspective on whether hospital consolidation has
delivered on its promises or has it led to an exercise
in market power?

MR. PALMISIANO: Well, thank you, Mark. On
behalf of the American Medical Association, I'm not the
person to talk about hospitals and what they delivered
other than the fact that we operate in hospitals, and
what we would like to stress is that when you look at
health care cost, we need to go one layer down and break
it up as we did in our testimony.

You need to divide out of the physicians. You
need to divide out the hospitals. You need to -- health
care cost, what the insurers are charging, how much goes
to profits so that you break all that up. Our point is
is that physicians -- and I have the advantage of
traveling all over the country to meet physicians on
behalf of the American Medical Association and listen to
their complaints of what was said earlier, physicians believe
the system is broken.

I also have the advantage that I continue to
practice when I go home to New Orleans, and my surgical
partners will greet me and say, What have you been doing
now up there, did you tell them what's going on, we can hardly keep the practice going under these circumstances.

When I heard a moment ago that there was no monopsony power, and even if it existed, it didn't make any difference. I would submit to you that no rational human being would sign a contract that contains, if they had any equal bargaining product, all products clauses most favored nations clauses, it's on page 15 of our written testimony, undisclosed fee schedules.

We don't even know, they can change fee schedules at will. So how do we budget to buy equipment, to hire staff, to deal with all the turn backs when you send the insurance in, Oh, it's not a clean claim, please fill out this form and do this, oh the line's busy, you'll have to call back at another time, we can't admit the person at this time.

We've gone through a paper morass and there's a feeling of hopelessness. We do need to work together. We need to cooperate, and AMA believes maybe the long-term situation, we won't need the Federal Trade Commission to do as much work in this area, is when we have defined contribution individual ownership and a way to make it happen, but that's perhaps the future.

Unilateral amendment of the contract by payor,

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slow pay, a big problem, restrictive definitions of medical necessity. It's not my job as a physician to ration necessary care, and if the insurance company promises a product, they should deliver on the product. If they want to exclude a product or service, they ought to say so in bold print.

The indemnification clauses for patient privacy violations, now I submit this is evidence on behalf of the AMA. If an insurance company violates the privacy of the patient, the medical record confidentiality, we have submitted in to Congress contracts that say we are responsible for indemnifying the insurance company. We are responsible for their defense costs. What rational human being would sign a contract like that if they had any bargaining power?

And you don't have any power when you deal with these folks. They say, Take it or leave it, doctor, so that's the problem.

As far as the hospitals, you have people here who can better answer whether hospitals are delivering. What I'm saying is that this system is broken. Physicians want to do ethical science based medicine. In a previous panel you talked about quality. I want to get in to the record AMA has a lot of quality efforts. We're involved in the National Guidelines
Clearinghouse. We're involved in the Physician
Consortium for Performance Improvement. We're involved
in the Practice Guidelines Partnership. We're involved
in so many entities, the JCAHO. We have commissioners in
there. We're involved in NCQA, working with them.

We founded the National Patient Safety
Foundation before the Institute of Medicine came out.
We founded that in 1997, and safety as you know is a
major component of quality, so there are so many things
going on, and I would just hope that the Commission and
the Justice Department would go beyond these words and
do their own independent gathering of data and then let
all the experts get together and see if this system
allows us to do quality medicine for our patients.

MR. BOTTI: Let me ask you to take it a step
further in terms of getting us guidance is where you
would like to see us go, and I will accept for purposes
of talking about it the proposition that physicians
don't have bargaining power and that payors do.

Who role does antitrust have to play there? Is
your proposition to give physicians this countervailing
market power? Is that where the AMA would like to see
antitrust enforcement go, or is there some type of
response you would like us to make to existing market
power by payors?
I understand that if there's consolidation that aggregates it, sure, people would like us to stop that, but we're talking about the situation as it is. What are your thoughts on this?

MR. PALMISIANO: I think earlier you heard Ms. Hanson talk about the Rule of Reason approach rather than automatic Per Se treatment under Section 1 of the Sherman Act. Also on page 15 of the written testimony, we would like you to look at each one of those items as well as additional comments that we have in there and put your sharp eye on that and say, Does this violate antitrust.

In other words, does this power prevent true competition in the marketplace. We would like you to do that.

Of course the American Medical Association is working in many directions, both at the state level. We talked on the state action doctrine, and in Congress we talk about the bills that deal with antitrust. You heard about earlier the Barr/Conyers bill, which by the way, that bill is different from the original Campbell bill 1304 in the previous session, and what this bill does is just make the Rule of Reason the standard, and it has two demonstration projects.

One demonstration project is basically the Campbell model in a small number of states and the other
model is the one that basically acts like a state action
doctrine, like they do with certain fisheries and
certain things where you have oversight, some
governmental oversight. We think the system needs to
be changed because we're heading for chaos.

Overhead for physicians continues to go up.
Pennsylvania is a particularly hard hit state. It's one
of our crisis states, 12 crisis states in the nation
with professional liability premiums, and so as the
overhead goes up and reimbursement goes down, 5.4
percent decrease with prediction of another 20 percent
over the next several years, if they don't do something
in this Congress, what you're going to have is a quality
problem because if you can't access a physician when you
need a physician, if you go to Wheeling, West Virginia,
you can't get a neurosurgeon to do trauma.

So that means when your child is involved in a
soccer game or football game and gets hit on the head
and is unconscious for a brief moment, they won't even
keep the child. They send the child away to Columbus,
Ohio, to Pittsburgh, and the helicopter can't fly in 30
percent of the time because there's fog or other adverse
weather conditions.

This system is broken right now, and we do need
to go beyond our words, everybody comes in good faith
trying to present their position and the role of
government, as we see it, is to be that objective entity
that looks at all of this so that we have true
competition. The bottom line is what's in the best
interest of the American public and our patients.

MR. BOTTI: Thank you. This idea of refereeing
the competition and making sure it's fair I think is a
good one, and I'm going to take your comments and turn
them over to Stephen Foreman, because, Stephen, I think
when I asked you the question about consolidation, you
said, Let's look at the current situation and where do
we go from here.

Let me ask you to talk about that. We're
talking now about if payors have some type of market
power, and I say if, I don't know that they do, but if
they have it and they're exercising it, what's your
proposition in terms of what role antitrust can play in
addressing that?

MR. FOREMAN: I think that ideally we would want
to get to a first best solution on this. If we could
restore competition to these markets and there's
mechanisms to do that, we would all be better off. Ruth
Givens here, she has an article, and Doug Holland has an
article, but the optimal size of health insurance firms
is not 4 million members.
There's things to think about there, so if we can restore competition at every level of this industry, we would all be better off.

If we're not going to do that, if we're going to leave a monopolist in place, and I'll start at the health insurance level, to presume that monopolist can pass through costs presumes that the monopolist is not currently monopoly pricing.

If the monopolist is monopoly pricing as rational monopolists should do, then they're charging as much as the market will bear. They're not going to pass through any more cost. If we give employers countervailing power in that kind of setting, you may get a welfare improving result. I said a minute ago we should do some research in this. There's good countervailing power theory on the books that isn't widely known to people.

The second part of that is that if a monopoly payor is deriving monopoly rent, to give countervailing power to hospitals or to physicians means that you'll reallocate this monopoly at random. You're not going to charge more to the employer if you think about it, so I mean, to think all of this through in the countervailing power setting is one way to go on this.

The other one is we can throw up our hands and
give up and go to single payor and say, Look, the
consolidation in this industry is too much for us to
bear.

Again, some of this is a generalization off of
some premises about some markets. Not every market is
consolidating at the payor level. Some markets have
competition. Other markets don't, and in those markets
we have payors dictating price. Small businesses don't
negotiate with health insurers in Pennsylvania.

Private physician practices in Pennsylvania with
some exceptions don't negotiate with the payors. They
have a fee schedule, and in fact there are letters from
the payors in Pennsylvania saying, we don't negotiate
with physicians, we can't do it administratively.
That's probably right.

So I think we have a list of preferences or
priorities that we ought to go down here before we give
up but restoring competition ought to be real high on
our list.

MR. BOTTI: Helen, let's assume we have a market
where we have payors with market power. Is
countervailing market power by physicians and hospitals
the solution that employers would prefer or what would
they have the agencies do in terms of antitrust, or is
it an antitrust question?

MS. DARLING: I'm not sure I can answer it, but let me back up a second and see if I can take it from where he has ended. Most employers with more than 500 employees, which is a lot, are self funded, and so they do in fact use networks, and they can shop around. They have multiple networks throughout the country that you can use. You can buy this PPO network or that PPO network. There are a lot of options.

Now, it's true that very small employers have to deal with an insured product, but there are multiple insured product in many places, and then there are more things coming down the road, so I'm not sure it's quite -- that piece of it isn't as grim at least as I see it and live it as it sounds like.

I think there is definitely the feeling that right now, and this is why the timing is so important, and this is the first time I've been in this my entire adult life, the first time that large employers feel that their biggest problem right now is provider consolidation, and that has not been true in the past.

They generally are not -- again, this is a generalization, it may vary by market, but it is not the absence of competing plans. They do have that. They have ways that they can pull out of dealing with a

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particular plan.

Now, you could in some markets, especially the Blues, do have some advantages. States where they used to have advantages, they no longer have the advantages, and so they're having to change on that so there's movement in all of them. It's like many moving parts simultaneously, and that's why you have to get back to the market.

If the FTC's role is to make certain that in every market and in every situation you have the optimal opportunities, and I know I'm not using the language of economists, I'm not an economist, but the maximum opportunities, the optimal opportunities for competition in all of the areas you need to have it in, that's what we need to make this system work.

I mentioned earlier, but I'll mention again, how important the consumer is today. We are already in a much more consumer driven health system than we have ever been in. We are going to be in it for at least the next three to five years. Maybe there will be some grand solution in our country, but I lived through Catastrophic Coverage Act which got repealed, so I don't know even if you get something passed, it will necessarily remain in law when people discover they have to pay for it. So, we may have a few more years to work
at some of these problems.

I think in the meantime, there's plenty of opportunities for the FTC to do what it's talking about doing and has done, and the dynamics have changed so dramatically that perhaps some of the unfortunate track record that you all have suffered from because you tried and the courts didn't let you move will be changed when they look at the new dynamics.

MR. BOTTI: Lawrence, I'm going to come back to you because you made a comment I want to follow up on. How do we tell the difference between good payor negotiation and bad payor negotiation of lower prices from physicians and hospitals?

MR. WU: That was actually going to be my follow up to the comments here, which is to answer your original question, I don't think there's an easy answer or a single answer to your question, whether we want to stop the exercise of market power and the existing payor or whether we should give physicians and other providers more bargaining power because in the end, as an economist, what I want to look for is what is happening to prices and what is happening to quality.

If prices go up and quality goes up and that's what the employers and employees want and are willing to pay for, then I would view that whatever is being
investigated as being a response to what employees and employers want.

It's really problematic if there are increases in price without a corresponding increase in quality, and/or no change in price and a decrease in quality, and this is nothing new for the antitrusters in the room, but again I think that is ultimately the guiding principle.

MR. BOTTI: I think with that, we should probably wrap up, David?

(Applause.)

MR. HYMAN: Some very quick announcements. First, I want to thank all the speakers, panelists and moderators for today, all of us have benefitted greatly by their insights. Second, we start tomorrow at 9:15 a.m. promptly. You have to clear through security again, so please allow an appropriate amount of time for that.

Your property rights for today do not translate into property rights for tomorrow, so it's a license. Here at the Commission we adhere to our contracts, so at 5:30, it's time to stop.

(Time noted: 5:27 p.m.)
CERTIFICATION OF REPORTER

CASE TITLE: Healthcare and Competition Law and Policy Workshop

HEARING DATE: September 9, 2002

We HEREBY CERTIFY that the transcript contained herein is a full and accurate transcript of the notes taken by us at the hearing on the above cause before the FEDERAL TRADE COMMISSION to the best of our knowledge and belief.

DATED: September 16, 2002

Sally Bowling

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I HEREBY CERTIFY that I proofread the transcript for accuracy in spelling, hyphenation, punctuation and format.

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