

This agenda is the complete history of the health care hearings, which were held February, 2003 - October, 2003. It is in one document to allow researchers to access the entire agenda and search for the issues discussed on various days, to see who participated on different days, and so on. Once you learn the date of the testimony you are interested in, please go to the transcript for that day to find testimony, or the agenda/materials for that day to find hand-outs and PowerPoint presentations.

**Agenda for Joint FTC/DOJ Hearings
on Health Care and Competition Law and Policy:**

Wednesday, February 26, 2003, Afternoon Session

Keynote Address:

Overview of the health care industry, market developments, and regulatory framework. How well does the health care marketplace perform with regard to cost, quality, and availability of the services that are provided? How is quality defined and measured? What is the optimal level of enforcement of competition law and policy in health care markets to ensure the continued delivery of high quality products and services?

Introductory Remarks:

Timothy J. Muris, *Chairman, Federal Trade Commission*
R. Hewitt Pate, *Acting Assistant Attorney General, U.S. Department of Justice*

Keynote Address:

Thomas A. Scully, *Administrator, Centers for Medicare & Medicaid Services,
U.S. Department of Health and Human Services*

Framing Presentations:

Paul B. Ginsburg, *Center for Studying Health System Change*
Mark V. Pauly, *Wharton School of Business, University of Pennsylvania*
Martin S. Gaynor, *Carnegie Mellon University*

Thursday, February 27, 2003, Morning Session

Title: Perspectives on Competition Policy and the Health Care Marketplace

Health care is a complex field, subject to extensive regulation at the state and federal levels. Although there is no “learned professions” exception to the antitrust laws, the application of competition law and policy to health care is often controversial. What specific market imperfections exist in health care and how severe are these imperfections? What pro-competitive and anti-competitive responses (both public and private) have emerged in response to these imperfections? What specific challenges and complications arise in applying competition law and policy to health care? What impact has competition law and policy had on health care markets?

Opening Remarks:

William E. Kovacic, *Federal Trade Commission*

Framing Presentations:

James F. Blumstein, *Vanderbilt University*

Peter J. Hammer, *University of Michigan*

Panel:

Helen Darling, *Washington Business Group on Health*
Jacqueline M. Darrah, *American Medical Association*
Charles N. Kahn, III, *Federation of American Hospitals*
Stephanie W. Kanwit, *American Association of Health Plans*
Arnold Milstein, M.D., *Pacific Business Group on Health*

Thursday, February 27, 2003, Afternoon Session

Framing Presentations:

Judy Feder, *Georgetown University*
Thomas L. Greaney, *St. Louis University School of Law*

Panel:

Henry R. Desmarais, M.D., *Health Insurance Association of America*
Timothy F. Doran, M.D., *American Academy of Pediatrics*
Frank Opelka, M.D., *American College of Surgeons*
Peter M. Sfikas, *American Dental Association*
Winifred Carson-Smith, *American Nurses Association*
Christine A. Varney, *Representing American Hospital Association*

February 28, 2003, Morning Session

Title: A Tale of Two Cities

In many geographic markets in the United States there has been a significant amount of market turbulence and varying degrees of consolidation among health care providers and insurers. Boston and Little Rock provide two points on the spectrum of market consolidation. To provide a frame of reference for the balance of the hearings, a day will be spent painting a comprehensive picture of current market conditions in Boston and Little Rock. The full range of competitive issues will be addressed, including the cost and quality of the care rendered, the degree of market concentration among providers and insurers, and the impact of market consolidation on the performance of the payor and provider markets.

Opening Remarks:

Deborah P. Majoras, *Principal Deputy Assistant Attorney General, U.S. Department of Justice*

Framing Presentation:

Stuart H. Altman, *Brandeis University*

Perspectives on the Boston Market:

Charles D. Baker, *Harvard Pilgrim Health Care, Inc.*
Harris A. Berman, M.D., *Tufts Health Plan*
James J. Mongan, M.D., *Partners HealthCare*
J. Mark Waxman, *CareGroup, Inc.*
Charles A. Welch, M.D., *Massachusetts Medical Society*

Framing Presentation:

Frances H. Miller, *Boston University*

Wednesday, March 26, 2003, Morning Session

Title: Hospital Round Table

Lee B. Sacks, M.D., *Advocate Health Care*
Ralph K. Andrew, *New York Eye and Ear Infirmary*
David Morehead, M.D., *Ohio Health*
Robert J. (Mike) Ryan, *MedStar Health, Inc.*
James D. (Denny) Shelton, *Triad Hospitals, Inc.*

Title: Defining Product Markets for Hospitals

The definition of the product market for hospitals has typically been at a high level of generality, with the product defined as "acute care inpatient hospital services" or "anchor hospitals." Health care is increasingly provided on an outpatient basis, and general inpatient hospitals face competition for the services they deliver from a range of providers. What, if any, are the impacts of these changes on the definition of a hospital product market? What, if any, are the impacts of these changes on competition for services provided by hospitals? What developments have there been in economic theory with regard to defining hospital product markets? How do payors (including employers) define product markets? How do patients and physicians define product markets? What data are available to assist in the formulation of an appropriate product market?

Panelists:

Seth B. Sacher, *Charles River Associates*
Jack Zwanziger, *School of Public Health, University of Illinois, Chicago*
Carol Beeler, *Federated Ambulatory Surgery Association*

Wednesday, March 26, 2003, Afternoon Session

Title: Defining Geographic Markets for Hospitals

The definition of the geographic market in hospital antitrust cases has been controversial. In several high-profile hospital merger cases, judges have rejected testimony from payors about their limited ability to steer patients to lower-cost providers in distant locations, and determined that the geographic market was quite broad. In most of these cases, the geographic market has been defined through the use of Elzinga-Hogarty patient flow criteria. Does the Elzinga-Hogarty model represent the best current tool for defining the relevant geographic market for hospital antitrust cases? What are the weaknesses of this model? What developments have there been in economic theory with regard to defining hospital geographic markets? What data are available to assist in the formulation of an appropriate geographic market? How do payors (including employers) define hospital geographic markets? How do patients and physicians define hospital geographic markets? Does the type of illness and the nature of the recommended treatment influence the size of the hospital geographic market? What is known about the actual size of geographic markets for hospital services?

Panelists:

Margaret E. Guerin-Calvert, *Competition Policy Associates, Inc.*
Gregory Vistnes, *Charles River Associates*
Barry C. Harris, *Economists Incorporated*
H.E. Frech, III, *University of California, Santa Barbara*
Gregory J. Werden, *U.S. Department of Justice, Antitrust Division*

Thursday, March 27, 2003 Morning Session

Title: Single Specialty Hospitals

In recent years, single-specialty hospitals have emerged in various locations in the United States. Instead of offering a full-range of inpatient services, these hospitals focus on providing services relating to a single medical specialty or cluster of specialties (typically cardiology/cardiac surgery or orthopedic surgery). What factors have driven this unbundling of inpatient hospital services? What have been the effects of this unbundling? Has quality of care been enhanced as "focused factories" have emerged? Have costs and access increased or decreased? How has competition been affected for services provided by both the general inpatient hospital and the single-specialty hospital, and for services provided only by the general inpatient hospital? Is this development any different than the emergence of specialized hospitals for children, rehabilitation, and psychiatry? What actions have general inpatient hospitals taken in response to the emergence of competition from single-specialty hospitals? Do any of these actions involve anti-competitive conduct?

Framing Presentations:

Cara S. Lesser, *Center for Studying Health System Change*

Panelists:

H.E. Frech, III, *University of California, Santa Barbara*
Dennis I. Kelly, *MedCath Corporation*
George F. Lynn, *representing American Hospital Association*
Edward Alexander, *Surgical Alliance Corporation*
David Morehead, M.D., *Ohio Health*
John G. Rex-Waller, *National Surgical Hospitals*
Dan Mulholland, *Horty, Springer & Mattern, P.C.*

Thursday, March 27, 2003, Afternoon Session

Title: Contracting Practices

In recent years, some providers have developed complex networks for the delivery of health care services. These networks frequently involve multiple geographic and product markets. In several instances, there have been complaints that such provider networks are requiring that payors that wish to contract with a "desirable" hospital in one product or geographic market, must also contract with all other hospitals offered by the network, and include all network hospitals in their "most favored" tier for purposes of co-payments and other financial incentives. Payors allege that these contracts restrict their ability to steer patients to lower-cost providers in particular geographic markets. How prevalent is such conduct? What does economic theory indicate about the circumstances under which such conduct is likely to emerge? When are such arrangements likely to be pro-competitive and when are they likely to be anti-competitive? Does traditional antitrust analysis, including but not limited to tying doctrine, adequately address the forms of anti-competitive conduct likely to emerge? Does the existence of such conduct have any implications for merger review?

Panelists:

Thomas R. McCarthy, *National Economic Research Associates, Inc.*
Margaret E. Guerin-Calvert, *Competition Policy Associates, Inc.*
Bradley C. Strunk, *Center for Studying Health System Change*
Arthur N. Lerner, *Crowell & Moring, LLP*
Vincent Scicchitano, *Vytra Health Plans*
Harold N. Iselin, *Couch White, LLP*

Debra Holt, *Federal Trade Commission*

Friday, March 28, 2003, Morning Session

Title: Issues in Litigating Hospital Mergers

Prior to 1994, the Federal Trade Commission and the Department of Justice had considerable success in challenging hospital mergers. During the intervening eight years the Commission and the Department lost seven successive cases challenging hospital mergers. What explains this string of losses? Do these cases suggest that courts have become more skeptical of competition law and policy as applied to health care? What, if any, are the broader prospective implications of these losses? What strategies should enforcement authorities employ to ensure their efforts are targeted appropriately in the future?

Toby G. Singer, *Jones Day*

Melvin H. Orlans, *Federal Trade Commission*

David Eisenstadt, *Microeconomic Consulting and Research Associates, Inc.*

Robert F. Leibenluft, *Hogan & Hartson, LLP*

David A. Argue, *Economists Incorporated*

Jon B. Jacobs, *U.S. Department of Justice, Antitrust Division*

Wednesday, April 9, 2003

Title: Hospitals - Horizontal Networks and Vertical Arrangements

Hospitals are increasingly affiliating into horizontal networks and entering into vertical arrangements with other health care providers (e.g., physicians, nursing homes, home health agencies, and other entities). These arrangements, which occur against the backdrop of other laws and regulatory constraints, have paralleled several transformations in the nature of hospitals, from doctors' workshops, to the center of integrated delivery networks, to complicated networked affiliates and contractual partners with other entities. Ronald Coase's theory of the firm suggests that transactions can either be organized inter-firm (i.e., through the market) or intra-firm. The development of these arrangements is one example of the reconceptualization of the boundaries of a Coasean firm. What horizontal and vertical arrangements have emerged in the health care marketplace? What are the key drivers for this behavior, and do the type of arrangements that prevail vary across geographic markets? Do consumers prefer these arrangements? Do employers and insurance companies prefer these arrangements?

How do these arrangements change the competitive dynamics, including the relative bargaining power of hospitals and insurers? How do these arrangements affect the definition of the relevant product and geographic markets? How do these arrangements affect cost and quality? Are certain types of consumers particularly adversely affected? What are the pro-competitive and anti-competitive consequences of these arrangements? Are there efficiencies associated with particular arrangements? How should competition law and policy address such arrangements when networks seek to merge? Should the analysis be different when there are other hospitals in the area or there is no geographic overlap among the hospitals? What does economic theory have to say about the circumstances under which these arrangements emerge? Does traditional antitrust analysis, including but not limited to tying doctrine, adequately address the forms of anti-competitive conduct likely to emerge?

Panelists:

Lawton Robert Burns, *Wharton School of Business, University of Pennsylvania*

Robert Town, *University of Minnesota*

Robert E. Hurley, *Virginia Commonwealth University on behalf of the Center for Studying Health System Change*
Jim Burgess, *Boston University School of Public Health*

Thursday, April 10, 2003, Morning Session

Title: Hospitals - Non-profit Status

Nonprofit hospitals comprise approximately 60% of community hospitals in the United States. Nonprofit insurers comprise/administer a substantial proportion of total premium dollars spent on health care in the United States. Conversely, physicians, nursing homes, and many other health care providers are organized as for-profit operations. How does entity status affect performance? Are there systematic differences between the performance of nonprofit and for-profit entities? How do consumers perceive the performance of nonprofit and for-profit entities, with regard to cost, quality, and access? Do consumers know when they are receiving care from a nonprofit entity? How should competition law and policy address nonprofit status?

Panelists:

William J. Lynk, *Lexecon Inc.*
Cory S. Capps, *Kellogg School of Management, Northwestern University,*
Gary J. Young, *Boston University School of Public Health*
Peter D. Jacobson, *University of Michigan School of Public Health*
Frank Sloan, *Duke University*
Eugene Anthony Fay, *Province Healthcare Co.*
Dawn M. Touzin, *Community Catalyst*

Thursday, April 10, 2003, Afternoon Session

Title: Hospital Joint Ventures and Joint Operating Agreements

Hospital joint ventures and joint operating agreements ("JOAs") raise a number of distinct issues for competition law and policy. Because these arrangements fall short of full merger, such collaborations may, even when entered into between rivals, present fewer competitive concerns than a merger would. On the other hand, lack of complete integration may limit the prospect for substantial, pro-competitive efficiencies to be realized. Joint ventures are discussed in the 1996 Statements of Antitrust Enforcement Policy in Health Care jointly issued by the Federal Trade Commission and the Department of Justice ("Statements"), but JOAs are not. What are the advantages and disadvantages of joint ventures and JOAs? Under what circumstances are joint ventures, JOAs, and other forms of cooperation likely to be pro-competitive and under what circumstances are they likely to be anti-competitive? Can some types of joint ventures help limit costly "medical arms races?" If so, would the reduction in this form of rivalry represent merely a savings to the parties, or would it constitute a net benefit to consumers? What other types of efficiencies may result from joint ventures, and what does the available historical evidence indicate about these claims? Do administrative efficiencies, in the absence of clinical integration or efficiencies, constitute a "unity of interest" so as to merit single entity treatment under *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 762 (1984)?

Panelists:

John (Jeff) Miles, *Ober/Kaler*
Robert Taylor, *Robert Taylor Associates*
Margaret E. Guerin-Calvert, *Competition Policy Associates, Inc.*

William G. Kopit, *Epstein Becker & Green, P.C.*
Robert Hubbard, *New York State Attorney General Office*
David Eisenstadt, *Microeconomic Consulting and Research Associates, Inc.*
Robert Moses, *Oxford Health Plans*

Friday, April 11, 2003, Morning Session

Title: A Tale of Two Cities: Little Rock

In many geographic markets in the United States there has been a significant amount of market turbulence and varying degrees of consolidation among health care providers and insurers. Boston and Little Rock provide two points on the spectrum of market consolidation. To provide a frame of reference for the balance of the hearings, a day will be spent painting a comprehensive picture of current market conditions in Boston and Little Rock. The full range of competitive issues will be addressed, including the cost and quality of the care rendered, the degree of market concentration among providers and insurers, and the impact of market consolidation on the performance of the payor and provider markets. (The session on Little Rock was postponed until this date due to inclement weather.)

Opening Remarks:

Commissioner Sheila F. Anthony, *Federal Trade Commission*

Panelists:

Jonathan R. Bates, M.D., *Arkansas Children's Hospital*
Russell D. Harrington, Jr., *Baptist Health*
James J. Kane, Jr., M.D., *Little Rock Cardiology Clinic, P.A.*
Joseph M. Meyer, *ALLTEL, Corporation*
Kevin W. Ryan, *Arkansas Center for Health Improvement*
Robert L. Shoptaw, *Arkansas Blue Cross and Blue Shield*
John Wilson, M.D., *Arkansas Medical Society*

Friday, April 11, 2003, Afternoon Session

Title: Hospitals - Post-Merger Conduct

Before a hospital merger is consummated, the parties routinely make representations about the pro-competitive benefits of the transaction. After a hospital merger, do the merged entities achieve the efficiencies they claim? Are the merged entities able to exert market power and raise prices? To what extent have hospitals actually combined administrative and/or clinical operations? Does patient flow data or "critical loss" computations accurately predict the post-merger behavior of hospitals in both the short and long-run? Do critical loss computations cast any light on the relative magnitude of post-merger price-increases, if any? How effective are payors at steering patients to alternative hospitals in response to post-merger price increases? What other strategies do payors have to resist demands for higher prices? How do state "sufficiency" requirements influence the bargaining power of hospital and insurers? What roles do patients, employers, insurance product design, and non-hospital facilities play? What is the significance of any excess capacity in the hands of rivals? How effective are "non-traditional remedies" (e.g., price freezes, indexed prices, community commitments, and the like) in addressing the market power that a merger may confer?

Panelists:

William G. Kopit, *Epstein Becker & Green, P.C.*
Lawrence Wu, *National Economic Research Associates, Inc.*

David Balto, *White & Case LLP*
James Langenfeld, *LECG, L.C.C.*
David A. Argue, *Economists Incorporated.*
Seth B. Sacher, *Charles River Associates*
Robert Taylor, *Robert Taylor Associates*
Kirby O. Smith, *Susquehanna Health System*
Jamie E. Hopping, *Ardent Health Services*

Wednesday, April 23, 2003, Morning Session

Title: Health Insurance Monopoly Issues - Market Definition

Health care coverage is a highly differentiated product, and comes in many varieties, including health maintenance organizations (“HMOs”), preferred provider organizations (“PPOs”), point of service plans (“POSs”) and indemnity plans. Some insurance products are regulated by the state in which the coverage is issued, while other arrangements are subject to partial or exclusive federal regulation. Many firms and individuals self-insure, with the extent of self-insurance influenced by the cost of coverage. Given these dynamics, what are the relevant economic and legal principles for defining the relevant product market in the health insurance setting? Do these principles differ in material ways from the principles of market definition applied in other industries? What information is required to determine the relevant market in a particular case? What, if any, guidance is provided by examining consumer behavior and enrollment shifts among these options over time?

Framing Presentation:

Paul B. Ginsburg, *Center for Studying Health System Change*

Panelists:

Henry R. Desmarais, M.D., *Health Insurance Association of America*
Roger Feldman, *University of Minnesota*
Barry C. Harris, *Economists Incorporated*
Arthur N. Lerner, *Crowell & Moring, LLP*
David Monk, *National Economic Research Associates, Inc.*

Wednesday, April 23, 2003, Afternoon Session

Title: Health Insurance Monopoly Issues - Competitive Effects

This session will explore the range of potential competitive effects theories that might predict higher prices or diminished quality following a merger. Are the merging plans sufficiently close substitutes for each other in their various price and non-price attributes that the merger might allow a unilateral competitive effect? Are the merging plans the low cost bidders for employer contracts such that auction theory would predict a price effect from the merger? How important is brand name loyalty in the health insurance industry? Because health insurance cannot be resold, do insurers price discriminate either geographically or among employers of different sizes? What does this imply about the competitive consequences of insurance plan mergers? Under what circumstances should the agencies be concerned about coordinated effects arising from a merger of insurance plans?

Panelists:

Helen Darling, *Washington Business Group on Health*
Jon Gabel, *Health Research and Educational Trust/American Hospital Association*
Michael J. Mazzeo, *Kellogg School of Management, Northwestern University,*

Lawrence Wu, *National Economics Research Associates, Inc.*
Steven Pizer, *Boston University School of Public Health*
Fred Dodson, *PacifiCare of California*

Thursday, April 24, 2003, Morning Session

Title: Health Insurance Monopoly Issues - Entry and Efficiencies

In most geographic markets in the United States, insurance plans frequently enter and exit. This session will examine entry, expansion, and product repositioning in this industry. Is entry generally likely in response to an otherwise anti-competitive combination, and is such entry generally timely, and sufficient to defeat each source of potential competitive effect? What factors do plans take into account when considering entry into a particular market? Do contracting practices such as “most favored nation” clauses or “all product” clauses make entry more difficult? What, if any, regulatory barriers to entry exist in health plan markets? What, if anything, does the exit of national and provider-sponsored plans from some geographic markets reveal about the existence and significance of barriers to entry in health plan markets?

A second part of this session will be devoted to possible efficiencies arising out of insurance plan mergers. A variety of empirical research has indicated that economies of scope and scale are exhausted at relatively modest levels in the provision of insurance. When insurance plans merge, however, they often claim that significant efficiencies will stem from the merger. What specific types of efficiencies are claimed? How should the agencies evaluate these statements and what factors or tests should they employ to evaluate whether or not the efficiencies are merger specific? What types of efficiencies are most likely (and least likely) to be cognizable and merger-specific?

Panelists:

Jay Angoff, *Roger G. Brown & Associates*
Stephen Foreman, *representing American Medical Association*
Ruth Given, *Deloitte Consulting and Deloitte & Touche*
Arthur N. Lerner, *Crowell & Moring, LLP*
Mary Elizabeth Senkewicz, *National Association of Insurance Commissioners*
Lawrence Wu, *National Economic Research Associates, Inc.*

Thursday, April 24, 2003, Afternoon Session

Title: Health Insurance Monopsony - Market Definition

Conceptually, monopsony can be viewed as the flip side of monopoly -- it is substantial market power being exercised by buyers over sellers. In the health insurance industry, health insurers are both sellers (of insurance to consumers) and buyers (of, for example, hospital and physician services). In this session we examine monopsony product market definition by asking how to apply the hypothetical monopolist paradigm to buyer side/monopsony concerns. We consider whether and how to reverse the standard seller-side formula that asks about the extent to which at-risk consumers can and will shift to other sellers in response to a post-merger small but significant and non-transitory increase in price (“SSNIP”). Do we, for example, ask in the monopsony context about the extent to which at-risk suppliers will substitute other outlets for their services in response to a small but significant and non-transitory decrease in price (“SSNDP”)? What are the costs faced by different suppliers in switching to different outlets for their services? What are the other outlets and how do such substitution possibilities differ across physicians, hospitals, or other potentially vulnerable supplier groups? How do we apply the concept of price discrimination in a buyer side case, and what are the potential product markets for such a theory? How do these theories apply to private and public purchasers of coverage from monopsony insurers? What

interesting or unusual geographic market issues for different supplier groups are implicated by insurer monopsony theory?

Panelists:

Roger D. Blair, *University of Florida, Gainesville*
Stephen Foreman, *representing American Medical Association*
H.E. Frech III, *University of California, Santa Barbara*
Thomas R. McCarthy, *National Economic Research Associates, Inc.*
John (Jeff) Miles, *Ober/Kaler*

Friday, April 25, 2003, Morning Session

Title: Health Insurance Monopsony - Competitive Effects

Mergers between health insurers may raise a concern that monopsony power could be exercised against providers. Many providers accuse insurance companies of forcing them to accept unreasonably low rates and unattractive contract terms. When a merger increases the share of a physician's patients covered by a given insurance plan, the cost to the physician of withdrawing from that plan in response to a lowering of rates increases. What is the relationship between market shares and this cost? How do the agencies distinguish between a shift in relative bargaining power and an unlawful exercise of monopsony power? Is it sufficient to show that provider prices will likely be reduced from premerger levels to demonstrate the exercise of monopsony power, or must we affirmatively show that price levels will fall below competitive levels? Must the acquisition and exercise of monopsony power be accompanied by a reduction in the output of provider services? Is it plausible that a payor without downstream market power could exercise monopsony power unilaterally? What are the conditions that must exist for such a payor to exercise monopsony power? Are those conditions likely to be satisfied in health care markets?

Panelists:

Sharon Allen, *Arkansas Blue Cross and Blue Shield*
Stephen Foreman, *representing American Medical Association*
H.E. Frech III, *University of California, Santa Barbara*
Dennis A. Hall, *Baptist Health System, Inc.*
Stephanie W. Kanwit, *American Association of Health Plans*
Thomas R. McCarthy, *National Economic Research Associates, Inc.*
John (Jeff) Miles, *Ober/Kaler*
Marius Schwartz, *Georgetown University*
Steve Mansfield, *St. Vincent Health System*

Wednesday, May 7, 2003, Morning Session

Title: Health Insurance/Providers - Countervailing Market Power

Providers have argued that health plans routinely wield monopsony power, reducing provider reimbursement and quality. Solutions proposed by providers include legislation or doctrinal development that would permit providers to acquire countervailing market power. The providers argue that, if permitted to acquire countervailing market power, they can correct the problems caused by the health plans' exercise of monopsony power. Assuming the possession of significant monopsony power by health plans, would the aggregation of market power by providers have a net benefit or cost? Under what conditions, if any, would the aggregation of market power by providers reduce the monopsony power of purchasers? Are those conditions likely to be present in health care markets? Does the reverse also hold, that is, should

health plans be permitted to acquire monopsony power in response to the possession of significant market power by providers? Should both physicians and hospitals be permitted to acquire countervailing market power, or is this an option that should only be available to certain providers? Leaving aside the economic justifications for acquiring countervailing market power, does existing legal precedent leave open the possibility of doctrinal developments that would permit providers to engage in what would otherwise be unlawful collective bargaining?

Panelists:

Donald Crane, *California Association of Physician Groups*
Stephen Foreman, *representing American Medical Association*
Martin S. Gaynor, *Carnegie Mellon University*
James Langenfeld, *LECG, L.C.C.*
Robert Leibenluft, *representing Antitrust Coalition for Consumer Choice in Health Care*
Monica Noether, *Charles River Associates*
Mark Tobey, *Office of the Attorney General, Texas*

Wednesday, May 7, 2003, Afternoon Session

Title: Most Favored Nation Clauses

A "most favored nation" ("MFN") clause is a contractual agreement between a supplier and a customer that requires the supplier to sell to the customer on pricing terms at least as favorable as the pricing terms on which that supplier sells to other customers. These clauses are not infrequently found in contracts health insurers enter into with hospitals or physicians. They allow the insurer to be confident that the reimbursement rates it pays providers are no greater than those that its competitors have negotiated. MFNs, however, may raise competitive concerns because they can discourage providers from lowering the reimbursement rates they offer to some insurers. Consequently, the agencies continue to receive and evaluate complaints about MFNs to determine whether they merit more complete investigation and enforcement action. This session will consider the following questions: What are the pro-competitive justifications for MFNs? What competitive concerns do they raise? What are the Agencies' prior enforcement activities with respect to MFNs, and what are the characteristics of the market and/or the contracts that lead to such action?

Panelists:

Jonathan B. Baker, *American University Washington College of Law*
William G. Kopit, *Epstein Becker and Green, P.C.*
Thomas Overstreet, *Charles River Associates*
Robert M. McNair, Jr., *Drinker Biddle & Reath LLP*
Steven E. Snow, *Partridge Snow & Hahn LLP*

Thursday, May 8, 2003, Morning Session

Title: Physician Hospital Organizations

A Physician Hospital Organization ("PHO") is a vertical arrangement that combines physician and hospital services within one organization. In theory, PHOs may create incentives to lower prices and enhance quality. In practice, many PHOs have declared bankruptcy or dissolved. The agencies have taken several enforcement actions against PHOs in response to specific anti-competitive conduct. What anti-competitive risks do PHOs create? For example, would doctors who are not members of the PHO be denied privileges at the hospital or given less favorable treatment? Under what circumstances might it be anti-competitive

for a physician hospital organization to offer an insurance product? What factors have led the agencies to take action against PHOs?

Panelists:

Bradford Buxton, *Illinois Blue Cross Blue Shield*
Serdar Dalkir, *Microeconomic Research Consulting Associates*
Margaret E. Guerin-Calvert, *Competition Policy Associates, Inc.*
John P. Marren, *Hogan Marren, Ltd.*
John (Jeff) Miles, *Ober/Kaler*
Ernest Weis, *representing the American Hospital Association*

Tuesday, May 27, 2003, Afternoon Session

Quality and Consumer Information: Overview

Quality of care has been extensively studied by health care providers and health services researchers. What is known about the quality of care provided in the United States? What measures (whether structure, process, or outcome) correlate with the quality of care that is delivered and how predictive are these measures? What institutions help ensure the quality of care delivered in the United States, and how effective have they been? How do employers factor quality into the equation when designing benefits? How do payors (both private and public) factor quality into their coverage decisions and their design of delivery options? What information is available to employers and payors in making such decisions? What are the economics of information provision and use in health care? What is the significance of the widespread use of process-based measures of quality?

Panelists:

Carolyn Clancy, M.D., *Agency for Healthcare Research and Quality*
Elliot Fisher, M.D., *Dartmouth Medical School*
Martin Gaynor, *Carnegie Mellon University*
Regina Herzlinger, *Harvard Business School*
Karen Ignagni, *American Association of Health Plans*
Michael Millenson, *Kellogg School of Management, Northwestern University*

Thursday, May 29, 2003, Morning and Afternoon Sessions

Title: Quality and Consumer Information: Hospitals

Information is an important component of a well-functioning market. What information do hospitals provide to consumers concerning the quality of the goods and services they offer? Is the type and amount of the information that hospitals provide concerning quality adequate to allow consumers to make well-informed purchasing decisions among hospitals? If not, what additional information do consumers need or want to make such decisions and why are hospitals not already providing it in the marketplace? Does the quantity and quality of the information that consumers would find helpful depend on the nature of the underlying condition (i.e., acute v. chronic) and treatment (i.e., surgical v. medical; curative v. palliative; elective v. medically necessary)? What is the state of the art with regard to measures of hospital quality, whether structure, process, or outcome? In particular, would the disclosure by hospitals of their nosocomial infection rate, or the type of physician who will be providing care (e.g., does the hospital use hospitalists and intensivists), or of medical professional staffing levels (e.g., nurses) assist consumers in making well-informed purchasing decisions? What are the risks of relying on (and disclosing) process-based measures of hospital quality? How would competition on quality measures affect costs, prices, and

decisions by payors and customers? How does compensation affect quality? Can compensation be harnessed to enhance the performance of hospitals?

Morning Session Panelists:

Gloria Bazzoli, *Virginia Commonwealth University*
Paul Conlon, *Trinity Health*
Nancy Davenport-Ennis, *National Patient Advocate Foundation*
Judith Hibbard, *University of Oregon*
Charles N. (Chip) Kahn III, *Federation of American Hospitals*
Daniel Kessler, *Stanford Business School*
Louise Probst, *Gateway Purchasers For Health and St. Louis Area Business Health Coalition*
Patrick Romano, M.D., *University of California, Davis*
William Sage, M.D., *Columbia University School of Law*

Afternoon Session Panelists:

Suzanne Delbanco, *The Leapfrog Group*
Nancy Foster, *American Hospital Association*
Irene Fraser, *Agency for Healthcare Research and Quality*
Stuart Guterman, *Centers for Medicare and Medicaid Services*
Arnold Milstein, M.D., *Pacific Business Group on Health*
Anthony Tirone, *Joint Commission on Accreditation of Healthcare Organizations*
Woodrow Myers Jr., M.D., *WellPoint Health Networks*
Cathy Stoddard, *representing the Service Employees International Union*

Friday, May 30, 2003, Morning and Afternoon Sessions

Title: Quality and Consumer Information: Physicians

Health services research has documented enhanced outcomes for certain procedures when physicians perform a high volume of such procedures (volume-quality relationships). Other research has demonstrated considerable geographic variation in physician practice patterns, without demonstrable effects on outcome. When care is provided at academic medical centers, treatment is routinely provided by physicians at all levels of training, but some have argued that patients do not realize that treatment is provided by less experienced practitioners. Other research has demonstrated that many patients do not receive the care they desire in the last few months of life, even after they have executed a living will or a durable power of attorney. What are the consumer information implications of these results? Should physicians disclose to potential patients the existence of volume-quality relationships and the number of such procedures they have performed? Should physicians disclose the existence of geographic variation in practice patterns to potential customers? What is the nature of disclosure to patients who receive care in academic medical centers about who will be providing their treatment? What is the nature of disclosure to patients about end-of-life care, living wills, and durable powers of attorney? How effective has the Patient Self-Determination Act been in enhancing disclosure to patients about end-of-life care, living wills, and durable powers of attorney? Does the failure to adequately disclose any of this information or to adhere to patient preferences in the delivery of health care goods and services raise consumer protection issues? How would competition on such measures affect costs, prices, and decisions by payors and consumers? Are there other measures that consumers would find helpful in determining which physicians to patronize? Does the quantity and quality of the information that consumers would find helpful depend on the nature of the underlying condition (i.e., acute v. chronic) and treatment (i.e., surgical v. medical; curative v. palliative; elective v. necessary)? What is the state of the art with regard to measures of physician quality,

whether structure, process, or outcome? How does compensation affect quality? Can compensation be harnessed to enhance the performance of physicians?

Morning Session Panelists:

Stuart Bondurant, M.D., *Association of American of Medical Colleges*
Christine Crofton, *Agency for Healthcare Research and Quality*
Charles Darby, *Agency for Healthcare Research and Quality*
Andrew Kumpuris, M.D., *Washington & Lee University*
LaMar McGinnis, M.D., *American College of Surgeons*
Arnold Milstein, M.D., *Pacific Business Group on Health*
Margaret O'Kane, *National Committee for Quality Assurance*
Reed Tuckson, M.D., *UnitedHealth Group*

Afternoon Session:

Opening Remarks:

Commissioner Thomas B. Leary, *Federal Trade Commission*

Panelists:

Robert Berenson, M.D., *AcademyHealth*
Wendy Levinson, M.D., *University of Toronto*
Joanne Lynn, M.D., *The Washington Home Center for Palliative Care Studies*
Glen Mays, *Center for Studying Health System Change*
Shoshana Sofaer, *Baruch College, CUNY School of Public Affairs*
Nancy Nielsen, M.D., *American Medical Association*

Tuesday, June 10, 2003, Morning and Afternoon Sessions

Title: Quality and Consumer Protection: Market Entry

In health care, market entry is influenced by a number of factors, including the necessity of meeting state regulatory requirements such as licensure and certificate of need. Professional associations and individual providers have used a variety of strategies to limit entry by potential competitors and prevent unbundling and de-skilling of the services that they provide. Thus, in many states, there are significant limitations on market entry by new competitors, and opposition to the efforts of existing competitors to expand the range of services they provide. What does the empirical evidence indicate about the cost, quality, and availability of services provided by nurse-midwives, nurse-anesthetists, dental hygienists, physician-assistants, pharmacists, optometrists, physical therapists, and other professionals and para-professionals? What regulatory and non-regulatory strategies have been employed to restrict independent practice or broadened clinical autonomy by these providers? What reasons have been advanced to justify such restrictions on entry? Do the regulatory strategies that have been employed reflect the least restrictive means of accomplishing the intended objectives? What consumer information and protection issues would be raised by a less-restrictive environment for market entry?

Morning Session Panelists:

Susan Apold, *American College of Nurse Practitioners*
Tammi O. Byrd, *American Dental Hygienists' Association*
John Hennessy, *Kansas City Cancer Centers*
Morris Kleiner, *University of Minnesota*
Lynne Loeffler, *American College of Nurse Midwives*

Thomas Piper, *American Health Planning Association*
Megan D. Price, *Professional Nurses Services, Inc.*
Robin Wilson, *University of South Carolina School of Law*

Afternoon Session Panelists:

Jeffrey C. Bauer, *Superior Consultant Company, Inc.*
Maxwell Gregg Bloche, M.D., *Georgetown University School of Law*
Steven Lomazow, M.D., *American Academy of Neurology*
Francis J. Mallon, *American Physical Therapy Association*
Jerome H. Modell, M.D., *representing American Society of Anesthesiologists*
Michael Morrissey, *University of Alabama, Birmingham, School of Public Health*
Russ Newman, *American Psychological Association*

Wednesday, June 11, 2003, Morning Session

Title: Noerr Pennington/State Action

How do Noerr Pennington and the state action doctrines affect competition law and policy? Are there specific anti-competitive practices that current enforcement efforts have not addressed because of the Noerr Pennington or state action doctrines, including but not limited to abuses of state licensure, certificate of need and other regulatory and petitioning processes? Does competition law and policy impede providers from jointly discussing their concerns with government payors? What are the appropriate boundaries for these doctrines given the competing interests at stake? Are antitrust enforcement efforts appropriately targeted in light of the impact of the Noerr Pennington and state action doctrines?

Panelists:

Meredyth Smith Andrus, *Office of the Attorney General, Maryland*
John Delacourt, *Federal Trade Commission*
Clark Havighurst, *Duke University Law School*
Kenneth W. Kizer, M.D., *National Quality Forum*
Dr. Brenda Lyon, *National Association of Clinical Nurse Specialists*
Mark McClure, D.D.S., *National Integrative Health Associates*

Wednesday, June 11, 2003, Afternoon Session

Title: Long Term Care/Assisted Living Facilities

An increasing number of elderly Americans spend time in long term care or an assisted living facility. What is the nature of the information that is disclosed to such consumers about the cost and quality of the services they will receive? Is the type and amount of the information that these facilities provide concerning quality adequate to allow consumers to make well-informed purchasing decisions? If not, what additional information do consumers need or want to make such decisions and why are these facilities not already providing it in the marketplace? Does the quantity and quality of the information that consumers would find helpful vary? What is the state of the art with regard to measures of nursing home and assisted living facility quality, whether structure, process, or outcome? What are the risks of relying on (and disclosing) process-based measures of quality? How would competition on quality measures affect costs, prices, and decisions by payors and customers? How does compensation affect quality? Can compensation be harnessed to enhance the performance of nursing homes and assisted living facilities?

Panelists:

Toby S. Edelman, *Center for Medicare Advocacy*

Karen Love, *Consumer Consortium on Assisted Living*
Barbara Manard, *American Association of Homes and Services for the Aging*
Barbara Paul, M.D., *Centers for Medicare and Medicaid Services*
Jan Thayer, *National Center for Assisted Living*
Keren Brown Wilson, *Jessie F. Richardson Foundation*

Thursday, June 12, 2003, Morning Session

Title: Financing Design/Consumer Information Issues

For the non-elderly, health care is financed through voluntary insurance contracts. Employment-based health insurance covers the majority of non-elderly insured Americans. How effectively do employers reflect the preferences of their employees in designing and implementing health insurance coverage? What distortions result from making employers the nexus of health insurance? Are there off-setting advantages associated with having employers involved in the health insurance market? What changes have there been in the structure of employment-based health insurance in recent years? What information is disclosed to employees in connection with obtaining health insurance? How does employment-based health insurance differ from insurance available in the individual market? Health insurance is aggressively regulated by the states, with more limited regulation by the federal government. What are the effects of this regulation on the cost and content of the health insurance products available in the marketplace? Does such regulation correct for specific failures in the market for health insurance coverage? Has the emergence of new forms of health insurance coverage (i.e., point-of-service options, consumer-driven health insurance, and medical savings accounts) had an effect on the health insurance market and the regulatory environment?

Panelists:

Marcia L. Comstock, M.D., *Wye River Group on Healthcare*
Helen Darling, *Washington Business Group on Health*
Newt Gingrich, *The Gingrich Group*
Warren Greenberg, *George Washington University*
Greg Kelly, *Coalition Against Guaranteed Issue*
David Lansky, *Foundation for Accountability*
Michael Young, *Aon Consulting*

Thursday, June 12, 2003, Afternoon Session

Title: Information and Advertising

To what extent do consumers use quality information in making choices among health care financing arrangements and among health care providers? What information regarding quality is available to consumers? How accurate is this information? Does the quantity and quality of the available information depend on the nature of the underlying condition (i.e., acute v. chronic) and treatment (i.e., surgical v. medical; curative v. palliative; elective v. necessary)? What effects does this information have on the behavior of health care providers? What quality information do health care providers disseminate through advertising? What characteristics distinguish health care providers who provide quality information through advertising from those who do not? Do health care providers who advertise quality differ from those who advertise price or other attributes of their services? What percentage of health care providers engage in any advertising? What role does comparative advertising (including scorecards) play in competition among health care providers? What role does comparative advertising concerning access to specialists or specialized services play in competition among health care financing options? Do governmental or professional restrictions limit the advertising of health care goods and services based on quality? What are the effects of these restrictions on competition in markets for health care goods and

services? What are the pro-competitive justifications for such restrictions? What empirical evidence supports these justifications?

Panelists:

Laura Carabello, *CPRi Communications*
Bernie Dana, *American Health Care Association*
Helen Darling, *Washington Business Group on Health*
John E. Gebhart, III, *DoctorQuality, Inc.*
Richard Kelly, *Federal Trade Commission*
Douglas D. Koch, M.D., *Baylor College of Medicine*
Thomas H. Lee, M.D., *Partners Community Healthcare, Inc.*
Peter M. Sfikas, *American Dental Association*

Wednesday, June 25, 2003, Afternoon Session

Title: Mandated Benefits

A number of states have long mandated coverage of a variety of health care services, including certain pharmaceuticals. How prevalent are these mandates? Which benefits are most and least widely mandated? What are the effects of these mandates? To what extent do these mandates increase the cost of health insurance coverage? To what extent would these benefits be available in the private coverage market, absent the mandate? For example, are these benefits typically provided by self-funded employee benefit plans, which are not subject to these mandates? What factors explain why certain states choose to mandate certain benefits?

Panelists:

Daniel P. Gitterman, *University of North Carolina, Chapel Hill*
David A. Hyman, *University of Maryland*
Ralph Ibson, *National Mental Health Association.*
Stephanie W. Kanwit (for Karen Ignagni), *American Association of Health Plans*
Anthony J. Knettel, *The ERISA Industry Committee*
Rachel Laser, *National Women's Law Center*
Tom Miller, *Cato Institute*

Thursday, June 26, 2003, Morning Session

Title: Pharmaceuticals: Formulary Issues

Pharmacy benefit managers (PBMs) have emerged as major factors in the marketing and distribution of pharmaceuticals. How do PBMs work? What information do PBMs disseminate about their operations? What factors enter into PBM formulary listing decisions and how transparent are those decisions? What tools do PBMs employ, and how effective are these tools? What are the effects of PBMs on the cost of pharmaceuticals? What state and federal laws affect how PBMs operate? What, if any, are the barriers to entry for potential competitors to existing PBMs? What consumer information, consumer protection, and antitrust issues are raised by the presence of PBMs in the market?

Panelists:

David Balto, *White & Case LLP*
Anthony Barrueta, *Kaiser Foundation Health Plan, Inc.*
Thomas M. Boudreau, *Express Scripts*

Jack Calfee, *American Enterprise Institute*
John Dicken, *General Accounting Office*
John Richardson, *The Health Strategies Consultancy*

Thursday, June 26, 2003, Afternoon Session

Title: Prospective Guidance

To provide prospective guidance to requesting parties and to the public, the FTC provides advisory opinions and the DOJ provides business review letters. Over the past decade, the FTC and DOJ have each generated approximately a half dozen such opinions and letters relating to health care per year. Does this modest volume reflect the true demand for prospective guidance, or are parties discouraged from obtaining advisory opinions and business review letters? Is prospective guidance helpful or unhelpful in the health care context? Is prospective guidance too costly or too slow? What changes would make prospective guidance more useful? How does the prospective guidance provided by the FTC and DOJ compare to that provided by other federal agencies?

Panelists:

Jeffrey Brennan, *Federal Trade Commission*
William Cohen, *Federal Trade Commission*
Ellen S. Cooper, *Maryland Office of the Attorney General*
Claudia H. Dulmage, *U.S. Department of Justice Antitrust Division*
Warren Grimes, *Southwestern University School of Law*
Clifton E. Johnson, *Hall, Render, Killian, Heath & Lyman, P.S.C.*
John (Jeff) Miles, *Ober/Kaler*
Vicky Robinson, *Office of the Inspector General, U.S. Department of Health & Human Services*

Wednesday, September 24, 2003, Morning Session

Title: Physician Product and Geographic Market Definition

How should the relevant product and geographic markets for physician services be defined and measured? How do quality and reputation affect product market definition and competition? How common is price variation among physicians providing comparable services in any given market? To what extent do patients and payors factor price variation into their decision-making? How, if at all, does integration allow physicians to exercise market power or constrain them from doing so? What are the barriers to entry in physician markets? Do these barriers vary in different geographic markets or at different points in a physician's career? What evidence, if any, indicates that physician concentration and price are related? How does managed care penetration, individual practice association ("IPA") participation, physician concentration, and other factors affect physician reimbursement?

Panelists:

David A. Argue, *Economists Incorporated*
Howard Feller, *McGuire Woods LLP*
Margaret E. Guerin-Calvert, *Competition Policy Associates, Inc.*
Astrid Meghriqian, *California Medical Association*
Monica Noether, *Charles River Associates*
John Wiegand, *Federal Trade Commission*

Wednesday, September 24, 2003, Afternoon Session

Title: Physician Information Sharing

What kinds of information (both price and non-price) are physicians who provide services in separate practices sharing (1) among themselves; (2) with payors; and (3) with others such as employer organizations, public interest groups and the media? Under what circumstances, if any, does such information sharing pose an unacceptable risk of competitive harm? What forms of aggregation might permit the sharing of pricing data and other information among competing physicians, without facilitating tacit or explicit coordination? What, if any, are the potential procompetitive benefits and anticompetitive risks of physician surveys of price, payor reimbursement amounts, and non-price information? What, if any, are the likely effects on physician competition of the recent business review letter issued by the DOJ and the advisory opinion issued by the FTC regarding such sharing of information in Washington and Dayton, respectively? What steps have providers taken to reduce the risk that their collective sharing of price or non-price information with payors or others might raise antitrust concerns?

Panelists:

Gregory G. Binford, *Benesch, Friedlander, Coplan & Aronoff LLP*
Roxane Busey, *Gardner Carton & Douglas*
Robert Leibenluft, *Antitrust Coalition For Consumer Choice in Healthcare*
Robert E. Matthews, *PriMed Physicians*

Thursday, September 25, 2003, Morning Session

Title: Physician IPAs: Patterns and Benefits of Integration

Individual practice associations (“IPAs”) are groups of independent physicians that contractually form a physician network joint venture that can contract with insurance plans. IPAs can integrate financially, clinically, or both. Some IPAs have adopted common medical protocols and made other efforts to clinically integrate. Other IPAs focus on contractually sharing risk, and devote minimal attention to clinical integration. Does one structural or contractual form of IPAs predominate in the market? Are differences in organizational structure and function related to geographic location, specialty, or other factors? For example, are multi-specialty IPAs structurally or functionally different than single-specialty IPAs? What are the regulatory and economic constraints on IPAs? Do IPAs enhance efficiency and quality? What types of clinical and financial integration have IPAs adopted? What, if any, strategic advantages do IPAs offer independent physicians, and how do these organizations affect the clinical and financial decisions of participating physicians?

Panelists:

Bartley Asner, M.D., *California Association of Physician Groups*
Lawrence Casalino, M.D., *University of Chicago*
Curt Hawkinson, *American Association of Physician Assistants*
Albert Holloway, *The IPA Association of America*
Markus H. Meier, *Federal Trade Commission*

Thursday, September 25, 2003, Afternoon Session

Title: Physician IPAs: Messenger Model

The messenger model has attracted considerable criticism from health care providers. What is the basis for that criticism? How prevalent and functional are the messenger model arrangements set forth in the 1996 Statements of Antitrust Enforcement Policy in Health Care jointly issued by the DOJ and FTC? What improvements could be made to those arrangements without increasing the risk of competitive harm? What approaches or methods could providers use as efficient alternatives to the messenger model arrangements

described in the Health Care Policy Statements? How timely and effective has Agency intervention been with regard to anticompetitive IPA conduct?

Panelists:

J. Edward Hill, M.D., *American Medical Association*
Arthur N. Lerner, *Crowell & Moring, LLP*
David Marx, Jr., *McDermott, Will & Emery*
John (Jeff) Miles, *Ober/Kaler*
Richard D. Raskin, *Sidley Austin Brown & Wood LLP*
Douglas C. Ross, *Davis Wright Tremaine LLP*

Friday, September 26, 2003, Morning Session

Title: Physician Unionization

Many employed physicians and other allied healthcare service providers are unionized. Expanding the scope of physician unionization to include non-employee physicians has been proposed to address disparities in bargaining power between payors and providers. What is known about the effects of unionization, if any, on the cost, quality, and availability of health care to consumers? Does collective negotiation focus on enhanced quality, higher salaries/prices for the services that are being provided, or both?

Panelists:

Carl Ameringer, *University of Wisconsin*
William Brewbaker, *University of Alabama, School of Law*
Mark Flaherty
Mark Levy, *Committee of Interns and Residents*
Michael Connair, M.D., *Yale-New Haven Hospital*

Friday, September 26, 2003, Afternoon Session

Title: Group Purchasing Organizations

The hospital group purchasing organization industry is currently in a state of flux as individual GPOs begin to modify their membership requirements and contracting practices in response to recent Congressional and public criticism. Given the recent changes, what current practices or attributes of the industry, if any, raise legitimate antitrust concerns? In particular, how prevalent are bundling of products, lengthy manufacturer/GPO sole source contracts, and high hospital/GPO commitment contracts? Does the analysis of Health Care Policy Statement 7 on joint purchasing arrangements remain valid, or should it be modified? In particular, should the safety zone provision in Health Care Policy Statement 7 for purchases that account for less than 35 percent of the total sales of the purchased product or service in the relevant market be modified? What, if any, are the circumstances under which bundling is anticompetitive or procompetitive? What is the proper approach for determining whether the term of a particular manufacturer/GPO sole source contract is sufficiently long to, on balance, harm competition rather than promote it?

Panelists:

Robert E. Bloch, *Mayer, Brown, Rowe & Maw*
Lynn James Everard, *The Foundation for Healthcare Integrity*
Gary Heiman, *Standard Textile*
Said Hilal, *Applied Medical Resources Corporation*

Merrile Sing, *U.S. General Accounting Office*
John W. Strong, *Consorta, Inc.*
Elizabeth Weatherman, *Warburg Pincus*

Tuesday, September 30, 2003, Morning Session

Title: International Perspectives on Health Care and Competition Law and Policy

A number of countries other than the United States have grappled with the application of competition law and policy to health care. How do other countries apply competition law to their systems for the coverage and delivery of health care services? What, if any, is the applicability of those experiences to U.S. competition law and policy?

Introduction:

Commissioner Mozelle W. Thompson, *Federal Trade Commission*

Panelists:

Sitesh Bhojani, *Commissioner Australian Competition and Consumer Commission*
Bruce Cooper, *Australian Competition and Consumer Commission*
Michael Jacobs, *DePaul University School of Law*
Dr. Liu, Len-Yu, *Taiwan Fair Trade Commission*
Declan Purcell, *Irish Competition Authority*

Tuesday, September 30, 2003, Afternoon Session

Title: Medicare and Medicaid

Medicare and Medicaid are major purchasers of health care services. For certain populations and illnesses, they are the sole purchaser of services, and their actions have spill-over effects on the rest of the market. How should the government's roles as regulator and purchaser of health care services be reconciled? How can the government utilize its purchasing power to encourage the disclosure of information and make healthcare coverage and delivery markets more efficient? What, if any, are the limitations on the government's ability to employ its purchasing power in this fashion? What steps, if any, should the government take or avoid so that its purchasing power does not harm consumers and competition?

Panelists:

Joseph R. Antos, *American Enterprise Institute*
Joseph A. Cashia, *National Renal Alliance, LLC*
Dan L. Crippen, *Former Director, Congressional Budget Office*
Walton Francis
Jeff Lemieux, *Progressive Policy Institute*

Wednesday, October 1, 2003, Morning Session

Title: Remedies: Civil/Criminal

Health care antitrust violations, like other antitrust violations, can be addressed through both civil and criminal enforcement proceedings. With respect to civil enforcement, under what circumstances, if any, should the Agencies seek relief beyond merely prohibiting the unlawful conduct? What are the comparative advantages and drawbacks of structural remedies such as dissolution and divestiture versus conduct remedies such as membership bars, restitution and firewalls? Have the civil remedies employed in

past cases been effective? Have the Agencies sufficiently monitored and enforced compliance with final judgments once they have been entered?

With respect to criminal enforcement, prosecutions of health care professionals by the DOJ are relatively rare. What circumstances, if any, justify criminal enforcement in health care antitrust cases, and what are the impediments to such prosecutions? Given the rarity of criminal prosecutions, are civil remedies adequate? How, if at all, should the availability of private treble damages affect the relief sought by the Agencies? What changes in remedies might make the application of competition law to health care more effective?

Panelists:

Jack Bierig, *Sidley Austin Brown & Wood LLP*
James A. Donahue, III, *Pennsylvania Office of the Attorney General*
Kevin Grady, *Alston & Bird LLP*
Gail Kursh, *U.S. Department of Justice*
Kevin J. O'Connor, *Godfrey & Kahn*
Melvin H. Orlans, *Federal Trade Commission*
Toby G. Singer, *Jones Day*
Gregory Vistnes, *Charles River Associates*