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9 HEALTH CARE AND
10 COMPETITION LAW AND
11 POLICY WORKSHOP
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1 P R O C E E D I N G S

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3 MR. HYMAN: Good morning. Thank you all for

4 coming to our Health Care and Competition Law and Policy

5 Workshop. My name is David Hyman and I'm a special

6 counsel here at the Federal Trade Commission. Rank

7 has its privileges, and the chairman of the Federal Trade

8 Commission is here to kick things off, Chairman Tim Muris.

9 CHAIRMAN MURIS: Thank you very much, David.

10 On behalf of my fellow Commissioners, it's my

11 pleasure to welcome you to the Federal Trade

12 Commission's Workshop on Health Care and Competition

13 Law and Policy. This two-day event will consider the

14 impact of competition law and policy on the cost, quality

15 and availability of health care, as well as on the

16 incentives for innovation.

17 Health care spending accounts for a substantial

18 part of our nation's GDP. Competition law and policy

19 should support and encourage both the efficient delivery

20 of health care products and services and innovation,

21 through new and improved drugs, treatments, and delivery

22 options. Developing and implementing competition policy

23 for health care raises complex and sensitive issues.

24 The goal of this workshop is to promote

25 dialogue, learning, and consensus among all interested

1 parties. I want to thank David Hyman in the Office of
2 the General Counsel, who with Bill Kovacic, Susan
3 DeSanti, Angela Wilson, and Sarah Matthias organized the
4 workshop. They have put together two days of
5 proceedings, featuring five panels and more than a dozen
6 experts. We appreciate the willingness of those
7 participating to share with us their perspectives.
8 The FTC has a long history in applying
9 competition policy to health care. In the mid-1970s,
10 the Bureau of Competition formed a group to investigate
11 potential antitrust violations involving health care.
12 As an Assistant to the Director of the FTC's Policy
13 Office, I was proud to help launch this effort.
14 A series of important cases followed, as the
15 Commission identified and addressed anticompetitive
16 conduct by every conceivable entity involved in health
17 care. The Bureau of Consumer Protection has also had an
18 important role in health care, challenging the deceptive
19 advertising of a variety of health-related products and
20 services.
21 The Bureau of Economics assists the other
22 bureaus in pursuing these enforcement initiatives. It
23 has also published several important papers on health
24 care and competition. The Bureau of Economics sponsored
25 a major conference on the role of competition in health

1 care in 1977, which resulted in a well-known book,
2 Competition in the Health Care Sector: Past, Present,
3 and Future.
4 We are pleased today to have the person who
5 organized that conference and edited the book, Warren
6 Greenberg, on our first panel this afternoon. At the
7 time of that conference, Warren was a staff economist
8 at the FTC. He is now a professor at George Washington
9 University.
10 More recently, the Commission has brought cases
11 involving price fixing by physicians and unfair methods
12 of competition by pharmaceutical companies that delayed
13 the entry of generic drugs for the treatment of high
14 blood pressure, anxiety, and angina. Details of these
15 cases are in the bound materials you received this
16 morning.
17 We are also looking hard at consummated hospital
18 mergers to determine whether there have been
19 anticompetitive consequences. We will seek
20 administrative redress if we find evidence of such
21 conduct and have a viable remedy.
22 The heads of our Bureaus of Competition,
23 Consumer Protection, and Economics, who are speaking
24 later this morning, will detail the Commission's recent
25 initiatives in health care. We have increased the

1 resources devoted to this industry and we are now seeing
2 the results.
3 Our enforcement efforts in the health care
4 sector have been complemented by our partners at the
5 Department of Justice and the State Attorneys General.
6 You will be hearing from representatives of both later
7 this morning as they discuss their own initiatives.
8 In addition to enforcement authority, the
9 Commission has unique jurisdiction to identify, analyze,
10 and report on competition and consumer protection issues
11 of major importance. Using this authority, in July, we
12 released a study on certain aspects of generic drug
13 competition under the Hatch-Waxman amendments. The
14 study examined whether the Commission's enforcement
15 actions against alleged anticompetitive agreements,
16 which relied on certain Hatch-Waxman provisions, were
17 isolated examples or represented conduct frequently
18 undertaken by pharmaceutical companies.
19 The study also examined, more broadly, how the
20 process that Hatch-Waxman established to permit generic
21 entry prior to expiration of a brand name drug patent
22 has worked between 1992 and 2000. Michael Wroblewski of
23 the Commission staff will speak in more detail tomorrow
24 afternoon about this study.
25 This workshop is also part of the FTC's research

1 agenda, and we hope to continue with other research
2 projects.
3 The FTC is the only federal agency with both
4 consumer protection and competition jurisdiction
5 over broad sectors of the economy. The Commission
6 enforces laws that prohibit business practices that are
7 anticompetitive, deceptive, or unfair to consumers. The
8 Commission also promotes informed choice and public
9 understanding of the competitive process.
10 I hope this workshop will help illuminate the
11 ways that competition law and policy can have a positive
12 impact on the health care sector, and ensure that
13 Americans receive top value for their health care
14 dollars.
15 Obviously, a two-day workshop cannot do justice
16 to the scope and complexity of a subject like health
17 care and competition. There are at least a dozen
18 important topics we will not cover, such as hospital
19 mergers, fraudulent health claims, vertical integration,
20 and the boundaries of the State Action Exemption. We
21 hope to address these issues in the future.
22 So, welcome, and thank you very much. I look
23 forward to learning a lot from you all. Thank you.
24 (Applause.)
25 MR. HYMAN: Thank you, Chairman Murris.

1 Some basic logistical announcements. First, the
2 technology people requested that everyone turn off their
3 cell phones, because they apparently interfere with the
4 taping of this workshop. It's also irritating to the people
5 near you, but that's a separate issue.
6 Second, there are bathrooms right outside and
7 there are bathrooms on each floor, if you're in one of
8 the overflow rooms.
9 Third, there will be about an hour and a half
10 for lunch. There's a hand-out sheet that lists a variety
11 of nearby locations for lunch, if you're not familiar
12 with the neighborhood.
13 Fourth, there are hand-outs outside. There are
14 four hand-outs that the Commission has prepared. There's
15 the tan book that includes biographies of all of the
16 speakers and a variety of documents relating to actions
17 that the various bureaus have taken, both enforcement
18 and research related. There's the generic drug study
19 that was prepared by the Office of General Counsel that
20 the chairman just alluded to. There's an annual report from
21 the Commission, and then there's an agenda separate and
22 apart from the agenda that's included in the tan book,
23 although they're identical. We just thought it would be
24 simpler if you had two. Individual speakers may have hand-outs.
25 There are three of them out there currently. There may

1 be more during the course -- actually four of them --
2 there may be more speaker hand-outs during the course of the workshop.
3 So, please check periodically.
4 We're going to very aggressively try to keep on
5 time, because we know people have schedules to keep as well.
6 To the extent we don't, your indulgence is appreciated.
7 There will not be questions from the floor. However, as the
8 Federal Notice Register reflects, the deadline for comments in response
9 to the workshop is September 30th. So, you have several weeks to go
10 back and if you were very unhappy with something someone said, the
11 ability to respond at length in writing, I suggest, is probably far
12 superior to yelling at them in front
13 of an audience.
14 And let me see if there's anything else. Our
15 first speaker today who will be providing an overview of
16 the health care industry -- oh, one other announcement
17 before I do that. Please, keep your name tags on if you
18 leave the building. It will make it much easier to get
19 back in after lunch; otherwise, you have to go through
20 the entire extended process again.
21 Our first speaker today is Professor William
22 Brewbaker from the University of Alabama School of Law,
23 well-known in health law, co-author of a two-volume
24 treatise that systematically goes through various parts of
25 the health care market and addresses the legal issues. This treatise

1 is very widely used by practitioners. Bill has also written on a
2 variety of other health law related subjects. He
3 will present a overview on institutions, entities, incentives,
4 and realities of the health care marketplace.
5 Professor Brewbaker?
6 MR. BREWBAKER: Thanks, David.
7 It's a pleasure to be here this morning. My job
8 is to give the view from 10,000 feet, as it were. My
9 wife, a physician, had the following reaction: Can you
10 see anything from 10,000 feet when it comes to health
11 care? Well, I hope you can. If you can't, there will
12 be lots of people looking more closely at individual
13 matters later throughout the next couple of days.
14 I want to start by asking a fairly obvious, but
15 nonetheless important, question, and that is: What's
16 the point of competition policy? We like markets for
17 all sorts of reasons, I suppose. Some of them have
18 nothing to do with the consequences they produce for us,
19 but in a room like this, and in this setting, clearly we
20 like competition, or we presuppose competition is a good
21 thing, because it does important things for us in health
22 care markets.
23 We expect it to contain cost. We hope that by
24 containing cost, it will enable us to extend coverage to
25 more people. And we assume, sometimes in the face of

1 the evidence, that competition can have a favorable
2 effect on the quality of the health care that we
3 receive.
4 Well, I would like to sort of divide the talk in
5 two parts: First I want to look and assess how we are
6 doing on the various indicia of health care cost and quality: Second
7 I will have some general observations on health care
8 and competition law and policy.
9 In this first part, I want to begin with some
10 facts, sort of unrelated to cost, and then move into the
11 cost area. First, where does the money that we spend on
12 health care come from? You can see from the slide,
13 we've got total national health spending of about $1.3
14 trillion. There's about a 55/45 split between the
15 private and public sectors, in that spending.
16 It's fairly self-explanatory. The money goes in
17 a variety of different directions, not surprisingly, the
18 lion's share to hospital care and physician and clinical
19 services, but again, a big chunk for prescription drugs.
20 Then this mysterious other spending block includes
21 things like non-physician providers, home health, DME,
22 over-the-counter medicines as sort of a catch-all
23 category.
24 Again, another self-explanatory slide, but it's
25 interesting to think about, it helps you get a sense of

1 just how large this sector of our economy is. A
2 million, almost, physicians, 6,100 hospitals, numerous
3 other facilities as well.
4 There's been a lot of talk about the make-up of
5 hospitals, and the trend toward investor-owned
6 hospitals, the consequences of a shift away from a
7 non-profit mode of delivering care. Some people are
8 concerned that patients may do better in an environment
9 where there's no incentive to exploit them somehow
10 through market mechanisms.
11 This slide is interesting in a couple of
12 respects. It certainly shows a slight trend in the
13 direction of investor-owned hospitals, although you will
14 see that the data are not all that recent. Nonetheless,
15 still, the vast majority of hospital care is provided in
16 the non-profit and public sector.
17 Trends in the identity of providers, and forgive
18 me if I go through this a little bit fast, but David
19 said he was going to tackle me if I went past 10:25.
20 A not surprising trend here, the big growth in
21 the provision of home health care agencies, and a
22 corresponding decline in hospital numbers. Again, about
23 a 10 percent decline since 1980, in the number of
24 hospital Medicare providers. Again, not surprising to
25 see corresponding increases in ambulatory surgery

1 centers, outpatient physical therapy. Of course there
2 may be a number of different things besides declining
3 lengths of stay going into these numbers, but an
4 important general overall trend.
5 All right, finally, cost. We're coming out of a
6 period of probably what seemed to many of us to have
7 been good news. You look back in the '80s, this period
8 of double-digit health inflation, ever-increasing
9 percentage of GDP, dedicated to the health care industry
10 because medical price inflation is growing so much
11 faster than our economy is. Then in the late '90s, a
12 period of stabilization, where we still have some
13 inflation, but the economy is growing. The numbers are
14 coming down, it looks like we're able to keep our level
15 right there between 13 and 14 percent of GDP.
16 Well, the bad news, as I suppose most of you
17 probably know, is that all predictions now are to the
18 contrary of that previous slide. You can see the tail end
19 up there, and tacked on is a prediction that says that
20 over the next ten years or so, we'll probably see
21 medical price inflation at a rate of about two and a
22 half percent over the growth of the economy.
23 Now, of course, we don't exactly know how fast
24 the economy is going to grow and we don't exactly know
25 how fast health care prices will increase, but again,

1 we're looking at perhaps a situation where we have 17
2 percent of our gross domestic product spent on medical
3 services by the end of the decade.
4 This is an interesting slide. Again, it's sort
5 of a general 10,000 foot view of trends in terms of
6 price inflation. If you look back in the early '80s
7 there, you see we've got terrible inflation,
8 double-digit annual inflation. Most of it is from
9 medical prices. That's the yellow bar on the graph.
10 We've got modest gains in utilization, and we see a
11 general trend until we find this sort of good graph
12 here, where we've still got a modest amount of
13 utilization growth, we're seeing prices come down.
14 Again, a trend that seems to be going in the
15 wrong direction. I'm sorry to say that may be a bit of
16 a theme in my presentation this morning.
17 Expenditures, where are we spending our money?
18 Again, I know it's hard for you to digest these graphs
19 in the 20 or 30 seconds you have to look at them, but
20 the main point of this graph is to show between 1990 and
21 2000 a decrease, a significant decrease in spending on
22 hospital care and then a fairly significant increase on
23 prescription drug spending with the other main
24 categories staying more or less stable.
25 Spending for in-patient treatment. Again, what

1 you see is a dramatic increase over the past 30 years in
2 Medicare percentage spending on in-patient treatment,
3 and a significant decrease overall as well. Again, this
4 is a matter of importance to this particular conference,
5 this question of prescription drug expenditure growth.
6 You've got here a chart that shows the annual percentage
7 growth in prescription drug expenditures.
8 If you look back, you'll see that we've had
9 double-digit inflation in prescription drug expenditures
10 pretty much consistently for the last 20 years or so.
11 Even when we've dipped down here in this decrease in the
12 rate of increase, we're still talking about six percent
13 growth, and of course now we're around 17 percent growth
14 annually in prescription drug spending.
15 Again, the lower line shows you the share of
16 national health expenditures that we would attribute to
17 prescription drug spending, and you find, again, a
18 sizeable increase in the percentage of our spending
19 that's being directed toward pharmaceuticals, from about
20 five percent all the way up to 9.4 percent in the data
21 on which this slide is based.
22 Another important trend is who's bearing that
23 increased cost? If you look back in the late '80s, you
24 see most of the spending on prescription drugs was done
25 by consumers out-of-pocket. By a couple of years ago,

1 private health insurance is absorbing a significantly
2 greater percentage of that spending, and of course
3 between 1988 and 2000 we've had lots of spending
4 increases.
5 So, this has put a lot of pressure on private
6 health plans to deal with this particular source of cost
7 increases. Not surprisingly, what you see is increasing
8 portion of spending being done out-of-pocket by
9 consumers, as there's probably some effort to shift
10 those costs back on consumers to encourage
11 cost-conscious spending on prescription drugs as well.
12 Well, so much for 10,000 feet in the air on
13 cost. What about coverage? Again, we've got the same
14 story. Here's the happy slide, I can almost put a happy
15 face, I suppose, on this one. This shows data from last
16 year, which shows an increase in the number of people
17 who are employed that have health insurance. Most of
18 them have their own employer coverage, some have other
19 coverage. In lots of cases that's going to be coverage
20 through a spouse who also works, and so an employee who
21 is offered coverage may decline it because he or she is
22 able to participate in family coverage through a
23 spouse's workplace.
24 We see a good trend there on the uninsured line
25 in terms of employed people, and in fact, even though

1 the economy was in the middle of a downturn last year,
2 we still had a fairly tight labor market, and even
3 though medical prices and premiums were rising, there
4 was still a tendency of employers not to cut back on the
5 health insurance benefits they were offering.
6 Well, just last week, the Kaiser Foundation and
7 HRAT released their annual survey of employer-sponsored
8 health benefits, and this is the bad news section of the
9 presentation. I'm just going to show you what's on
10 their website and what's also an interesting discussion
11 in the most recent issue of Health Affairs, if you would
12 like to have a look at that.
13 But basically, here's the bad news: 12.7
14 percent annual increase in family premiums paid for
15 employees. Following along, of course, an 11 percent
16 increase, and almost a double-digit increase the year
17 before.
18 The really bad news about this is that there's
19 reason to believe this is not just the result of the
20 underwriting cycle. Of course the underwriting cycle in
21 insurance would correct itself, but Gabel and colleagues
22 in this same issue of Health Affairs suggests that this
23 is actually due to an increase in underlying medical
24 claims expenditures, and is not then likely to be
25 necessarily self-correcting.

1 Percentage of all firms offering health
2 benefits, here we see sort of the end of this era where
3 you're seeing more and more employers offering benefits,
4 at least it looks that way. It's hard to tell from a
5 year or two, but certainly the news isn't good on the
6 information we do have.
7 Finally here a slide that shows the sort of
8 coverage that employees have. This is an important
9 point to realize, this isn't just a binary decision, an
10 employee is covered or is not covered at the workplace.
11 There are all sorts of different permutations of what
12 different coverage means.
13 Not surprisingly, this chart in the black area
14 documents the decline of conventional indemnity health
15 insurance over the past couple of decades, where it's a
16 negligible part of the employer market right now.
17 Again, remarkable growth in PPO plans as well.
18 So, this tells a story of HMO growth, a little backlash
19 as the HMO numbers go down, continuing movement into
20 PPOs, and then again interestingly, a little bit of an
21 increase this past year in selection of HMOs by
22 employees.
23 It's hard to know exactly why that is, perhaps
24 more employers are offering HMOs in the face of price
25 increases. It may be that HMOs as they have moved to

1 looser coverage arrangements have been able to attract
2 consumers again. Consumers may be more price sensitive
3 in an economy that's trending downward, perhaps, as
4 well.
5 Again, another feature of the employment market
6 is that most consumers or many consumers certainly don't
7 have a great deal of choice in the health care they
8 receive. Certainly if you work for a small employer,
9 defined as under 200 workers in the firm, there's a
10 nine out of ten chance or better that you will just be
11 given a take-it-or-leave-it offer of health insurance
12 through your employer with a plan that the employer
13 picks for you.
14 There's about a 50 percent chance that the same
15 situation will exist even if you're in a mid-size firm,
16 that is defined as one up to a thousand workers. Only
17 when you get in the large and jumbo firms, meaning firms
18 of more than 5,000 workers, is a pretty good assurance that
19 you are going to have a choice of between two and three
20 and even more health care plans. These results are not
21 surprising, given the administrative costs of organizing
22 that coverage.
23 This is some survey data, and the question
24 asked is: What decisions are large employers likely to
25 make if the bad economic news continues? And this

1 basically, you can see here, it's somewhat likely, very
2 likely. So, it's the purple and white bars that give
3 you a sense of the direction that employers seem likely
4 to move should the economic downturn continue.
5 You see one thing that's not at all likely is
6 that the employers are going to drop coverage. Most of
7 them say that's very unlikely or perhaps only somewhat
8 likely, and you get up to two percent when you do that.
9 Restricting employee eligibility, somewhat more
10 likely response. The most likely response, of course,
11 is to increase the amount employees pay, whether it's
12 through cost sharing or through increasing the monthly
13 paycheck deduction for premiums. I know that's a --
14 that may sound like a nonsensical statement to the
15 economists in the room, but in the short-term sense, at
16 least, that's the idea.
17 Reduce the scope of benefits, also another
18 possible strategy, but it looks like there's a trend
19 toward greater financial burden by the employees for the
20 health insurance that employers are providing.
21 There's another trend that's been noted a lot,
22 and I think we don't really have good data to know
23 whether this is a trend or an aberration or a flash in
24 the pan or what, is a trend towards so-called defined
25 contribution plans in health care.

1 Now, if you're talking about a so-called pure
2 defined contribution plan where the employer basically
3 says, I'm tired of worrying about your health insurance
4 arrangements, here's some money, go buy your own, I
5 don't think that anybody thinks that's a very likely
6 scenario. Certainly the surveyed employee benefits
7 managers weren't interested in that option.
8 But you do see an interest reflected in the
9 offerings of certain large health plans in MSA type
10 coverage. That can take a variety of different forms
11 that could or could not include flexible spending
12 accounts for employees, but do include, certainly,
13 higher deductibles, a more catastrophic insurance
14 orientation, we're seeing some more of that.
15 Another sort of option is to provide employees
16 with coverage that is simultaneously potentially
17 broader, more flexible, but more shallow. What does
18 this mean? Broader in the sense that employers in some
19 cases are showing a willingness to cover more items,
20 more items they've particularly been worried about moral
21 hazard in connection with. Procedures that some people
22 would consider optional or a dubious benefit.
23 The reason that they may be willing to do that
24 is because where coverage is becoming more shallow, that
25 is where there's more cost sharing or co-insurance or a

1 greater premium contribution on the part of the
2 employee, then the moral hazard problems tend to take
3 care of themselves. There's a sense that the employee
4 is paying for more of these questionable services if
5 indeed they're questionable, out of his own pocket, and
6 therefore the employer isn't taking the same degree of
7 risk that would otherwise be the case.
8 Also a trend toward greater co-insurance as
9 opposed to copayments. Again, the point here is that in
10 a copayment situation, say you had a $25 copayment for a
11 physician visit, the consumer's indifference to the
12 complete price that is charged the payer in a situation
13 like that. Whereas if you have coinsurance, the
14 consumer has an incentive to care about the overall
15 price structure of the provider. So that if a consumer
16 chooses to seek care through a relatively expensive
17 network, then the consumer bears at least some of the
18 consequences of that choice, whereas in a copayment
19 arrangement, maybe the copayment varies a slight amount,
20 but once that initial payment is made, the consumer
21 doesn't have much of an incentive to worry about the
22 cost structure that the health plan itself or the
23 employer is facing.
24 What are the policy trade-offs with these new
25 defined contribution or consumer-driven plans? If we

1 are going to have shallower coverage and more flexible
2 coverage and more choice where the consumers can go on
3 the web and select benefits they want and select networks
4 they want, that immediately raises the specter of adverse
5 selection. We get all the healthy people going to the
6 thin coverage and all the sick people going to the thick
7 coverage, and soon the thick coverage, the comprehensive
8 coverage becomes unsustainable.
9 And of course that's a real obvious problem.
10 Interestingly, though, and here let me credit Jamie
11 Robinson, a very interesting discussion of these trends
12 on the web, the Health Affairs webpage, there are
13 trade-offs here, though. One of the advantages is to
14 incentivize cost-conscious employee purchasing, and
15 given the tax structure that we have, that may be a
16 benefit that is worth having in some way, assuming we
17 can find some way to muddle through.
18 Similarly, if you allow consumers to go on the
19 web and pick from a range of networks, a range of
20 benefits and mix and match, you're introducing an
21 enormous amount of administrative complexity. Indeed,
22 that complexity is also increased by the fact that
23 you're seeing different gradations of copayments and
24 coinsurance, depending on benefit selection in many
25 cases.

1 How do you handle all that administrative
2 complexity? Doesn't that create all sorts of efficiency
3 problems? Isn't that confusing for consumers? Well, of
4 course it is, right? The trade-off there is, though,
5 greater consumer choice. So, similarly, diminished
6 cross subsidies, as you focus purchasing and focus price
7 selection, creates a problem, but it also creates an
8 opportunity for lower income consumers who aren't
9 covered in public programs to avoid having to purchase
10 so-called gold-plated coverage if that's not what they
11 want.
12 Finally, of course, as we all know, I suppose,
13 from the Rand Insurance Experiment a couple of decades
14 ago, cost sharing tends to discourage care that's needed
15 and unneeded, if it's not pretty carefully done. So,
16 there's an issue of diminished access here. But again,
17 Robinson argues that it's not entirely obvious what the
18 policy consequences of that are, and again, there's a
19 possibility to do something about an entitlement
20 mentality that has developed in our society about health
21 care spending and services. Some interesting food for
22 thought at the least.
23 All right, what about quality? What are we
24 doing about quality? Now this is a subject about which
25 certainly almost everybody in the room has heard

1 something in the past year or so. I want to talk about
2 it, again, from 10,000 feet, along two dimensions: The
3 first dimension is safety, and the second, we'll just
4 use the word appropriateness, there are different
5 definitions of that.
6 Patient safety. Well, the IOM published a
7 report a couple of years ago, extrapolating from the
8 data, showing a really deplorable rate of deaths from
9 medical errors. If their extrapolation is right,
10 medical error turns out to be something like the eighth
11 leading cause of death in the United States in 1997.
12 7,000 deaths alone from medication errors, in that year,
13 and look at the total national costs of preventable
14 injuries.
15 Preventable injuries. If we're talking about
16 the relationship between quality and cost and coverage,
17 I think we see something important here. Not to mention
18 other social costs that don't come back through the
19 health insurance system.
20 What about appropriate care? Now, I apologize
21 in advance for using this slide, it's a little bit
22 complicated, but let me try to explain it to you as best
23 I can. On the left axis here, the -- what's that?
24 That's a vertical axis, isn't it? I'm a lawyer, not an
25 economist, but I think that's what that is.

1 We have the percentage of these are geographic
2 areas, basically. And what we would like to see in this
3 slide which deals with optimal treatment for heart
4 attack victims is that these four recommended
5 interventions that occur at discharge are occurring for
6 the vast majority of heart attack patients. These are
7 non-controversial interventions that anybody that's had
8 an acute heart attack should have.
9 All right. So, what we would like to see is
10 that 80 percent or more of the appropriate candidates,
11 in any given region, are getting appropriate care.
12 Well, what would that graph look like? That would be
13 four purple bars going all the way to the top, okay?
14 And we would like to see the green bars and the red bars
15 where it says, these are 60 to 80 percent are getting
16 appropriate care, 40 to 60 percent are getting
17 appropriate care, less than 40 percent are getting
18 appropriate care. We would like to see none of these
19 blue bars and lots of purple bars, okay?
20 Well, what do we see? Well, we see two -- we
21 see two things here. The first thing that we see is
22 lots of variation. Lots of variation across regions.
23 Right? These are geographically-based distributions,
24 and we see that if you live some places, there are a few
25 places in America where you might actually get beta

1 blockers at discharge in 1994 and 1995. Hopefully there
2 are more places in '02. So, you hope you live there,
3 right?
4 And then the question is, how come you get them
5 there, and if you live over here or in most places, it
6 looks like only 40 to 60 percent are going to get them?
7 All right, so we've got this repeat of the story of
8 geographical variations without any apparent rationale
9 in medical science.
10 The second story, which is at least as
11 disturbing, is just intrasystem performance. Poor
12 performance. Here you have only 2.6 percent of these
13 geographic areas where people are basically getting
14 appropriate care with respect to this measure. 3.6
15 percent here, 8.5 percent here, and thank goodness, we
16 can remember to give people some aspirin on the way out
17 the door, that's an easier intervention, but one that's
18 very important.
19 What's notable, not to be carrying a dark cloud
20 around with me, is that in 60 percent of the cases we
21 can't do that or weren't able to do that then.
22 Certainly we can do that, no doubt we are doing better
23 now than we were before, but this is a serious problem.
24 Another example, same sort of thing, I'm not
25 giving you a Rorschach test or anything here, each one

1 of these little orange dots is in another one of these
2 geographic regions. Now, how many women between the
3 ages of 65 to 69 should have mammograms in a year? The
4 answer should be 100 percent, okay? So, the goal here
5 in terms of appropriate care for this slide is 100
6 percent.
7 The top rated geographic area shows that 50
8 percent were getting the one appropriate intervention.
9 The bottom rated, 12, 13 percent. Where is most of the
10 United States at the time this data is produced? Right
11 down here in a pretty deplorable 20 to 40 percent range.
12 So, again, this is not a pretty picture.
13 This I'm going to spend a little time on, this
14 is the same song, third verse, and it's harder to
15 explain, but basically what you see here is a big gap.
16 We should have 100 percent eye examination, hemoglobin
17 testing and blood lipids testing for diabetics. We're
18 seeing variation across regions on each of these scores,
19 and overall, a big gap in each of these interventions
20 between where we should be, where we want to be, and
21 even where a benchmark HMO would be.
22 So, this is a Medicare screening. The slide is
23 not entirely visible, but I think you're beginning to
24 get the point probably.
25 Okay, what can we do? What can we do about

1 quality? Well, one thing we could do is decide we're
2 not spending enough, for example, in the Medicare
3 program, and raise costs. Now, my point in showing this
4 slide is not to suggest that Medicare spending is evil
5 or bad or anything like that, it's just to show that
6 it's possible to spend lots of money and not get very
7 much back from it.
8 So, what you see here is that Texas, for
9 example, Medicare spends lots of money on patients in Texas,
10 per capita. See that? Now, at this time $5,000 to $6,000.
11 What's the quality rating for the care that they're getting
12 Texas Medicare recipients, down at the bottom? You're about
13 42, 43. Similarly, look at Minnesota, spending much
14 lower, significantly lower, the quality indicator near
15 the top.
16 So, again, the point is not that Medicare
17 spending is bad, it's just that you have to be careful
18 to consider what it is that you're buying.
19 I hesitated to bring this slide with me, but I'm
20 going to do that anyway. This slide is not intended to
21 show that physicians are bad either. Physicians are
22 good, even orthopedic physicians and neurosurgeons are
23 good. I can walk today because of something good an
24 orthopedic physician did for me last year. But
25 interestingly, if you notice there's a little trend

1 here.

2 Do you see this trend line? This is back
3 surgery rates, normalized where the U.S. is one, and
4 this is supply of orthopedic surgeons and neurosurgeons.
5 What does this tell you? Well, what are orthopedic
6 surgeons and neurosurgeons trained to do? Operate on
7 backs, right? So, what do they do? They operate on
8 backs. Does that mean all this care is inappropriate?
9 No. But it is suggestive that there might be other
10 things we might want to consider as we allocate these
11 resources. Is this back surgery effective? Is it cost
12 effective? Are we getting good outcomes?

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

20 Okay, quickly, challenges for competition
21 policymakers. Well, I've tried to organize these
22 according to cost and coverage and quality, but
23 obviously there's some overlap there. One is market
24 structure. There are some intractable, or seemingly to
25 us, intractable problems in the way health care markets

1 work that are challenges as we make competition policy.
2 The first is geography. If you live in Alabama
3 like I do, there's places where there's one hospital,
4 one doctor within shouting distance for each sort of
5 intervention you might want to have, and competition
6 seems like a difficult thing to implement. It doesn't
7 mean it's impossible, but it means that you might not be
8 able to have a one-size-fits-all strategy for the entire
9 United States.
10 Differentiated products. These are sort of
11 classic competition economics things. You don't have
12 perfect competition where you have differentiated
13 products, or you have information problems. Well, all
14 these things we have in health care. We have an aging
15 population. When we're talking about costs, that's
16 important. We have technological growth at a rapid
17 rate. We have difficulties assessing that technology.
18 So, we've got some considerable cost drivers,
19 and lots of the additional spending we may be faced with
20 the choice of doing, lots of it will be very valuable.
21 So, we can't always presuppose that more spending is
22 bad, we have to sort of separate the wheat from the
23 chaff and figure out how we're going to pay for it.
24 A second feature that affects our ability to use
25 competition to control cost is the political structure.

1 And here, let's just begin with the conflicting
2 expectations that we have of markets. We expect markets
3 to control cost for us, but we don't like it when they
4 eliminate the cross subsidies that allow hospitals, for
5 example, to provide things like indigent care. We
6 expect markets to control appropriate utilization, but
7 when a utilization reviewer makes somebody get out of
8 the hospital sooner than they wanted to, we don't like
9 that either.
10 We expect markets to rationalize our investment
11 in health care facilities, and infrastructure, but we
12 don't like it when local hospitals close and when
13 providers, individual providers are dislocated or watch
14 their economic situations change dramatically in the
15 course of months or years.
16 So, we live in a democracy. What are those
17 people who come out on the short end of this
18 reallocation do? Well, they come to Washington, or to
19 Montgomery, right? That creates problems to the extent
20 we view competition policy as rooted in some sense of
21 economics, that's good economics or bad economics, this
22 creates a real tension for policymakers.
23 Now, most of us don't want to do away with
24 democracy either, right? And the same sort of
25 observation I might make about our regulatory

1 enforcement structure. There might be great ideas
2 emanating here at the FTC, but guess who can undo them?
3 State legislatures can often undo them with the State
4 Action Exemption for example. So, there are numerous
5 venues for rent-seeking activity, and I don't want to get
6 too normative on that, but it's a fact, that you can go
7 lots of places to get relief in our system. That's a good
8 thing, that's one of the reasons most of us like living
9 in America, but it creates problems for enforcement policy.
10 Similarly, we've got separation of powers. We
11 see the -- a number of different health care competition
12 decision makers in courts and administrative agencies
13 and legislatures. Here in Washington, of course, we've
14 got two different administrative agencies that have
15 something to say about health care enforcement policy.
16 Sometimes even when they try to work together, some
17 politicians won't let them.
18 In any event, these are the challenges we face.
19 I don't think any of us wants to get rid of democracy or
20 federalism or separation of powers in order to solve
21 them.
22 Finally, or sorry, I've got two more slides.
23 Oh, good, I'm going to make it and not get tackled.
24 Coverage. One of the problems that competition
25 policymakers face, too, is the tendency of markets to be

1 what I've called uncooperative as well as unpredictable.
2 I think if you look back ten, 15 years ago, when the
3 managed care revolution was starting, many of us wanted
4 to pull out Alan Enthoven's book, which talked about
5 consumers having choices between tightly integrated
6 health plans, it made so much sense at a theoretical
7 level that we just assumed that we would know a good
8 market had come to pass, a well-functioning market had
9 come to pass when we observed on the ground the specific
10 entities that were predicted by managed competition theorists.
11 Well, lo and behold, what happens? Consumers,
12 at least in the past ten years or so, have said, we
13 don't really like tightly integrated networks; we like
14 being able to choose our doctor; we're worried about
15 maybe the excesses of utilization review; if we're given
16 a choice, we want a PPO or a POS plan or something like
17 that. Is that a permanent choice? Can we assume that
18 the market is always going to look like that? No, we
19 can't.
20 I think the place this comes up is in the
21 question about whether we're going to a defined
22 contribution system and broader, narrower, more flexible
23 coverage or not. We don't know if that's a genuine
24 market response that we ought to try to really deal with
25 and accommodate. Is it a flash in the pan? Is it

1 unsustainable? The good thing about economically
2 unsustainable arrangements is they usually don't stay
3 sustained. So, maybe we don't have to worry about that
4 too much, but one of the dangers we can get into is
5 presupposing the final outcome of the market.
6 Again, we've got vexing insurance problems, I've
7 alluded to some of those about adverse selection, and we
8 still don't do risk adjustment very well to solve that.
9 We don't have good technology to deal with that problem
10 yet. Maybe we're getting better at it, but it's not
11 good.
12 Finally, rewarding quality. I think there's a
13 good argument that this is the biggest challenge markets
14 face right now. Why? Because quality affects costs,
15 affects coverage, we've talked about already. There's
16 some big obstacles here. The first is just medical
17 uncertainty, right? We just don't have data about the
18 effectiveness of lots of the interventions that are
19 performed on a regular basis.
20 So, how can you make a good decision if you
21 don't have good data? Well, you have to guess, right?
22 People are going to guess differently about those
23 things. It's hard to know which guesses are right and
24 which guesses are wrong, which is something we would
25 like to know when we're talking about quality without

1 that data.
2 Even when we do have the data, providers don't
3 always have it, and if the providers don't have the
4 data, they don't do the right thing and we don't get the
5 quality we want. Focus on systems, again, is something
6 we're working on.
7 Here's the final slide. Can markets reward
8 quality? I think some people are pessimistic about
9 that. I'm not necessarily pessimistic about that, but
10 here's what you have to have: Some sort of demonstrable
11 differentiation among the people who are giving the
12 service. Markets can't reward or punish very well if
13 consumers can't vote with their feet. And to vote with
14 their feet over quality requires knowing the difference
15 between a high quality provider and a lower quality
16 provider.
17 So, if you know that, and if the information
18 gets to the consumers, or to the consumers' agents,
19 whether that's an employer or some sort of cooperative,
20 then the possibility is there that people who don't care
21 about quality, don't invest in quality, don't invest in
22 error prevention, get punished for it. That probably
23 would be a good way of getting people more interested in
24 preventing errors and giving appropriate care.
25 Finally, there's got to be some sort of choice

1 and accountability. And again, maybe that choice takes
2 place at the employer level, so that it's not
3 necessarily a disaster if consumers don't have a choice
4 of health plan everywhere they turn in their employment
5 situation. Of course I think most of us would feel
6 better if consumers had more choices on the ground
7 themselves.
8 All right. I don't want to be entirely
9 negative, I think one thing that you can say positive
10 about our situation, and I think the market deserves
11 some credit for this, is out of the industrialized
12 countries, we are doing the best at investigating the
13 quality that we provide. I think one of the reasons for
14 that is the people who are buying the quality. I think
15 a lot of the large employers have done some helpful work
16 on this, are insisting, are asking the question, what am
17 I getting for the amount of money I'm spending?
18 That's a very helpful question. To be sure
19 we've got an awful long way to go about answering that
20 question and about disseminating the answers to the
21 public in the form of usable information, but we've come
22 a long way over the past ten years on that score, too.
23 Who had heard of report -- whatever you think of health
24 plan report cards and their effectiveness, who had even
25 heard of one 15 or 20 years ago?

1 So, we are making strides. I think the
2 direction we're moving in is good. So, we see some
3 policy opportunities here. I think a critical area is
4 information flow. At the risk of inadvertently
5 offending somebody, I think our competition policy just
6 has to be hard on people who want to restrict the flow
7 of information about what they're doing.
8 I know there are good reasons to be careful with
9 the way information is presented, but when providers
10 don't want to see that information out there and they
11 ban together to prevent it, I hope as a citizen that the
12 people I'm looking to at the Federal Trade Commission
13 will do something about that.
14 Well, this has been a story of a transition
15 from, as I said, from a sort of happy last few years, a
16 smiley face the last few years in the health care
17 sector, to one where the future looks considerably more
18 interesting. It makes me think of the old Confucian
19 curse, may you live in interesting times.
20 Thanks a lot.
21 (Applause.)
22 MR. HYMAN: Bill actually spent the last year on
23 sabbatical in England, and I am pleased to hear that the
24 year that he spent living under a constitutional
25 monarchy hasn't changed his view of federalism and

1 democracy, but one never knows.

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

11 Bill?

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

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

23 So, what I am going to talk about today is I am
24 going to play to my comparative advantage and I am going
25 to talk about what does the economics literature have to

1 say about antitrust in health care. My presentation is
2 going to be based on a book chapter that I co-wrote with
3 a colleague of mine at Carnegie Mellon, Martin Gaynor,
4 the chapter is entitled Antitrust, and it's a chapter in
5 The Health Book of Health Economics.
6 So, when I am doing a review of the academic
7 literature, what I am going to talk about is naturally
8 going to be a lagging indicator of the policy concerns
9 of the moment. Both because the academic literature is
10 a lagging indicator of the policy concerns of the moment
11 because it takes a while to do academic research, and
12 also because the chapter was written a little while ago,
13 it was written in 1999, although I am going to try to
14 update the material presented there where that's
15 relevant.
16 It turns out that the academic literature on
17 health care antitrust is very hospital merger-centric.
18 Hospital mergers were a very hot issue in the '80s
19 and the early '90s, and academics produced a vast
20 profusion of work on that topic. That's mostly what
21 I am going to talk to about today, because that's mostly
22 what academics think they know something about.
23 However, there's also some work that's been done
24 on HMO mergers, there's a little bit of work on
25 monopsony and there's a little bit of work that's been

1 done on vertical restraints and integration.
2 The first thing that I am going to talk about
3 is hospital mergers. When a court or internally at the
4 FTC or the DOJ, when I do an analysis of a merger to see
5 whether that merger should be challenged or whether that merger should
6 be permitted to continue, they go through a fairly
7 routine set of steps in their analysis. The ultimate goal
8 of the analysis is to decide will this merger harm consumers, either by
9 increasing price, or reducing quality, or by
10 having some other affect adverse to consumers?
11 What they do when they analyze one of these
12 mergers is the first thing they have to do is define
13 what market are these merging firms in. There are
14 two characteristics of the market that they want to
15 define.
16 The first is the product market: What do
17 these firms sell? Typically in a hospital merger case,
18 the product market that the firms are found to be in is
19 the market for in-patient hospital services. It's kind
20 of an agglomeration of the hundreds and thousands of
21 kinds of treatment that the hospitals actually produce.
22 The second thing that the antitrust agencies and
23 the court have to do is to determine what's the
24 geographical market for the service. If the geographical
25 market for hospital in-patient services were the entire

1 United States, then that would be 6,100 firms in that
2 market, and a merger between any two of them would
3 probably raise no antitrust concerns whatsoever.
4 So, the objective, then, is to draw a line
5 around the two merging hospitals and to determine how
6 big is the market and how many of those firm's potential
7 competitors should we count at competitors in thinking
8 about whether competition is going to be harmed. So,
9 the next step is the identification of competitors, that
10 just amounts to looking inside the circle that's been
11 drawn. And then they calculate indexes of one kind or
12 another to try to determine how concentrated is the
13 market before the merger, how concentrated is the market
14 after the merger and does this change in concentration
15 lead us to think that price will go up or quality will
16 go down?
17 Finally, the courts or the enforcement agencies
18 consider what other factors might mitigate or exacerbate
19 the exercise of market power and the harm to
20 competition. Typical things considered there are the
21 efficiencies defense. Often the firms argue, if you let
22 us merge, we're going to realize huge cost savings,
23 those cost savings are going to be passed on to
24 consumers so prices won't go up.
25 Another mitigating factor often considered is

1 entry. The firms might argue, look, maybe we could harm
2 consumers if we merged, but what's going to happen is as
3 soon as we try to harm consumers, some other firm is
4 going to enter, because that's going to provide them
5 with an opportunity to serve consumers better.
6 Another mitigating factor that's been brought up
7 in health care antitrust is the sort of the
8 not-for-profits defense, which is that the merging
9 hospitals say, yeah, maybe we can get market power by
10 merging, maybe we could theoretically harm consumers
11 with this power that we get; however, we're
12 not-for-profit institutions, we care about the welfare
13 of the community, and so we're not going to use any
14 market power that we get to hurt consumers.
15 So, this is to sort of set a framework for what
16 goes on in analyzing a merger so that I can then point
17 to which parts of that I think the academic literature
18 has something to say about.
19 So, here's a list of hospital merger cases.
20 They are more or less in reverse chronological order,
21 and I believe that the most recent ones. And as you can
22 see, and let me point out that the column winner does
23 not necessarily reflect the final disposition of the
24 case.
25 In particular, the District Court's decision in

1 the Augusta case was eventually overturned by the
2 Circuit Court, and it's roughly correct to say that the
3 government ended up winning that case. However, the
4 District Court did decide in favor of the hospital. So,
5 since the purpose of this graphic is to show you the
6 kinds of places in that structure that I presented on
7 the previous slide that economic analysis might help us
8 with the fact that some courts thought the
9 not-for-profit defense is relevant.
10 So, the obvious thing here is that the hospitals
11 always win, that's true since 1991. And the variety of
12 different reasons that the government loses. So, going
13 back just quickly to this merger analysis, what happens
14 is the government presents to the court proposals for
15 what they think for each of those bullet points the
16 correct analysis is. And if the government wins on all
17 of those points, then the merger is stopped. If the
18 people trying to merge manage to break the government's
19 case on any one of those points, the merger is allowed
20 to go through.
21 So, this column that says Reason, there isn't
22 any reason to give you when the government wins, the
23 reason the government wins is that it wins on all of its
24 points. So, when the government loses, there has to be
25 some reason that the government loses from those points.

1 So I am giving you the typical reasons. The typical
2 reasons are geographic markets, product markets or this
3 not-for-profit defense.
4 So, now, again, referring back to the slide two
5 slides ago, I talked about calculation of indexes of
6 competition. The most common index of competition
7 that's used, or that has been used in hospital merger
8 cases is something called the Herfindahl-Hirschman
9 Index. The Herfindahl-Hirschman Index is an index of
10 how concentrated a market is.
11 The highest value the HHI can take is 10,000,
12 and that would represent a monopoly, one single firm
13 controlling the market. The lowest value it can take is
14 zero, and that would present sort of textbook perfect
15 competition, so an infinite number of firms each with no
16 market share.
17 And the government has a benchmark for what
18 makes a market highly concentrated. So in highly
19 concentrated markets, the government would argue that
20 one should be very suspicious of merger.
21 The government's threshold for a highly
22 concentrated market is an HHI of 1,800. So, what I want
23 you to take out of this slide is if you look in the post
24 HHI column, in essentially all of the markets that this
25 slide considers, the Herfindahl-Hirschman Index was high

1 enough that one would think that all of these mergers
2 should have been illegal.
3 The government lost in particular in the three
4 rows of the table in red. Now, I can't have entries in
5 this table for cases where the government lost on market
6 definition, because if the government lost on market
7 definition, then there isn't really a calculation of the
8 Herfindahl-Hirschman Index.
9 The Poplar Bluff case I've left in the table
10 because of the District Court level the government won
11 on market definition, so I can calculate HHI, but then
12 at the Circuit Court level the government lost on market
13 definition, so this disappeared.
14 So, in the cases in red, the government lost,
15 even though in all of those cases -- well, not in
16 Joplin, but in the other two cases, the market was
17 highly concentrated and the merger caused a large
18 increase in the Herfindahl-Hirschman Index, in this
19 index of concentration.
20 So, the reason the government lost, the most
21 important reasons, the first is the not-for-profit
22 defense. In Grand Rapids, Joplin and the Augusta cases,
23 the hospitals argued, look, we're not-for-profit
24 organizations, if you let us merge, maybe we could get
25 market power, maybe we could harm consumers, but we

1 won't. And we won't because we have good motivations.
2 We don't want to harm consumers, we're not trying to
3 maximize profits, we're trying to serve the community.
4 In the Grand Rapids case, the court also found
5 the efficiencies defense persuasive. In the
6 efficiencies defense, the hospitals argue, look, we're
7 going to merge, we're going to realize great cost
8 savings from this merger, and we're going to pass those
9 cost savings on to consumers, so actually we're going to
10 help consumers by merging.
11 Finally, all the other cases were on market
12 definition, that was typically on geographic markets,
13 sometimes on product market.
14 So, the things that economists have thought
15 about, at least a little bit, that are relevant to this,
16 is the question of are not-for-profits different?
17 There's actually a huge economic literature on whether or
18 not not-for-profits are different, and there's a pretty
19 large economic literature on the question of whether
20 not-for-profit hospitals are different from for-profit
21 hospitals.
22 Another point we believe, some research of
23 whether or not there are efficiencies, and there's
24 actually a pretty big literature on the question of
25 what's the right size for a hospital, does making a

1 hospital bigger actually reduce costs per case, and so
2 on.
3 There's a large literature asking the question
4 is it the case that when a hospital market is more
5 concentrated, prices are higher? There's also
6 literature on whether hospital prices rise after a
7 merger.
8 Okay. So now I'm going to talk about
9 not-for-profit status. Well, the question of whether or
10 not not-for-profits are different is, as I mentioned,
11 actually very well studied in economics. There's a very
12 good chapter, again in the health book Handbook of
13 Health Economics by Frank Sloan in which he basically
14 analyzes this literature about whether not-for-profit
15 hospitals are different from for-profit hospitals.
16 So, the questions that we might want to ask
17 ourselves about not-for-profit hospitals is first of all
18 just the general question of is it the case that
19 not-for-profit organizations which provide outputs in a
20 goods market actually behave differently from for-profit
21 organizations at all.
22 Suppose the answer to that question were to be
23 yes. That still wouldn't be enough to justify the
24 not-for-profit defense because we would still want to
25 know, well, is that difference in behavior relevant for

1 antitrust purposes? So, maybe these not-for-profit
2 organizations do behave differently from for-profit
3 organizations, maybe they like to generate profits and
4 then spend it on high-tech medical equipment or they
5 like to generate profits in order to fund lots of
6 charity care and so on and so forth.
7 For those kinds of motivations, it probably is
8 not the case that the differences in motivation between
9 for-profits and not-for-profit organizations would be
10 relevant from an antitrust perspective because still, if
11 the not-for-profits merged, they would have an incentive
12 to jack up the prices on the people who can pay in order
13 to get this fund of money to spend on all the nice
14 things that they like to spend money on.
15 So, the difference between not-for-profits
16 and for-profits has to be such a difference that it makes
17 them want to pass on any savings to consumers, and it makes
18 them want to not jack up prices on people who can't pay.
19 First on the general question. As I
20 said, there's a pretty big literature on this, and Frank
21 Sloan reviews it very ably. He goes through all of
22 these different points on how might the behavior of
23 not-for-profits and for-profits differ. One thing
24 you might think is that costs might be different between
25 not-for-profits and for-profit organizations, and there

1 are lots of reasons to think costs might be different.
2 You might think that not-for-profits, not having the
3 discipline of stockholders and the potential for
4 takeovers and so on, might become lax and inefficient
5 and have high costs.
6 On the other hand, you might think that because
7 not-for-profits often have access to debt financing at
8 tax advantaged rates, then maybe they should have lower
9 costs than for-profit hospitals.
10 The literature on this point basically says that
11 there isn't a difference, or at least there isn't a
12 detectable difference in costs for for-profit and
13 not-for-profit hospitals, they're very similar. The
14 same thing is true for pricing. Perhaps there's some
15 evidence that not-for-profits charge a slightly lower
16 price than for-profits, but the evidence is decidedly
17 mixed on pricing as well.
18 So, the place that you might really believe that
19 there would be a difference is in charity care.
20 Not-for-profits invariably in their mission statements
21 claim that charity care is one of their missions, and of
22 course for-profits don't have charity care for one of
23 their missions. They may do it because they're required
24 to do it, but certainly it doesn't enhance the bottom
25 line.

1 But, even in this case, the literature is
2 reasonably clear that the not for-profits don't provide
3 very much more charity care, if more charity care at
4 all. In fact, what small difference there is in charity
5 care is accounted for by the location of the
6 not-for-profit hospitals.
7 So, for-profits and not-for-profits located in
8 similar markets, in similar places, provide the same
9 amount of charity care. It's just that not-for-profits
10 tend to locate more often in central cities where
11 there's more charity care to be done. So, in fact, the
12 behavioral difference in charity care is very small or
13 nonexistence.
14 Similar things are true with technology. It is
15 the case in general that not-for-profit hospitals are
16 larger than for-profit hospitals, they treat more
17 patients in average, they have more beds on average, and
18 so on. But if you control for the size of the hospital,
19 it's not the case that not-for-profit hospitals are more
20 or less technologically advanced than for-profit
21 hospitals in general.
22 Again, for all of these points, I am
23 generalizing over a large literature, so there are
24 likely to be particular findings in particular studies
25 where what I am saying isn't exactly true. I'm talking

1 about sort of the broad pattern of evidence.
2 Again, the same thing is true for quality.
3 There aren't any detectable quality differences in terms
4 of, say, mortality between for-profit and not-for-profit
5 hospitals.
6 A final source of evidence that you might look
7 to is it makes the news quite a bit that many hospitals
8 throughout the '90s, in particular, were switching
9 ownership status from not-for-profit to for-profit or
10 from for-profit to not-for-profit. There are actually
11 quite a few switches in each direction. It is the case
12 that switching status, either from for-profit to
13 not-for-profit or not-for-profit to for-profit does
14 change outcomes you might be interested in. Prices,
15 cost, profits and so on, but it seems to be the
16 conversion itself that causes the change and not the
17 ownership status.
18 So, a hospital changing from not-for-profit to
19 for-profit looks about the same in terms of its changes
20 as a hospital changing from for-profit to
21 not-for-profit.
22 Finally, the evidence from other sectors of the
23 economy where not-for-profits and for-profits compete in
24 good-producing sectors, and from other countries as
25 well, is that the critical factor is not the ownership

1 of the institution, the critical factor is how
2 competitive is the market?
3 Monopolies, whether they're for-profit,
4 not-for-profit or government-owned, tend to be lax about
5 cost, not innovating, whereas institutions in highly
6 competitive markets tend to have low prices, low costs
7 and so on. The ownership status is not nearly so
8 important as the competitiveness of the market that it's
9 in.
10 Pricing and competition I am going to talk
11 about a little later. So, let's go on to talk about
12 efficiencies. The question that's usually posed in
13 terms of efficiencies are whether there are what's
14 called economies of scale. Remember these hospitals
15 are claiming in their efficiencies defense, all right,
16 we're going to merge, we're going to save lots of money
17 and we're going to pass on the money to consumers.
18 The way that this is addressed in the
19 economics literature is the economists have looked at
20 hospitals of different sizes, and asked: Do the big ones
21 have a lower cost per case than the little ones? If so,
22 that's evidence that being big saves money.
23 Well, there are two problems with using that
24 literature that answers the efficiencies defense
25 question. One is that when two small hospitals merge,

1 it's not clear that what they make is one big hospital,
2 because they often keep both campuses of the hospitals
3 open, so no one achieves the kind of integration that
4 you might expect to lead to these economies of scale.
5 The second problem with that literature is that
6 if cost per case goes down, that doesn't necessarily
7 tell you that the savings are going to be passed on to
8 consumers. Even if you ignore that first problem, the
9 fact that costs are going down doesn't mean that the
10 consumers are going to save money, it means the costs
11 are lower.
12 With that being said, there's a pretty large
13 literature on this question of hospitals, and again that
14 literature compares big hospitals to little hospitals
15 and looks at cost per case. What this literature
16 basically says is that I think a fair summary of this
17 literature is that it's all over the place. But if
18 we're willing to be very broad-minded about what
19 patterns we want to draw out of this literature, it's
20 probably the case that there aren't very large scale
21 economies above about 200 beds.
22 So there's an older literature and a newer
23 literature, but both are about the same. There's one,
24 at least is I see it, big problem with this literature,
25 which is that there are usually not very good controls

1 for case mix. So, let's take my broad-minded summary as
2 given. Let's suppose costs per case are exactly the
3 same at little hospitals and big hospitals. Or at least
4 as long as they're bigger than 200 beds.
5 Well, if it's the case that big hospitals tend
6 to treat sicker patients, and lots of people think that
7 is the case, then the fact that they have the same cost
8 per case, little hospitals and big hospitals, actually
9 says that there are economies of scale. That big
10 hospitals are cheaper and they only look like they cost
11 about the same because their patients are sicker.
12 And there is some recent work examining this,
13 somewhat obliquely, which basically says that that is a
14 big deal. That if you omit these important variables
15 like case mix, that biases greatly your measure of scale
16 economies.
17 So, I'm going to go back to my previous point,
18 which is it's often the case that these hospitals don't
19 actually combine their campuses, they keep their
20 campuses separate. So, their efficiencies defense tends
21 to rely on things like, well, we're going to integrate
22 our laundry services and we're going to eliminate our
23 administrative services and that's where all the savings
24 are going to come from. This isn't the case, by the
25 way, in every hospital merger, but most of the time this

1 is what the efficiencies defense looks like.
2 There's a paper addressing exactly this
3 question, which is, okay, let's not look at overall
4 scale economies, let's just look at scale economies in
5 laundry and administrative expenses and so on.
6 Interestingly enough, that paper comes to exactly the
7 same conclusion that the broad-minded summary of the
8 overall literature comes to, which is that there are
9 some scale economies but they're mostly gone by about
10 200 beds. Once you get up above 200 beds, there
11 aren't any scale economies left to be had.
12 On the related question of do mergers raise
13 prices, there are two paradigms for addressing that
14 question. One is called the structure conduct
15 performance paradigm. The structure conduct performance
16 paradigm basically says, we're going to look across
17 markets. We're going to look at markets where there are
18 only a few competitors and we're going to look at
19 markets where there are lots of competitors and
20 we're going to compare prices in those two kinds of
21 markets, controlling for everything that we think we can
22 control for.
23 A second method of looking at this question is
24 to do event studies. An event study means we go and
25 we look at a merger and we say, okay, in this market two

1 hospitals merge and we look at before and after and see
2 how the prices moved compared to some control group
3 somewhere where there was no merger. Let me start with structure
4 conduct performance studies. There are a very large number of these
5 studies, there are two slides worth. And let me talk about how the
6 price effects in these tables are calculated.
7 What we did was to take a large bunch of
8 studies and to ask the same question of every study,
9 which is let's imagine that there is a market with five
10 equally-sized hospitals in it, and let's imagine that
11 two of those hospitals merge. So, a market with five
12 equally-sized hospitals would have Herfindahl-Hirschman
13 Index of 2,000, so it would be highly concentrated. And
14 we're going to ask, what would happen to prices if two
15 of those hospitals merged?
16 Here are the results of a bunch of
17 studies. You can see that because data is very easy to
18 get in California, and because California is a big
19 state, lots of studies are done in California.
20 Now, for the most part these studies find that
21 prices go up in markets that are more concentrated. So,
22 the fewer firms there are, the higher prices are in
23 general. But first of all, you notice the empirical
24 base is quite narrow, it's mostly California, and even
25 if we look at some of the older studies, it's still the

1 case that most of the empirical basis is California.
2 Now, there are a couple of interesting patterns
3 in these two tables. The first is that in general the
4 California studies show bigger price effects than the
5 studies in other places. So this Michigan study
6 actually showed a price decline from the merger and this
7 study of Indiana showed a very small price effect, and
8 note the study of the entire U.S. showed a negative
9 price effect.
10 In general, the California results show a
11 bigger merger effect than the results from other places.
12 It's also the case that these studies tend to show that
13 the price effects are bigger in more recent years. So,
14 hospital mergers look more and more like what we think
15 of as normal markets, as normal mergers in more recent
16 years.
17 And what both of those points might make you
18 think is that managed care is important. California has
19 higher managed care penetration than the rest of the
20 country, and it's the case that managed care penetration
21 has been going up over time. So, maybe the fact that
22 more recent data in California data give you a bigger
23 effect is because managed care is somehow important.
24 You might think that's important because managed care
25 organizations tend to be sort of aggressive shoppers for

1 price discounts, and so should make competition more
2 important.
3 There are a couple of studies that find exactly
4 that. Where managed care penetration is higher, there
5 are lower costs, lower prices, and when managed care
6 penetration is higher, the association between price and
7 concentration is stronger. Managed care organizations
8 do a better job of playing competitors off against one
9 another than non-managed care payers.
10 So, let me go back to this other question of
11 other not-for-profit differences. There are a few
12 studies that break out the effects of the standardized
13 merger between for-profit organizations and
14 not-for-profit organizations. In general, there's a
15 finding of larger effects for for-profits, but with the
16 exception of a couple of studies by Bill Lynk, in
17 general, the not-for-profit mergers also cause price
18 increases.
19 So, it's hard to just generalize greatly based
20 on five studies where the vote is three to two, but
21 there's more evidence that not-for-profits are the same
22 than there is that not-for-profits are different.
23 Another place that you might think consumers
24 might be harmed by merger is in quality. There is
25 some literature on the relationship between

1 concentration and quality. There's an early literature
2 from the'80s which is called The Medical Arms Race
3 Literature, and the idea of this literature is, let's
4 see whether or not hospitals compete on quality
5 dimensions.
6 This literature look at things like are costs higher
7 where there are more competitors, that being some kind
8 of indication of the hospitals spending more on quality.
9 Or are there more high-tech services in markets where
10 there are more competitors? Again, some kind of
11 indication that the hospitals are competing on quality.
12 That literature found that yes, both of those
13 things were true. Where there were more competitors,
14 there was higher costs, and more technology.
15 There are a few recent high quality papers which
16 show some association between concentration and
17 mortality. What these two papers show is that in
18 markets with a high concentration, in markets closer to
19 a monopoly, risk adjusted mortality is higher. The
20 second paper, they don't find that for the Medicare populations,
21 although they do find it for the private insurance populations.
22 Next, event studies. I am going to blaze through
23 these event studies. I have two event studies to talk
24 about, one is by Krishnon in the Journal of Health
25 Economics, the other is by Vita in the Journal of

1 Industrial Economics and there are a couple of papers by
2 Connor, Feldman, Dowd & Radcliff. We'll talk about the
3 first two first.
4 The Vita study and the Krishnon study, the
5 methodology of all these studies is the same, they
6 identify the mergers and look at how was price moving
7 before the merger, how was price moving after the
8 merger, and then they found comparison groups and note
9 out how was price moving in comparison groups before and
10 after the merger.
11 What the first two papers show, what Vita and
12 Krishnon both show is that price goes up when the merger
13 occurs. Krishnon's findings is about nine percent,
14 and Vita's finding is 25 percent.
15 There are also several papers by Connor, Feldman,
16 Dowd & Radcliff. They examined 122 mergers from '86 to '94,
17 and they find basically no price effect. They find
18 actually a small price savings to consumers from the
19 mergers.
20 There's one kind of odd thing about these
21 studies which is that the Herfindahl-Hirschman Index
22 actually decreased in the merging markets relative to
23 the non-merging markets. And that doesn't make a lot of
24 sense if you think that the merger is increasing
25 concentration. It should happen that the

1 Herfindahl-Hirschman Index goes up.
2 So, I think one interpretation of their
3 findings, and an interpretation that I don't think they
4 would be terribly distressed about, is that a lot of
5 these mergers went back to the failing firm mergers.
6 There were a bunch of firms that were going to fail,
7 some of them merged and some of them didn't. In markets
8 where they didn't, the Herfindahl-Hirschman went up
9 because the firms failed, and in the markets where they
10 did, the Herfindahl-Hirschman went up because of the
11 merger.
12 There is also a small literature on HMO mergers,
13 looking at HMO mergers between '85 and '93 in papers like Christianson,
14 Engberg, Feldman & Wholey. They found no detectable effects in mergers
15 on premiums. However, in cross section, if they did obstructed conduct
16 performance kind of analysis rather than an event analysis, they did
17 find that
18 prices were higher in markets that had fewer HMOs.
19 So, those two findings are obviously in tension
20 with one another, one says mergers have an effect, one
21 says that mergers don't. And the way that they resolve
22 that is again with this kind of failing firm idea. So,
23 from '85 to '93, it's the case that there's a shake-out
24 in progress in the HMO industry and lots of plans are
25 failing.

1 And those plans could fail in two ways: They
2 could fail by going out of business or they could fail
3 by being taken over by some other HMO's plan. And what
4 they did is look across states at the aggressiveness of
5 antimerger regulations. And they found that in states
6 with very aggressive antimerger regulations, mostly HMOs
7 fail. In states with not very aggressive antimerger
8 regulations, most of the HMOs were acquired. So that
9 most of the mergers that were going on at this time
10 period in their data, I think, are mergers of a failing
11 firm. So, it isn't particularly surprising that there
12 isn't a big competitive impact with that.
13 Monopsony. There's a relatively small
14 literature on monopsony power, and monopsony is sort of
15 the opposite of monopoly power. Monopoly power the idea
16 is that monopolists can jack up prices for a service
17 that it sells. In monopsony power the idea is that a
18 big buyer can jack down prices for a service that it
19 buys.
20 So, there is a fair sized literature with, I
21 think, actually, pretty serious problems, so I wouldn't
22 put a whole lot of stock in the development of this
23 literature, which basically says that hospitals that
24 have a higher share of their patients from Blue
25 Cross/Blue Shield give Blue Cross/Blue Shield a bigger

1 discount.
2 Again, there's a small literature on bilateral
3 monopoly. It has been argued that given that the payer
4 side is highly concentrated, it might be a good idea to let the
5 provider side become highly concentrated, so that both
6 sides have bargaining power and their bargaining power
7 can balance off against one another.
8 Again, this literature isn't especially
9 strong or large, however there is this one study by
10 Melnick in 1992, again, about Blue Cross/Blue Shield
11 which finds that hospitals that have a high share of
12 their patients coming from Blue Cross/Blue Shield get
13 lower prices, but hospitals which provide a high
14 proportion of Blue Cross/Blue Shield's care in a
15 particular market area get higher prices. And the idea
16 is that maybe the first bullet point is a measure of
17 Blue Cross/Blue Shield's power pushing down prices and
18 second is -- sorry, the third is a measure of the
19 hospital's power pushing up prices.
20 Finally, vertical restraints in integration.
21 There have been two kinds of vertical restraints
22 which have been studied at all in health care cases, and
23 the literature here is very, very thin. First most favored nation
24 clauses, and then physician hospital organizations.
25 Let me tell you what a most favored nation

1 clause is. One contractual form that you can have
2 is that the buyer of a service negotiates with the
3 seller and says, okay, let's agree on a price. They
4 agree on a price, and then the buyer says, oh, but by
5 the way, if you sell to any other buyer at a price lower
6 than this, I want the lower price. If the seller agrees
7 to that, that's called a most favored nation clause.
8 There's sort of a reason, and at first blush, of
9 course, you might think, well, that's no problem at all
10 for competition, because that's just ensuring that
11 everyone is getting the low price and isn't that what
12 markets are supposed to do, deliver on the low price?
13 But that contract term does create incentives for conduct that
14 undermines competition by the seller.
15 If you think about the seller that signed a
16 most favored nation contract, and they are now going to
17 negotiate with another buyer, and that buyer is trying
18 to push down their price. When they think about their
19 incentive to cut their price to that new buyer, that
20 incentive is blunted by the fact that if they cut their
21 price to the new buyer, they have to cut their price to
22 the old buyer, too. So, their loss and profits from the
23 lower price is much larger than it would be absent the
24 most favored nation clause and that gives them incentive
25 to keep their price higher.

1 All right. So, there's one paper that I know of
2 about this, which is that effective in 1991, Congress
3 passed the law in 1990, Congress imposed essentially a
4 most favored nation clause for drugs for the Medicaid
5 program. Actually the law is much more complicated
6 than that, but one of the things they did is create a most
7 favored nation clause.
8 Now, if it's the case that most favored nation
9 clauses increase the price, then we ought to see the
10 price of pharmaceuticals going up in the aftermath of
11 this, and that's roughly what happened. So, there is a
12 paper in the Rand Journal of Economics which found that
13 there is about a four percent price increase caused by
14 this most favored nation clause.
15 Finally, there's a working paper about the
16 integration of physicians with hospitals. The kind
17 of things they're interested in are physician hospital
18 organizations and in particular they're interested in
19 physician hospital organizations that are exclusive.
20 So, these are agreements in which the physicians say,
21 we're not going to practice at any hospital except
22 yours.
23 Again, there are two sides to these
24 regulations, one side which is sort of the old Chicago
25 School way of thinking about this stuff is that, well,

1 that's got to be a good thing. It must be the case that
2 there are efficiencies to be had from coordination. In
3 fact, in this case, there are reasons to believe that.
4 You would think that you might save on duplicative tests
5 and other things by having the physician in the hospital
6 integrated.
7 On the other hand, when one hospital in a market
8 locks up a group of physicians, that means those
9 physicians aren't available to the other hospitals in
10 the market which is likely to decrease their
11 attractiveness to patients and payers, which is likely
12 to increase the demand for the hospital that has the
13 exclusive arrangement, allowing them to increase the
14 price.
15 So, this paper is about figuring out which of
16 those two is going on. What they find is that closed
17 physician/hospital organizations, but not open ones --
18 the open ones are ones that permit the physicians to
19 practice at other hospitals -- closed physician
20 organizations generate about a 30 percent increase in
21 price. Simultaneously, they generate an increase in
22 volume, and the idea is that increase in volume comes
23 from the fact that now the other hospitals in the market
24 are less attractive because the physician has been
25 locked into the first.

1 There's also some evidence, however, that there
2 is an increase in quality caused by these physician/
3 hospital organizations. So, it isn't a slam dunk that
4 these things are anticompetitive, there are two things
5 going on, quality goes up and price goes up.
6 So what are the conclusions from the academic
7 literature? There's a robust relationship between price
8 and concentration. More concentrated markets have
9 higher prices. That's especially true when there's a
10 lot of managed care penetration.
11 There's mixed evidence on efficiencies. It may
12 be the case that big hospitals are cheaper, it may not.
13 I don't want to overplay the last point, but in
14 my view, the balance of the evidence is that
15 not-for-profits are not different from for-profits.
16 Not-for-profit hospitals are not different from
17 for-profits in antitrust relevant ways, but that
18 literature is by no means settled and it could happen
19 that my conclusion would change tomorrow.
20 I think that is all that we have. No, I don't.
21 There is also some small evidence of HMO
22 mergers. There's a little bit of evidence of a price
23 concentration relationship among HMOs, not as strong as
24 for hospitals, and there's some evidence both of
25 efficiencies and from price increases from mergers.

1 There is also some evidence of scale economies,
2 but this is based on a pretty narrow empirical base and
3 I wouldn't want to be too aggressive in conclusions from
4 it.
5 Finally, based on a very, very weak empirical
6 base, one paper each, there is some evidence that most
7 favored nations, so this is vertical restraints, there's
8 some evidence that most favorite nations clauses
9 increase prices and there is some evidence that tight
10 vertical integration increases prices.
11 Finally, on monopsony -- well, on monopsony,
12 evidence is especially weak, but there is some evidence
13 that insurance plan market power causes lower prices for
14 providers.
15 Thank you.
16 (Applause.)
17 MR. HYMAN: Thank you, Bill.
18 I think we're going to try and keep going with
19 the hope that we'll stay on time between now and lunch.
20 Next up is Cara Lesser from the Center for
21 Studying Health System Change. That takes us from the
22 macro or 10,000 feet perspective to the micro
23 12-community perspective. Those of you who are like me
24 on the mailing list for the center, every week or so
25 we'll find something new in your mailbox and even more

1 frequently on their website. We are very lucky to
2 have Cara who is the project director for the 12-city
3 study here to talk about some of the results and recent
4 developments in health care markets, and the policy
5 implications for competition law and policy.
6 Cara?
7 MS. LESSER: Thank you.
8 Well, as David said, I am going to take us down
9 a little bit to a ground level perspective of what's
10 happening in local health care markets across the
11 country based on work we've been doing in the field
12 since 1996.
13 Let me just start by giving you an overview of
14 the major points I want to make today. First, to
15 provide some further context for today and tomorrow's
16 discussions, I want to highlight what we see as the two
17 major trends shaping health care markets over the past
18 several years, and that is the rapid ascent and
19 subsequent retreat from tightly managed care and then
20 the second is consolidation.
21 Together, these trends have had really visible
22 effects on local market dynamics and on health care cost
23 trends, and I am going to talk about those effects more
24 specifically. And finally, based on these observations,
25 I want to highlight what we've learned in terms of

1 competition in local health care markets and leave you
2 with some thoughts about where we think we're headed in
3 the near future.
4 Before launching into this discussion, let me
5 just step back for a minute and give you some background
6 on my organization, the Center for Studying Health
7 System Change. HSC was established by the Robert Wood
8 Johnson Foundation in 1995, just on the heels of the
9 demise of the Clinton health reform effort, as it became
10 really clear that we were embarking on significant
11 market-based change in the health care system in this
12 country. The foundation created HSC with the goal of
13 tracking those changes and their impact on people and
14 really a focus on highlighting the implications for
15 policymakers.
16 Our mission is to provide timely and objective
17 information to policymakers and decisionmakers in the
18 industry who are shaping the changes we're observing.
19 The core of our work is the community tracking study,
20 which is an independent research effort to track health
21 system change and its effects. The study is
22 longitudinal, and as I said in the beginning, it's been
23 ongoing since 1996.
24 As the name implies, the study has a community
25 focus, based on the notion that ultimately all health

1 care is local. We defined our communities based on MSAs
2 as defined by the Bureau of Economic Analysis, and this
3 allows us to have a consistent measure of a geographic
4 market over time.
5 Obviously this is somewhat different from how
6 actors in the industry may define their geographic
7 market at different times, but this allows us to have
8 consistency from year to year.
9 In some cases, the market area is somewhat
10 broader than market actors would describe it, in other
11 cases there are some clear geographic submarkets within
12 our MSA definition of the community.
13 We have multiple ways that we collect data in
14 these communities. We conduct surveys of households,
15 physicians and employers, and we also conduct site
16 visits every two years. I should back up and say that
17 we have a total of 60 communities that were selected,
18 they were randomly selected to be nationally
19 representative. So, while we do have this local focus,
20 we also have the opportunity to aggregate up our
21 findings and talk about national trends.
22 Our site visits are conducted in a subset of 12
23 of the 60 communities that also were randomly selected,
24 and those represent a population of 200,000 or more. In
25 the site visits, we interview anywhere from 50 to over

1 100 leaders of the local health system, including
2 representatives of the major local health plans,
3 hospitals, physician organizations, representatives of
4 major local employers, state and local policymakers, so
5 it's really getting a broad perspective on the health
6 care market as a whole. We conduct our site visits
7 every two years.
8 This slide just gives you a map of the 60 study
9 sites, highlighting the 12 where we conduct our site
10 visits. As you can see, the sample is geographically
11 diverse, and the communities vary in size as well as
12 managed care characteristics and general health system
13 characteristics.
14 We have a number of large metropolitan areas,
15 such as Boston or Miami, Orange County, California, as
16 well as smaller communities that have less experience
17 with managed care like Little Rock and Greenville, South
18 Carolina.
19 So, unlike other studies that focus on
20 particular communities that are viewed as leaders or the
21 bellwether of change, studies that focus on Minneapolis
22 or Southern California, our work really is able to
23 capture the diversity of change occurring across the
24 country and provide a more balanced view.
25 As David mentioned, we are very busy at

1 disseminating our work. We produce a whole range of
2 research products. We have issued briefs and tracking
3 reports that are our own publications, community reports
4 that highlight the really case studies of the individual
5 communities and how they're changing every two years.
6 We also publish in peer review journals. In order to
7 get our work out more quickly than peer review journals
8 sometimes allow, we have a working paper series to
9 really allow us to disseminate the work there to the
10 policy community more quickly.
11 We also conduct briefings with policymakers and
12 speak at conferences and meetings like today. All of
13 our work is available on our website, hschange.org, I've
14 also prepared a list that I think is available on the
15 table up front, selective publications that I thought
16 would be of particular interest to this audience. So,
17 that might be worth picking up.
18 Okay, getting into the meat of the talk, as I
19 said at the beginning, I want to talk about two major
20 trends that have been shaping the health care system
21 since we've been tracking it, since 1996. And of
22 course, the first major trend was the growth of managed
23 care. In the early to mid-1990s, the economy was quite
24 sluggish, and we were in a period of rapidly rising
25 health care costs, and employers become very aggressive

1 in shifting their employees into managed care options,
2 and there was rapid enrollment growth in HMOs and PPOs.
3 This set off a wave of change in health systems
4 across the country, based on the real or expected growth
5 of tightly managed care arrangements. Throughout the
6 industry, there was the expectation of increased
7 reliance and selective provider networks. That would
8 allow plans to drive business to more efficient
9 providers. In this context, providers proved very
10 willing to accept often steep discounts in exchange for
11 volume. Or promises of volume I should say.
12 There was increased use of gatekeepers and prior
13 authorization requirements to control utilization, and
14 expected growth of capitated payment to give providers
15 greater financial incentives to managed care. So, the
16 combination of these factors gave health plans
17 tremendous leverage and really put providers on the
18 defensive.
19 So, take two, not too much farther down the
20 road, by the late 1990s, managed care experienced an
21 abrupt reversal of fortune, as really intense consumer
22 backlash against managed care took hold. This coincided
23 with a time of great economic boom, so a real contrast
24 to the time when managed care was in ascendance, and
25 also incredibly strong tight labor market that made

1 employers much more amenable to their employees' demands
2 for open access to care.
3 During this time, HMO enrollment stagnated, and
4 plans moved toward more open access products with looser
5 utilization management, and an emphasis on broader
6 provider networks that could protect consumer choice.
7 Both plans and providers moved away from risk
8 contracting arrangements, in part because these were
9 more difficult to operationalize in the more loosely
10 managed health insurance products, and in part because
11 this environment gave providers more leverage and they
12 were able to push back in their negotiations with plans
13 to get out of these risk arrangements that many had come
14 to view as really a losing proposition.
15 Meanwhile, a second related trend developed, as
16 we've been talking about this morning, and that's the
17 move toward consolidation. There is a great deal of
18 experimentation with new organizational forms, as
19 managed care was growing, but the key strategy that's
20 really had lasting effects on the organization of the
21 delivery system is horizontal consolidation,
22 particularly among hospitals.
23 In contrast, physician markets have changed
24 relatively little and remain really fragmented. And
25 while there was some consolidation among health plans,

1 the focus there was really on more of this cross-market,
2 cross-geographic market concentration or consolidation
3 as opposed to the consolidation within markets that
4 hospitals were experiencing.
5 So, let me go into each of these in a bit more
6 detail. As we heard about just before, there was
7 extensive merger activity in the early to mid-1990s. In
8 the time period of just 1994 to 1997, there were 700
9 hospital mergers reported during that three-year period.
10 Although at the time, there was a great deal of
11 attention to the growth of for-profit hospital chains,
12 such as Columbia HCA, really the majority of hospital
13 mergers that occurred during this period involved local,
14 not-for-profit hospitals merging with one another.
15 Often these mergers involved leading hospitals
16 in the community and hospitals of considerable size, of
17 400 or 500, sometimes even a 800 or 900 bed hospitals
18 merging with one another. In some cases, the mergers
19 involved one hospital being absorbed by another in a
20 true sort of takeover model. So, for example, that's
21 what we saw in Lansing, one of the communities we track
22 where Sparrow Health System absorbed St. Lawrence
23 Hospital and they became a merged entity.
24 In many other cases, we saw mergers of equals,
25 where two hospitals were consolidated under a single

1 system, but really retained their underlying identities.
2 This was a really common strategy for the academic
3 medical centers, in particular.
4 So, for example, in Boston, this was how
5 Massachusetts General Hospital merged with Brigham &
6 Women's and they performed a partners health care
7 system, but both Massachusetts General and Brigham &
8 Women's remain as independent entities.
9 The same in Indianapolis, Indiana University
10 Hospital and Methodist Hospitals merged to form the
11 Clarion system, but still remain as two independent
12 entities.
13 Regardless of those differences, we found that
14 hospital mergers were driven by two primary goals: The
15 first was to streamline operations in order to survive
16 the discounts under managed care, and the second was to
17 improve leverage in negotiations with health plans.
18 Tracking the hospital mergers in our sites, and
19 we saw mergers in ten of the 12 sites in our first round
20 out, we saw results pretty similar to what you heard
21 described from the literature. There was extensive
22 administrative consolidation in the majority of the
23 mergers that we observed. That really did yield some
24 significant up-front savings, but those savings also
25 were offset to some degree by the added costs associated

1 with the system-level administration that was required.
2 So, for example, one system reported $160
3 million savings in the first three years after their
4 merger, but then have estimated $50 to $60 million costs
5 annually just for the system costs. So, there's a
6 trade-off there.
7 While there was extensive consolidation of the
8 administrative services, such as purchasing and finance,
9 there really was very little consolidation of clinical
10 services or of capacity. In general, this was a period
11 of downsizing for the hospital sector, but we found it
12 was not common to see greater downsizing as a result of
13 the mergers in these cases. In fact, it was just as
14 common to see expansions of services and expansions of
15 capacity to take advantage of the geographic breadth in
16 the merger partners brought them.
17 So, despite limited consolidation in terms of
18 clinical services and capacity, there was a clear effect
19 on the markets in terms of increased concentration of
20 ownership. This next slide really captures that. This
21 graph shows hospital concentration as measured by total
22 adjusted in-patient days. It shows how it's increased
23 between 1996 and 2000, so it's really capturing our 12
24 sites right at the time that merger activity was at its
25 peak and looking at how it's affected the concentration

1 of markets today.
2 The actual level of concentration of these
3 markets is somewhat skewed by the size of the market.
4 Remember, our market definition is the MSA, so this
5 really isn't necessarily how the hospital geographic
6 market lines would be drawn, but what's really important
7 to focus on here is the consistent increase that you see
8 when you look across these bars.
9 So, Lansing on the right is off the charts
10 really, and that's in part because it's such a small
11 market relative to the other ones that we track. And
12 Boston on the left is very moderately concentrated
13 because it's such a large population. We define the
14 Boston area as the four million plus people who live in
15 Boston itself and the surrounding suburbs.
16 So, focus less on the actual level than on the
17 change that you see here. There really is a consistent
18 trend across the 12 markets that we track of increasing
19 concentration.
20 Some markets have seen real sizeable jumps.
21 Cleveland, for example, went from a Herfindahl here of
22 less than 1,000 to just under 2,000 in this four-year
23 period. This was the result of a series of mergers and
24 acquisitions, and the closure of one downtown hospital.
25 Today the local hospital association in Cleveland

1 estimates that the two major systems there, the
2 Cleveland Clinic and University Hospitals and Health
3 System now account for just under 70 percent of the beds
4 in the total Cleveland area.
5 While there's been substantial consolidation on
6 the hospital side, as I said, there's really been
7 relatively little consolidation on the part of
8 physicians. Despite expectations about managed care and
9 the need for large physician organizations to manage and coordinate
10 care, there's really been very limited growth
11 of large groups.
12 Let me just flip to this next slide to give you
13 a graphic here. This slide is based on our physician
14 survey data and it shows the distribution of physician
15 practice size and how it's changed from between 1997 and
16 2001. As you can see, the bulk of physicians continue
17 to practice in groups with fewer than ten physicians,
18 but at the same time there has been some growth,
19 especially over the past couple of years, in groups with
20 three to nine physicians in particular.
21 Most of the growth that we're seeing in this
22 three to nine physician category is really attributed to
23 growth in single specialty groups. Primarily
24 procedure-based specialties like cardiology, orthopedics
25 and oncology.

1 These groups, which we've really been seeing
2 develop across the country, are motivated by two goals:
3 One is to attain the scale necessary to purchase
4 technology and facilities that allow the physicians to
5 supplement their professional fees with profitable
6 revenue from these other sources. The second goal,
7 again, is to increase leverage with health plans. In
8 fact, many groups are finding that they can achieve
9 considerable leverage without that many physicians,
10 especially in a single specialty group. Particularly if
11 those physicians represent a sizeable portion of the
12 market in that area or a sizeable portion of the market
13 for that geographic submarket.
14 Single specialty groups also avoid the conflict
15 of income distribution within the group that
16 multispecialty groups really struggle with. So, this is
17 a much more attractive option for physicians in the
18 field today.
19 The other major way that physicians attempted to
20 consolidate during the early managed care year was
21 through PHOs and IPAs and contracting entities of that
22 sort. These organizations really were established to
23 facilitate risk contracting and to help improve
24 physicians' leverage in those negotiations. But as
25 plans move away from risk-based payment, the mechanism

1 by which physicians can really rely on these
2 organizations to help them increase their leverage, that
3 mechanism is undercut. So, these organizations, there
4 still are many that exist, but they really have been
5 devalued in the current environment.
6 Finally, turning to health plans, local health
7 insurance markets were already concentrated in 1996 when
8 we began the community tracking study. In fact, an
9 analysis that was based on our initial round of site
10 visits found that looking across all product types, so
11 I'm including HMO, PPO and indemnity products, that nine
12 of the 12 sites were considered concentrated at that
13 time.
14 Much of this was due to the historical presence
15 of long-standing dominant plans. Typically the local
16 Blue Cross/Blue Shield plan or a pioneering group or
17 staff model HMO such as Group Health Cooperative in Seattle,
18 or Harbor Pilgrim in Boston.
19 So, it's really their long-standing dominance in
20 the market that resulted in this concentration, not
21 consolidation. Even though there are a growing number
22 of competitors in markets as managed care was in
23 ascendance, in most communities we track, the market
24 share remained concentrated in that handful of
25 historically dominated plans. It was difficult for new

1 entrants to really gain a significant foothold.
2 In some cases, market share became concentrated
3 even further as these plans that attempted entry
4 ultimately exited the market or provider-sponsored plans
5 which some hospitals got into this business exited that
6 market. So, there was some continuing concentration,
7 but really despite some ups and downs, it was those
8 long-standing dominant plans that remained in place and
9 continue today.
10 Let me flip to the graphic here. This graph
11 shows HMO concentration and how it's changed between
12 1997 and 2001 using interstudy data. A shortcoming here
13 is that this graph shows only HMO enrollment, which of
14 course is just one segment of the health insurance
15 market and one that may be declining in importance, but
16 the problem is there really is no reliable data on PPO
17 enrollment at the local market level. So, this is the
18 best that we can do in terms of looking at how
19 concentration of managed care products has changed over
20 time.
21 So, unlike the graph of hospital concentration,
22 you can see that there is no clear direction of change
23 in HMO concentration across markets during this period.
24 Market share became less concentrated or remained
25 essentially unchanged in as many markets as it

1 increased.
2 In general, the smaller markets like Lansing and
3 Little Rock and Greenville have remained highly
4 concentrated, and that's really where the local Blue
5 Cross/Blue Shield plans have long dominated the market.
6 In contrast, larger cities like Miami and Phoenix have
7 continued to be more contested markets with multiple
8 players vying for growing population base and creating
9 an environment that's more conducive to the successful
10 entry and growth of national plans.
11 What consolidation has occurred among health
12 plans has focused on mergers across geographic markets
13 to gain economies of scale in terms of information
14 systems, administration, to help them expand products
15 and services and a big focus on better serving
16 multistate employers.
17 Much of this involved national plans in the mid
18 to late 1990s, such as Aetna or United, and more
19 recently the activity is focused on regional or now
20 multiregion Blues Plans like Anthem or WellPoint.
21 The mergers and acquisitions involving the Blues
22 Plans are particularly interesting since these play to
23 the strengths of what plans can hope to achieve through
24 consolidation; that is, the economies of scale through
25 information systems and administrative services, while

1 minimizing the problems associated with entering new
2 markets that national plans experience such as the
3 difficulty of establishing local provider networks, the
4 local sales force and things that really remained very
5 local in nature.
6 By acquiring the often dominant local Blues
7 Plans, the Anthems and the Well Points of the world have
8 found this strategy to skirt the diseconomies of scales
9 associated with entering new markets and have avoided
10 this difficulty of establishing a stronghold in new
11 areas.
12 So, what have these trends meant for the
13 workings of health care markets? As I said at the
14 beginning, there really have been some very visible
15 effects of these changes on health care market dynamics.
16 First, the concentration from tightly managed care and
17 the effects of increased concentration in the hospital
18 market have increased provider leverage and given rise
19 to this growing phenomenon of contract showdowns between
20 plans and providers, as providers push for increased
21 payment and better contract terms across the country.
22 Hospitals in particular are adopting the
23 strategy of terminate and then negotiate, and this
24 tactic is really threatening continuity of care for
25 hundreds of thousands of consumers in these communities.

1 One of the most vivid examples we saw in the communities
2 that we track was in Boston when there was a contract
3 dispute between Partners Health Care System and Tufts
4 Health Plan, and Partners threatened to terminate its
5 contract with Tufts, and this would have affected over
6 100,000 Tufts members who relied on either one of the
7 hospitals in the Partners Health System or one of the
8 4,000 physicians that were affiliated with Partners.
9 So, this created a great deal of consternation
10 in the market, as I'm sure you can imagine. Ultimately
11 local employers and the state attorney general stepped
12 in and the dispute was settled with Tufts giving
13 Partners sizeable rate increases.
14 The second major effect of these trends that
15 we've seen in markets is the revival of this medical
16 arms race mentality that was mentioned earlier. As
17 hospitals shift back to a retail rather than a wholesale
18 strategy of competing for patients through managed care
19 contracts, they returned to competing for patients by
20 adding attractive services, adding these amenities, and
21 focusing on competing for the revenue-generating
22 services.
23 This has really led to a proliferation of
24 specialty hospitals, stand-alone surgery centers,
25 centers of excellence and so forth throughout the

1 country. There's a great deal of mimicking behavior
2 going on in individual communities.
3 So, for example, in Indianapolis, there are now
4 four new heart hospitals under construction and
5 scheduled to come online within the next couple of
6 years. Some of this activity has been driven by single
7 specialty groups, either on their own or with the
8 backing of national firms such as Med Cath that have
9 sought to establish these niche facilities that
10 specialize in profitable procedures without the drain of
11 the less profitable care like emergency care or
12 uncompensated care.
13 This leaves traditional acute care hospitals in
14 a real bind. Either they have to compete for these
15 patients and these physicians, or they stand to lose
16 this important source of revenue. So, this phenomenon
17 has really instigated increased joint venture activity
18 around these specialty centers as a way to keep the
19 physicians loyal to the traditional hospitals in the
20 community.
21 Finally, as was discussed earlier, the market
22 trends that we've seen have had really visible effects
23 on underlying health care costs again today. We
24 actually track health care costs on an annual basis, and
25 our latest report is coming out later this month in

1 Health Affairs, but I can preview it for you today just
2 by saying that there have been significant increases in
3 underlying costs again in 2001, and we are reaching
4 levels that's comparable to the pre-managed care era in
5 1990.
6 I think the really important point here is that
7 the pharmacy costs continue to play an important role,
8 hospital costs have superseded pharmacy in terms of
9 what's contributing to underlying cost growth today. In
10 the analysis that's coming out in Health Affairs, we
11 really dissect this a bit and show that it's both
12 increases in hospital utilization and increases in
13 hospital prices that are driving this trend.
14 So, stepping back from the twist and turns we've
15 observed in health care markets over the past several
16 years, there are several key lessons that we've learned
17 about the nature of competition in health care markets
18 as a result of watching this activity. First is that
19 health care markets have a certain level of inherent
20 concentration, in part because health care delivery
21 occurs largely at the local level, and in part because
22 it's dependent upon relationships between hospitals and
23 physicians, providers and plans, and of course patients
24 and providers.
25 It's difficult to replicate these relationships

1 across multiple actors, that there are real limits to
2 that. In addition, there are limits to how far we want
3 to go with health care markets, given that health care
4 is ultimately a public good. So, as a result, the
5 degree of competition in health care markets really
6 needs to be assessed within this unique context and it
7 might be quite different, and probably is, quite
8 different from markets in other industries. This
9 doesn't mean that there shouldn't be attention to making
10 health care markets more competitive, but this needs to
11 occur with recognition of the trade-offs that are
12 associated with this goal and with the close examination
13 of the factors that contribute to competition in health
14 care.
15 So, for example, one of the things that we've
16 observed from our work tracking markets is that ease of
17 entry may actually be changing or may be different from
18 conventional wisdom. On the one hand, the growth of
19 these single specialty hospitals may be a sign that the
20 hospital market actually may have less significant
21 barriers to entry than long believed.
22 To the extent that these hospitals can come into
23 the market and by virtue of focusing on a narrower set
24 of services, they have the potential to provide higher
25 quality of care at lower costs. And in that respect,

1 they can create procompetitive pressure for the delivery
2 of these special services.
3 But the trade-off is that as traditional acute
4 care hospitals rush to compete with these new entities,
5 it becomes more difficult for them to cross-subsidize
6 other essential yet lower margin services such as
7 emergency care or uncompensated care. So, as a result,
8 competitive pressure for the delivery of these specialty
9 services may yield positive effects, but the health
10 system as a whole experiences stress.
11 Some observers suggest that in the longer run,
12 competition over specialty services may result in
13 overcapacity with reduced quality and increased cost.
14 So, that's something that really needs to be monitored
15 over time.
16 In terms of ease of entry on the other hand,
17 when we look at the health insurance market, we're
18 seeing that there may be greater barriers to entry than
19 long believed. It's becoming increasingly clear that
20 plans are unlikely to remain in the new market unless
21 they are able to obtain the certain scale. Difficulties
22 establishing a viable provider network is a key barrier
23 to gaining the necessary market share to compete
24 effectively.
25 Although theory would lead you to believe that

1 there would be procompetitive effects from using plan
2 entry, it's unclear that this goal is attainable, given
3 the relationship-dependent nature of health care.
4 Finally, our work has taught us that
5 cross-sector competition is subject to significant
6 change over time as we've seen with these dramatic
7 swings in plan and provider leverage over the past few
8 years. Our work has shown that leverage is determined
9 by more than just firms' market share or the
10 concentration of the market, but that there really are
11 multiple internal and external factors at play here.
12 I'm just going to run through some of those
13 quickly. On the provider side, this slide shows the
14 internal factors affecting providers' leverage include
15 things like reputation and stature in the community.
16 This is something that's been very important for
17 academic medical centers in particular. Strength of
18 relationships with providers, tightness of the hospital
19 relationships with physicians or for physicians their
20 relationships with hospitals, the financial stability of
21 these organizations and so forth. Plus there are a
22 number of environmental factors: Employer's preference
23 for broad provider networks has strengthened providers'
24 leverage, as have emerging market-wide capacity
25 constraints that make providers less desperate to accept

1 discounts.

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

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

19 Provider leverage may decline, if there's this
20 build-up of capacity that certainly seems that that's
21 the direction that we're heading in, both to respond to
22 current shortages and in response to this medical arms
23 race behavior. This could create real problems for
24 providers, particularly if this recent spike in
25 utilization turns out to be a one-time increase as many

1 really suggest that it is, really just a one-time
2 adjustment to the loosening of managed care again.
3 Plus plans will shift more financial
4 responsibility on to consumers for the increased cost of
5 care, the increased copays and coinsurance requirements
6 on consumers, as they've really been doing as a strategy
7 to manage these year-after-year, double-digit premium
8 increases. Analysts are projecting that this will cause
9 utilization to slow again soon.
10 So, providers may be getting themselves into a
11 situation of increasing capacity, declining utilization,
12 and really being out on the market for volume again.
13 Plus, as I talked about before, this increased
14 pressure from potential substitutes has the potential to
15 decrease provider leverage, particularly if these new
16 specialty facilities are able to produce lower cost
17 services on the market.
18 But at the same time, providers really remain
19 under significant pressure, both from the nursing
20 shortage and the shortage of ancillary personnel that
21 continues to drive up their input costs. And pressure
22 from the continuing squeeze on Medicare payment. So,
23 while their leverage may be in decline, they will
24 continue to face strong pressure to test the waters with
25 health plans and push for higher payment rates on the

1 private market.
2 Meanwhile, there's some changes on the horizon
3 that have the potential to increase plan leverage.
4 First and foremost is increased employer interest in
5 controlling premium increases, which is giving plans
6 license to develop new strategies to manage care more
7 tightly again. At the same time, the trend to give
8 consumers more skin in the game by increasing their
9 copays and deductibles, this makes consumers a potential
10 ally for health plans in their efforts to control costs.
11 But to date, plans really have had limited
12 success with these new strategies. For example, one
13 strategy that a number of plans across the country are
14 pursuing now is this concept of tiered provider networks
15 in which consumers pay a different amount based on the
16 tier that their provider is in. It's essentially the
17 same concept as a three-tier pharmacy, which plans have
18 had a lot of success with. Three-tier pharmacy is the
19 idea that you pay a lower copay for generic and then
20 increasing amounts for preferred or brand name drugs.
21 This has really helped plans to control pharmacy
22 growth, and as you saw in the earlier slide, we're
23 seeing that cost trend dip down again now. So, the idea
24 is to take the successful strategy and apply it to the
25 provider networks, but plans have been having a harder

1 time rolling this out in their provider networks and
2 providers have been really resistant to this concept.
3 So, Boston is one market where we've seen a number of
4 plans propose this, and their tiering was really based
5 on academic medical centers in one tier and community
6 hospitals in another tier. And the academic medical
7 centers have fought that very hard.
8 In general, there still is also this general
9 unease about restricting access to certain providers or
10 to certain services on the part of both employers and
11 consumers. So, it really makes it questionable how
12 successful this tiered network strategy can be. I think
13 the important context here is that even though the economy
14 has slowed considerably since the hey-day in the late
15 1990s and the labor market has become somewhat weaker,
16 it still hasn't become as weak as it was in the early
17 1990s when employers really moved aggressively into
18 managed care and were able to lead off this managed care
19 revolution.
20 In fact, the labor market is expected to remain
21 relatively tight over the next ten years. So, it is
22 really questionable how much momentum will materialize
23 to lead plans to move towards more restrictive products
24 again.
25 So, the bottom line is that while there are a

1 number of forces on the horizon that could increase
2 plans' relative leverage again, there also are a number
3 of mitigating factors, and I think that the lesson that
4 we want to leave you with today is that really
5 monitoring these changes over time will be critical to
6 assessing the degree of competition that exists in
7 health care markets, how that's changing, and what needs
8 to be done about it.
9 Thank you.
10 (Applause.)
11 MR. HYMAN: Thank you, Cara.
12 We're now going to hear from the heads of three
13 bureaus at the Federal Trade Commission. First will be
14 Joseph Simons from the Bureau of Competition, second
15 will be Howard Beales from the Bureau of Consumer
16 Protection, and finally will be David Scheffman from the
17 Bureau of Economics. Each of them will give you
18 their perspective on health care and competition law and
19 policy, talking a little bit about where the FTC has been
20 and some about where they would like to go. Each has
21 about ten minutes to do so.
22 MR. SIMONS: Good morning, everyone, and thank
23 you all for coming. Your presence here today,
24 particularly in such large numbers, there is a big
25 overflow in the other rooms as well, really indicates

1 the increasing importance of health care and the health
2 care industry to our nation's economy.
3 As Tim said earlier, during the introduction, we
4 really do hope to learn an awful lot during this two-day
5 workshop. To provide some background and context, what I am going to
6 do is just to briefly describe the Bureau of Competition's initiatives
7 over the last year in the health
8 care industry.
9 First let me say, however, that the Commission
10 has a very long history of activity in health care, and
11 it particularly emphasized health care during Tim's last
12 stint at the Commission. For those of you who
13 haven't noticed, one of the characteristics about Tim,
14 not just in health care, but in other areas as well, his
15 past is very definitely prologue. So, a lot of what we
16 did previously when Tim was here, we're going to be or
17 we are re-emphasizing again.
18 Moreover, health care has really become a much
19 more important part of our economy over the last few
20 years and thus the Bureau of Competition has really
21 started to dramatically increase the resources that we
22 are devoting to health care.
23 Our activities have focused primarily on
24 horizontal and vertical restraints and mergers involving
25 hospitals, pharmaceuticals and physicians. Our recent

1 enforcement activities can be characterized basically in
2 three areas: Price fixing among the health care
3 providers, hospital merger retrospective, and
4 pharmaceuticals. I'll talk briefly about each of those
5 three areas.
6 So far this year, the Commission has entered
7 into five consent agreements with physicians groups
8 settling what are pretty much price fixing cases. Now,
9 I mentioned past is prologue, and we did this previously,
10 we did this during the '80s, we did this during the
11 '90s, and we were criticized by folks for some of our
12 efforts in the area of going after physician price fixing.
13 Basically what the criticism involved was that
14 we were picking a doctor here, a couple of doctors
15 there, generally in rural areas, and why were we wasting
16 our resources doing that? Well, whatever you think of
17 that old criticism, it really doesn't apply to what
18 we're doing now.
19 The cases that we've brought in the last year
20 have been in large metropolitan areas and involved
21 fairly large numbers of doctors, especially the recent
22 case in Dallas which involved over 1,200 doctors engaged
23 in price fixing.
24 Just last month, the Commission provisionally
25 accepted a consent agreement with System Health

1 Providers, which is a multispecialty physician group
2 with about 1,250 doctors practicing in the eastern part
3 of the Dallas metropolitan area.
4 The second, third and fourth cases that we
5 brought involve orders issued against or orders
6 provisionally accepted by the Commission for comment,
7 three physician groups in Denver, Colorado. The first
8 one, P-I-S-D, affectionately known as PISD, is a group
9 of 41 primary care doctors practicing in the southern
10 part of Denver; AAPCP had about 45 primary care doctors
11 located in the suburb of Aurora; and PIWC involves a
12 group of more than 80 Denver obstetrician/gynecologists.
13 In each of these matters, the non-physician
14 agent who organized the group or who acted as the agent
15 in dealing with the payers was also named in the
16 complaint and is also bound by the order.
17 The fifth doctor case involved Napa County,
18 California. That case involved a group of almost all of
19 the obstetrician/gynecologists in Napa County. As a
20 result of the doctors' actions, at least according to
21 our complaint, some health plans actually stopped
22 providing HMO coverage in that county entirely. The
23 order requires the group to dissolve.
24 Finally, as it relates to physician matters, we
25 issued an advisory opinion to MedSouth, which is a

1 Denver IPA. As that letter indicates, we are very
2 receptive to innovative forms of health care provider
3 integration where it stands to benefit consumers by
4 either reducing costs, or by improving quality.
5 Let me just be clear, in terms of the cases that
6 we've brought this year, the five cases that I
7 mentioned, those were really price fixing cases, none of
8 those cases involved any form of serious integrated
9 activity. One of the things that Tim's been emphasizing
10 since he got here is efficiencies. He's emphasized that
11 in mergers, and in non-mergers as well, and that's
12 really critical to what we're doing in the health care
13 area. We are very sympathetic to efficiency claims and
14 to quality concerns, and we are committed to looking
15 very seriously any time those arguments are in play.
16 Let me talk a little bit about the hospital
17 merger retrospective. You had a presentation a little
18 bit earlier today which kind of put the line-up on the
19 board of the government's success or really its failure
20 in the area of hospital merger enforcement. In fact, I
21 think we're zero for our last seven.
22 Coming into this, we had a couple of
23 choices. Basically we could just say, ah, let's fold
24 our tents, there's nothing we can do, or we could try
25 something significantly different than what we had been

1 doing. So, we picked the latter.
2 What we thought we might do is, a lot of us had
3 a suspicion that even though we lost all of those cases,
4 that we were really right, at least in some substantial
5 part of them, and that prices were really affected. So,
6 what we have committed to do is going back and actually
7 looking to see in a variety of contexts whether the
8 mergers, after the fact, can be shown to have increased
9 price.
10 We're doing this for two reasons: The first one
11 is if we find a transaction where we can show a price
12 effect and a remedy is available, we'll fix it, and we
13 would do that through the administrative process. Then
14 two is if by studying these consummated transactions we
15 can actually show there was, in fact, an effect when the
16 court said, oh, no, there wouldn't be, well then we can
17 use that to inform the cases going forward and
18 re-institute the challenges to mergers prior to
19 consummation. So, we're looking at that from those two
20 perspectives.
21 The final area that we're involved with that I
22 want to talk about today is pharmaceuticals. Everyone
23 who pays any attention to the news sees the concerns
24 about rapidly increasing costs of prescription drugs on
25 behalf of virtually everybody, patients, employers, the

1 government. Consequently, the Commission over the
2 last several years has been devoting an increasing
3 amount of resources to the pharmaceutical industry. We
4 are now to the point where we focus more than 20 percent
5 of all competition resources on the pharmaceutical
6 business.
7 There were three very significant non-merger
8 matters this year in the pharmaceutical industry that
9 were brought by the Commission. The first one involves
10 Biovail. This was a landmark case for us involving a
11 wrongful listing in the FDA's Orange Book. Biovail is
12 basically a two-fer for us. It's our first wrongful
13 listing case in the Orange Book, and it also involved a
14 vertical acquisition, in this case of a patent.
15 Biovail manufactures a drug known as Tiazac. It's
16 a product used to treat high blood pressure and
17 chronic chest pain. Another company had filed an
18 application with the FDA for approval to provide a
19 generic of Tiazac, and certified that it did not
20 infringe any of Biovail's patents that were listed in
21 the Orange Book.
22 Biovail sued them for infringement anyway and
23 the generic prevailed at trial, but before the generic
24 could get to the market, Biovail acquired an exclusive
25 license to another patent that was not required to

1 manufacture Tiazac, but which Biovail claimed the
2 generic would infringe anyway in making the generic for
3 Tiazac. Biovail then listed that patent in the Orange
4 Book, sued the generic and the 30-month stay under the
5 Hatch-Waxman Act was triggered.
6 The complaint that the Commission filed charged
7 both that the acquisition of the license and the
8 wrongful listing in the Orange Book unlawfully
9 maintained Biovail's monopoly in violation of both
10 Section 7 of the Clayton Act and Section 5 of the FTC
11 Act. The consent order required Biovail to divest part
12 of the exclusive license that was preventing the generic
13 entrant from entering, the order prohibits the company
14 from taking any action to cause any additional delay
15 under the Hatch-Waxman Act, and the order also prohibits
16 Biovail from wrongfully listing any patents in the
17 Orange Book relating to any products that Biovail
18 produces.
19 The second case also involves Biovail. It was a
20 big year for them. Biovail and Elan were the only two
21 manufacturers that had FDA approval to produce a generic
22 version of branded Adalat, which is an antihypertensive
23 drug. What the parties basically did was they agreed
24 that only Biovail would have the control of the
25 distribution and Biovail would share in all of the

1 profits whether the product was Elan's products being
2 sold or whether it was Biovail's product being sold.
3 The order that we obtained there terminates the
4 agreement between the two companies and it prohibits
5 them from entering into similar agreements in the
6 future.
7 The third case in this area is the Schering
8 case, and that case is currently in part III litigation.
9 This is the first case that the Commission is litigating
10 that involves a patent settlement with what we call a
11 reverse payment where the brand pays the generic, the
12 alleged infringer, to stay off the market. The
13 complaint alleged that Schering-Plough paid Upsher-Smith
14 $60 million and American Home Products at least $15
15 million in exchange for those companies' agreements to
16 stay off the market with respect to their generic
17 potassium chloride supplements, the generic for what
18 Schering was selling, which was its K-Dur 20 product.
19 The staff has appealed the decision of the ALJ
20 dismissing the complaint and the case is now on appeal.
21 In addition, AHP had settled that case before the trial
22 began. So, that's on appeal to the Commission, and I'm
23 very hopeful that the Commission will reverse the ALJ,
24 and in any event I think the Commission is going to have
25 an excellent opportunity to write a highly interesting

1 opinion.
2 The other area in pharmaceuticals that we're
3 focusing on is mergers. We have been extremely active
4 there as well. There's one quite large investigation
5 that's ongoing, and in addition a very good example of
6 our activity there is a recent transaction involving
7 Amgen and Immunex which was a deal involving a big
8 deal in the biotech sector.
9 All right, what lies ahead? Well, what lies
10 ahead depends in part on what we learn here in these two
11 days and then what comes about as a follow-up from these
12 two days of hearings. The Commission really over the
13 last few years has been quite active in holding these
14 types of hearings and workshops and they've been highly
15 informative. So, we're really optimistic about getting
16 some excellent input from the folks at these two
17 hearings, the two days of hearings, and then what
18 follows.
19 But in any case, we're certainly going to
20 continue to devote a very substantial portion of the
21 bureau's resources to the health care industry. We are
22 very much committed to trying to revitalize hospital
23 merger enforcement, and we have many cases in the
24 pharmaceutical industry in our pipeline and of course
25 we'll be very active with respect to mergers in the

1 health care arena also.

2 That concludes my remarks for this afternoon.

3 Thank you so much for your attention. I'm sure that

4 the rest of the workshop will be extremely interesting

5 and very thought-provoking. Thanks again.

6 (Applause.)

7 MR. BEALES: I may or may not be a speaker that

8 needs no introduction, but I get no introduction. I'm

9 Howard Beales, I'm Director of the Bureau of Consumer

10 Protection.

11 The Bureau of Consumer Protection shares the

12 Bureau of Competition's goal of ensuring that the consumers

13 enjoy the full benefits of a competitive marketplace.

14 However, we come at it from a somewhat different perspective.

15 In particular, we focus on the crucial role that the free flow

16 of truthful advertising plays in competitive markets. Truthful

17 advertising enables consumers to make well-informed decisions about

18 their health care options, including, their choices or health care

19 goods and services.

20 As George Stigler once wrote, "Advertising is an

21 immensely powerful instrument for the elimination of

22 ignorance." Unfortunately, there's a good deal of

23 information in the marketplace that's not truthful, and

24 not even close in many cases.

25 A key part of our mission is to target

1 advertisers that deceive consumers, particularly
2 vulnerable consumers who are desperate to find a cure
3 for their cancer, guard their family from bioterrorism,
4 or shed a few unwanted pounds to improve their health.
5 We commit substantial resources to keeping
6 abreast of new health care developments to prevent deceptive
7 advertising. In doing so, we coordinate our efforts
8 with other federal and state agencies, in order to
9 leverage the resources that we have available.
10 Let me give you a few examples: One
11 long-standing priority of our program is to combat
12 health fraud by marketers who sell unproven cures to
13 desperate consumers suffering from cancer, AIDS, arthritis,
14 or other serious diseases.
15 Unfortunately, the advent of the Internet has
16 made it inexpensive to reach a large, potentially world-wide
17 audience, with claims that are plainly false or unsubstantiated.
18 The FTC, in cooperation with other federal and state agencies, has
19 cracked down on companies that use the Internet to deceptively market
20 products for the
21 treatment of a wide range of serious health conditions.
22 Most recently, we settled charges with BioPulse
23 International, which advertised its alternative cancer
24 treatments at a clinic in Tijuana. The company claimed that
25 it's therapy would cure cancer by inducing a coma with insulin. To

1 this audience, that's probably all that needs to be said about the
2 substantiation for that claim.
3 In addition to bringing actions against these types of
4 marketers, we use Operation Cure-all as an educational
5 tool to alert consumers to health care fraud online and
6 offline.
7 Another major project has involves bioterrorism.
8 Consumer fraud is by definition an opportunistic
9 endeavor. Last fall, just after the nation-wide anthrax
10 scare, we learned that unscrupulous marketers were
11 preying on consumers' fears and marketing products to
12 detect biological agents or prevent or treat anthrax, smallpox, and
13 other biohazards.
14 We launched, together with the FDA and 30 state
15 enforcement agencies, an Internet surf to identify sites
16 making suspicious claims. We sent out more than 100
17 warning letters to marketers, demanding
18 that they immediately discontinue their claims. We
19 followed up the warning letters, and ultimately we
20 brought enforcement actions against several companies,
21 including Vital Living Products.
22 Vital Living Products advertised a do-it-yourself home anthrax
23 testing kit.
24 Unfortunately, when we tested the kit against
25 anthrax, it said there was none: when we tested it

1 against common household bacteria, it said we had
2 anthrax. Fortunately, we stopped them before any test
3 kits were actually sold. In this area, prompt federal
4 and coordinated federal and state enforcement efforts
5 were successful in preventing the emergence of more
6 widespread frauds involving bioterrorism-related products.
7 Of course, not everything we do is fraud. In
8 some cases, marketers of legitimate products will stray
9 over the line in an effort to obtain a competitive
10 advantage. When they do, it's our job to pull them
11 back. In March, for example, we announced a settlement of
12 allegations that the makers of Wonder Bread and its
13 advertising agency made the deceptive claim that added
14 calcium in Wonder Bread could improve children's brain
15 function and memory.
16 Now, calcium is wonderful stuff, and if you
17 don't have any calcium, then probably your brain won't
18 function very well, but to go from there to a claim that
19 adding calcium to your diet will improve memory and brain function, is
20 more of a stretch than the evidence will support.
21 Although ordinarily our actions are effective in
22 bringing advertisers into line, there are some
23 intractable problems out there. One has been in the
24 area of weight loss, where marketers continue to take
25 advantage of consumers' desperation to lose those pounds

1 or change the shape of their bodies. There seem to be
2 countless new ploys to separate overweight consumers
3 from their money with a new one emerging every few months.
4 In May, we filed federal court complaints
5 challenging claims made by three widely advertised
6 abdominal exercise belts. You probably saw the ads. The
7 companies claim that you could wear the belts for a few
8 minutes a day and have washboard abs with no effort
9 whatsoever. Unfortunately, it wasn't true.
10 This action follows a series of FTC actions
11 against other products with names that also say it all,
12 like Exercise in a Bottle, and Fat Trapper Plus. If only
13 it were true! Our actions were often accompanied by orders that
14 required the payment of millions of dollars in consumer redress. There
15 will be more of these enforcement actions.
16 What probably interests us most about this
17 workshop is the session on prescription drug advertising to consumers.
18 This is something that the Commission has in the past defended as
19 consistent with the benefits of truthful advertising
20 in competitive markets, and it's something that really
21 has the potential to revolutionize the way consumers
22 find out about important new treatments.
23 Because such advertising has such significant
24 potential benefits, it's also especially important that
25 it be truthful. Now, the FDA has primary jurisdiction over

1 prescription drug advertising. But this is one area where we also have
2 jurisdiction and one area where we can work closely with the FDA, as we
3 do in other areas. We're looking at ways to do that in order to ensure
4 that prescription drug advertising directly to consumers remains
5 truthful and fulfills the potential benefits that it can offer.
6 Prescription drug advertising raises a variety of issues, from
7 its effect on prices to its effect on physician/patient relationships,
8 and we look forward to the discussions in the panel tomorrow on that
9 issue. Thank you very much for your attention, and we look forward to
10 your input during the workshop.
11 (Applause.)
12 MR. SCHEFFMAN: Hi, I'm David Scheffman, I'm the
13 head of the Bureau of Economics, we're the brains behind
14 all these lawyers, we like to think.
15 Economics is important to what we're doing in
16 health care. I'm going to talk very briefly about what
17 we're doing. Tim Muris has long believed in and been a
18 very strong proponent of enforcement. In the '80s he came in with a
19 very aggressive enforcement program, with health
20 care being one of the targets. He has also always believed that
21 having research to supplement our efforts is important. As he
22 indicated in his remarks today, the Bureau of Economics has a long
23 history of producing research in the health care area. He talked about
24 the Greenberg Conference and Monica Noether's
25 report from the early '80s which was for a while successful in

1 supporting hospital merger cases.
2 Let me talk a little bit about some of the areas
3 where the Bureau of Economics is currently active. First, as
4 a number of people have already said, we're looking at consummated
5 hospital mergers. This is part of a broader program of looking at
6 mergers in lots of industries where enforcement
7 decisions were unsuccessful. We are trying to determine whether
8 we had the analysis right. What's involved is looking at data
9 and trying to determine as a matter of economic analysis
10 whether prices appear to have gone up more than they should
11 have as a result of anticompetitive behavior.
12 It's fundamentally an empirical issue. We
13 don't have any answers yet, and we're analyzing a lot of data. It is
14 going to be interesting, in my view, as many of us have
15 watched the unsuccessful jurisprudence on hospital mergers.
16 The courts probably haven't gotten the market definition
17 right in terms of geographic market. This is a bit
18 disappointing because the court's decision must have been based on
19 economic testimony, and based on patient migration data.
20 Many people have said for some time, including
21 a Greg Werden article, that patient migration data may not
22 tell you a lot about market definition in a situation where
23 you have networks and bargaining power and where the sales
24 are made to third party payers and not directly to patients.
25 I think that if we find evidence in our empirical analysis

1 that demonstrates that some of these mergers that were not successfully
2 challenged were anticompetitive, it's going to
3 fundamentally change the way we do market definition. I
4 think appropriately so, but it's an empirical issue and
5 we don't know the answer yet.
6 In addition, the analysis of competitive effects in hospital
7 mergers is going to have to be rethought. There's nothing better than
8 having actual examples of post merger activity to use to analyze how
9 hospital competition really
10 works, as opposed to how we usually analyze mergers prospectively
11 We're also doing a lot of thinking about health-care providers.
12 As Joe indicated, we have a lot of investigations
13 of essentially naked price fixing arrangements among doctors. An
14 important issue for economic analysis to address in these
15 investigations is the competitive impact of provider group integration.
16 The question is if the provider groups get big enough, and sufficiently
17 integrated, will there come a point where is big enough becomes too
18 big, and where we might foresee an anticompetitive effect. We're
19 analyzing this issue.
20 On the enforcement side we also continue to be very busy with
21 Hatch-Waxman related pharmaceutical matters. BE also has an active
22 research agenda. We've brought in Bill Vogt to help spearhead our
23 research efforts, and we're delighted with that. We have some
24 outstanding health care researchers in the Bureau like Mike Vita and
25 Lou Silvia and other folks who have been actively working on health

1 care issues for some time. We have also made contact with some of the
2 leading health care economists in the country and are working with
3 them.
4 We understand that quality is the most important
5 issue in health care. For an enforcement agency is critical to be able
6 to demonstrate that enforcement actions don't have an adverse effect on
7 quality.
8 In the rest of antitrust, we generally don't think there is a
9 "quality competition trade-off." However, for years we've actively
10 enforced in the pharmaceutical area, where our cases are often based on
11 reductions in quality and variety, and that's
12 noncontroversial. We're sponsoring a lot of research with leading
13 researchers on the quality issue. So far, we have contracted with four
14 researchers to examine the relationship between health care competition
15 and quality. The issues they are investigating include the
16 relationship between hospital surgical volume and quality, and the
17 relationship between physician practice organizations market structure
18 and quality.
19 So, those are things we're doing as part of
20 this, as the other speakers have talked about, these
21 hearings are very important because we're bringing some
22 of the leading people in the area to come and talk and
23 we'll be listening. If you have more to tell us, more
24 than in the conference in terms of papers, data,
25 economic analysis, of any sort, we would be delighted to

1 hear from you.

2 Thank you very much for coming.

3 (Applause.)

4 MR. HYMAN: We're now going to hear from

5 representatives of two of the entities that are partners

6 of the Commission in enforcing the nation's antitrust

7 laws, first representing the Department of Justice is

8 Deborah Majoras, who is Deputy Assistant Attorney

9 General for Civil Enforcement in the Antitrust Division.

10 MS. MAJORAS: Thank you, David.

11 I'm pleased to have the opportunity today to

12 tell you about some of the Antitrust Division's

13 initiatives and enforcement actions recently in the

14 health care industry. I thank Chairman Muris and the

15 Federal Trade Commission for sponsoring this workshop and

16 for inviting our participation.

17 Strong antitrust enforcement plays a significant

18 role in encouraging and facilitating competition in the

19 health care industry, and in the few minutes I have, I am

20 going to give you a brief overview of what we are doing

21 in this area, identify some areas of concern and

22 interest for us, and tell you where I think our efforts

23 will be directed in the future.

24 I first want to address a matter that I think

25 has been the subject of some misunderstanding by some

1 observers, and that is the absorption of the
2 responsibilities and most of the resources of our Health
3 Care Task Force into our newly created Litigation I Section earlier
4 this year. That action did not signal
5 and has not resulted in the Division's exit from a significant
6 enforcement role in the health care sector. Rather, it was
7 part of a Congressionally-approved and Division-wide modernization
8 effort to concentrate industry expertise in six civil litigating
9 sections of roughly equal size, each having broad merger and non-merger
10 responsibility in particular industries and each with sufficient staff
11 to perform those responsibilities efficiently and effectively.
12 Now, in the case of the Health Care Task Force,
13 the staff, and of course their expertise, was not
14 dissipated in this reorganization; rather, that staff
15 was essentially transferred wholesale into the new
16 Litigation I Section. Led my Mark Botti and John Reed,
17 our Chief and Assistant Chief, respectively, those staff
18 members continue to investigate health care matters
19 within the context of that full-fledged section. In
20 accordance with the philosophy that underlies our
21 modernization effort, we expect that Section to engage
22 in "community policing" in this important industry.
23 Now, one area of primary concern for Litigation
24 I, I will be the evaluation of mergers and of unilateral or
25 coordinated conduct by health insurers. For consumers

1 to benefit from competition in health care markets,
2 sufficient competition must be maintained not only among
3 providers, but also among the health plans that purchase
4 the providers' services on behalf of the plan members.
5 Our competitive interest in this regard has been
6 heightened by the generally increased level of
7 consolidation of health insurance markets in the past
8 few years. Given these ongoing market changes, we will
9 pay close attention to whether any particular merger
10 would give the merged insurer sufficient market power to
11 increase prices or reduce quality in the sale of managed
12 care plans in specific geographic areas or to acquire
13 monopsony power over providers. We will make close
14 scrutiny of health insurance plan mergers a priority.
15 Likewise, we will continue to focus on
16 collective or unilateral activity by insurers that may
17 raise competitive concerns, depending, of course, on the
18 insured's market power and other relevant market
19 conditions. To cite some examples, we recently
20 scrutinized a health insurance market in a major
21 metropolitan area for possible evidence of coordination
22 or collusion among managed care plans operating there.
23 In addition, within the past several months, we
24 investigated a complaint by providers that a form of "all
25 products clause" instituted by an insurer with

1 substantial market power -- that is, a clause that gives
2 providers more favorable reimbursement rates if they opt
3 to participate in all of an insurer's plan offerings -- was
4 anticompetitive.
5 Furthermore, we continue to receive and evaluate
6 complaints about managed care plans' use of "most favored
7 nations" clauses to determine whether they merit more
8 complete investigation or ultimately enforcement action.
9 These types of clauses generally operate to protect insurers against
10 other plans getting better reimbursement rates, and so they often
11 provide a disincentive to providers to lower their rates. In this
12 regard, we have, for example, investigated the use of an MFN clause by
13 a Blue Cross plan in Alabama, an investigation we closed only upon
14 confirming through our investigation that the plan abandoned the MFN
15 policy. Similarly, in Western Pennsylvania, Highmark, an insurer with
16 significant
17 market share, recently proposed to the Pennsylvania
18 Department of Insurance the inclusion of an MFN clause
19 in their contracts with hospitals. Now, in the mid-1990s, the Division
20 had advised the Pennsylvania Insurance Department that Highmark's then-
21 proposal to institute an MFN policy had serious
22 competitive concerns. While we were evaluating the MFN
23 this time, Highmark abandoned it.
24 Another area of the health care sector that we
25 are currently focusing on and that has absorbed an increasing

1 amount of our resources is the rather broad category
2 referred to as "ancillary health care products and
3 services." The Dentsply case is a recent example.
4 That lawsuit, which we filed in federal district court
5 in Delaware, challenges the use by Dentsply, the
6 dominant manufacturer of artificial teeth in the United
7 States, of restrictive dealing arrangements with dental
8 laboratory distributors. The trial of that case this spring lasted
9 three weeks, and we have closing arguments
10 scheduled for September 20.
11 In that case, we're challenging two exclusive dealing
12 practices by Dentsply, which has an 80 percent share of the artificial
13 tooth market in the U.S. and sells all of its teeth to dealers. Under
14 Dentsply's Dealer Criterion No. 6, if a dealer
15 selling Dentsply teeth begins selling a competitive brand, Dentsply
16 pulls its teeth from that dealer. (I'm sorry, I couldn't resist!) In
17 addition, Dentsply has a practice of
18 requiring new dealers to drop some or all competitive
19 brands in order to take on Dentsply's teeth in the
20 first place.
21 Now, there are several important legal
22 issues presented by this case and I will just highlight
23 two for you: One issue is whether exclusive dealing
24 arrangements that are, as a technical matter, terminable-at-will can
25 nevertheless cause anticompetitive effects in the market. Dentsply

1 sells its teeth to dealers on a purchase order basis, and there is no
2 express duration to their agreements. Yet, as a practical matter,
3 these agreements have been perpetual in length because no dealer has
4 been willing to give up substantial Dentsply tooth business to add a
5 rival tooth brand. Dentsply's policy, then, presents dealers with an
6 all-or-nothing proposition: if you add competitive brands, you will
7 lose all of your Dentsply business. Given the 80 percent market share,
8 that choice has been an easy one for dealers in the last 15 years
9 During that time, while some had expressed an interest
10 in adding rival tooth brands, none has done so.
11 Another issue in this case relates to the
12 importance of a traditional proxy used by courts in
13 assessing exclusive dealing arrangements. Traditionally,
14 courts have examined such factors as the duration of the
15 agreement and amount of foreclosure and we believe we
16 have strong evidence to support that these factors in
17 our case support a violation. But we also have direct
18 evidence, from a variety of sources, of the actual
19 anticompetitive effects of these practices, that is
20 evidence that the practices have substantially reduced
21 competition and consumer choice, deterred entry, and increased prices.
22 And that evidence we are arguing, ought to be enough for us to prevail
23 in this case. We are optimistic that the evidence we presented will
24 result in a finding of liability, enabling us to restore competition in
25 this market for the benefit of

1 consumers.

2 Now, our significant attention to the areas of

3 health insurance and health care products should not be

4 taken as an indication that the Division will in any way ignore

5 issues in provider markets. While we believe our focus

6 on health insurance is complementary to the FTC's

7 increased commitment to enforcement in provider markets,

8 we will continue to use our expertise regarding

9 providers to open investigations and take action where

10 appropriate. Currently the Division is pursuing a number of

11 health care matters focused on provider conduct,

12 including a number that we have opened in recent months.

13 Litigation I will continue to focus heavily on

14 horizontal activity. For example, in *United States versus Federation*

15 *of Physicians and Dentists*, we are in the process of

16 securing entry of a stringent consent decree that would

17 put an end to illegal collective action under taken by

18 orthopedic surgeons in private practice through their

19 membership in a professional union operating nationwide.

20 In that case, we have alleged that the

21 Federation had recruited nearly all of the private practice

22 orthopedic surgeons in Delaware as members, who then agreed to

23 designate the Federation's executive director as their agent to

24 negotiate the fee levels they would accept from Blue Cross/Blue Shield

25 of Delaware. When Blue Cross declined to negotiate with the doctors

1 through the Federation, the Federation and others persuaded the doctors
2 to deal with Blue Cross only through the
3 Federation and ultimately organized nearly all of its
4 member orthopedists to terminate their contracts with
5 Blue Cross in the belief that the action would force
6 Blue Cross to accede to their fee demands.
7 The proposed consent decree is nationwide in
8 scope and prohibits the Federation from participating
9 in, encouraging, or facilitating any agreement or
10 understanding between competing physicians or from
11 negotiating on behalf of competing physicians about any
12 payer contract or contract term -- activities that if
13 undertaken would force health plans to pay increased
14 fees.
15 We continue to investigate other allegations
16 that professionals in various markets are using
17 seemingly legitimate joint conduct as a pretext for
18 collusion. Over the past several months, we've been
19 conducting an investigation into a physician-owned joint
20 venture that provides a multipractice network of
21 physicians to health care payers in a substantial urban
22 area. The network began operating in 1995 and now has
23 several hundred physician members representing over 90
24 percent of the physicians practicing in this market.
25 We have also opened an inquiry into a hospital network, and

1 we are reviewing a hospital joint operating agreement in
2 another instance of physician collective bargaining,
3 just to give you the flavor of some of the things we
4 have before us.
5 It must be recognized that if, in our scrutiny of
6 horizontal conduct, we discover health care businesses
7 that cross the line to engage in explicit collusive
8 arrangements regarding fees or market allocation, we
9 will consider prosecuting criminally. In this regard,
10 we have strengthened our liaison relationship with the Federal Trade
11 Commission recently so that FTC staff who uncover evidence of such
12 explicit agreements when they are doing their own investigations can
13 quickly bring the evidence to the attention of our staff in the
14 National Criminal Enforcement Section here in
15 Washington.
16 I would just like to say a few words on the
17 procedural front and highlight our merger review process
18 for a moment. Assistant Attorney General Charles James
19 has made it a top priority to make our merger review
20 process more efficient and manageable for the Division
21 and for all parties in all industries, including the
22 health care sector. The effort began with the
23 announcement of our Merger Process Review Initiative in
24 which we established a number of methods for making
25 initial waiting periods more productive, as well as

1 streamlining both the Second Requests that are issued and the staff's
2 assembling and analysis of information. The procedures outlined in
3 this Initiative are designed to encourage our staff and the merging
4 parties to move more quickly to identify critical legal and economic
5 issues regarding proposed mergers, to
6 facilitate a more efficient and more focused
7 investigative process, and to provide for a more effective
8 process for reaching conclusions based on an evaluation
9 of evidence. While the dearth of merger activity has led to
10 only limited experimentation with this Initiative, the
11 early feedback both from staff and from parties has been
12 quite positive, and I encourage all parties to continue
13 working cooperatively with us through this initiative.
14 In closing, I want to emphasize that the
15 Division intends to closely monitoring and, where
16 appropriate, take enforcement action in this vitally
17 important health care sector of the economy. In doing
18 so, we expect to give greater attention than we
19 traditionally have given to the area of health care
20 insurance. At the same time, though, we will maintain
21 flexibility to enable us to adapt our enforcement focus
22 to any significant anticompetitive activities that arise
23 in this industry. Using our strong expertise, and in
24 partnership with the FTC, we intend to work to ensure a competitive
25 health care marketplace for consumers.

1 Thank you very much.
2 (Applause.)
3 MR. HYMAN: A couple of logistical
4 announcements and then I'll introduce the last speaker
5 before lunch. First, all of the materials that were
6 referenced by the heads of various bureaus are included
7 in the photocopied tan-colored book of which there are
8 copies outside of each of the rooms in which this workshop
9 is being held. We are also going to put together a relatively easily
10 accessible set of all of those things on our website.
11 So, if you're interested in getting more details on any of those
12 enforcement actions, or any of the papers, those will be easy to find
13 on the workshop
14 website.
15 Second is there will be a transcript of this
16 entire session that will be posted on the website as
17 well.
18 Third, for those who prefer moving pictures, you
19 can purchase a video, once that gets processed. The slides that people
20 have been showing will also be posted on the website after the workshop
21 is completely over. If you check in about a week, all of them should
22 be up.
23 Fourth, lunch lasts from 12:35 until about 2:00.
24 We are planning to start promptly again at 2:00 and we
25 will begin panel discussions, the subjects of which are

1 outlined in the agenda.

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

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

11 Now, we figured it would tax the patience of a
12 saint to bring in all 50 of the State Attorneys General
13 or at least representatives and so we instead picked one
14 who will offer a broader perspective. We're very lucky
15 to have Ellen Cooper, who is an Assistant Attorney
16 General and the Chief of the Maryland Antitrust
17 Division. She's also the Chair of the Health Care
18 Working Group of the Multistate Antitrust Task Force of
19 the National Association of Attorneys General, so she
20 will be able to, in one ten-minute session, give you a
21 50-state perspective on health care and competition
22 policy.

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

25 It's an honor to be here today representing the

1 State Attorneys General in this very important and
2 timely workshop. Before I get started, I have to say
3 that the views that I express are my own and not those
4 of any state attorney general or the Attorney General of
5 Maryland.
6 I would also like to thank my colleagues, Bob
7 Hubbard from New York, Kevin O'Connor from Wisconsin and
8 Meredith Andrus from Maryland in their help for my
9 preparation for these remarks.
10 First, let me give you some context before
11 describing some recent state health care antitrust
12 initiatives. State attorneys general tend to
13 concentrate their antitrust enforcement resources on
14 problems that profoundly affect consumers within the
15 state or that disproportionately impact the state's
16 general social and economic welfare. Providing
17 affordable health care to citizens in both urban and
18 rural areas is a problem that meet both criteria.
19 Also, the activities of health care providers
20 like hospitals, physicians, home health agencies and
21 ambulance companies are often local in nature, affecting
22 only a single region of the state, or a single
23 metropolitan area. For this reason, federal agencies
24 may not wish to devote resources to the matter.
25 The attorneys general, in contrast, may be

1 particularly competent to analyze competitive conditions
2 in local markets, and also particularly motivated to do
3 so. Many state attorneys general have expressly
4 articulated health care issues as an antitrust
5 enforcement priority. However, attorneys general have
6 responsibilities, and this is the context part, that are
7 much broader than antitrust enforcement.

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

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

23 Despite these often conflicting roles, the
24 attorneys general of the majority of states have
25 antitrust divisions more and more often headed by career

1 antitrust enforcers that approach antitrust
2 investigations in a systematic, professional and highly
3 confident way.
4 Currently, the primary focus of the states is
5 the pharmaceutical industry. In a series of multistate
6 cases, some prosecuted in cooperation with the FTC, and
7 some litigated with private class action counsel, the
8 states have sued both brand name and generic drug
9 manufacturers.
10 In Mylan Laboratories, the states and the FTC
11 sued a generic drug manufacturer for tying up the supply
12 of chemicals of two antianxiety drugs needed by other
13 generic manufacturers to compete by entering into
14 exclusive contracts with these suppliers.
15 In a $100 million settlement negotiated by the
16 states and the FTC, jointly, encompassing all 50 states
17 and the FTC, the FTC obtained disgorgement. The
18 states were able to ensure, by working with chain
19 pharmacies, that an unusually high number of affected
20 consumers were able to recover monetary relief, ranging
21 from $200 to $2,000, depending upon the length of time
22 that they purchased the two drugs.
23 At the present time, various combinations of
24 states are challenging the practices of major
25 pharmaceutical companies related to extensions of their

1 patents on the following drugs: Cardizem CD, Hytrin,
2 K-Dur 20, Taxol and Buspar. The specific acts
3 complained of vary.
4 In some cases, like Cardizem CD, the states
5 challenged the settlement of a patent infringement case
6 brought pursuant to the Hatch-Waxman Act. In other
7 cases, like Taxol, the states have claimed fraud on the
8 patent office. Each case is unique, but I would like to
9 use Taxol as an example of a current state initiative.
10 Taxol, as you may know, is a chemotherapy drug
11 developed by the National Cancer Institute of the
12 National Institutes of Health. NIH entered into a
13 statutory research and development agreement with
14 Bristol-Meyers Squibb which allowed Bristol to market
15 Taxol exclusively for five years without patent
16 protection, after which time generic entry was expected.
17 According to the states' complaint, notwithstanding this
18 arrangement, Bristol applied for and obtained a method
19 of use patent failing to disclose several material
20 publications to the PTO.
21 The states contend that this fraudulently
22 obtained patent maintained Bristol's monopoly and
23 precluded generic entry. Most of the patents' claims
24 have subsequently been declared invalid and
25 unenforceable. Two claims are still in litigation.

1 Bristol also agreed to list in the FDA Orange
2 Book a patent owned by a competing generic company,
3 American Bioscience, Inc., ABI, which further delayed
4 generic entry into the market for packs of Taxol. ABI's
5 patent was later declared invalid. The Taxol case is
6 now entering the discovery phase.
7 More than simply looking at pricing problems in
8 the pharmaceutical industry in antitrust terms, the
9 attorneys general through the National Association of
10 Attorneys General, have created a pharmaceutical pricing
11 task force to address issues of cost and access as well
12 as how to redress collusion, fraud, and misinformation
13 through litigation, legislation, and education.
14 Most antitrust violations affecting health care
15 are local, though, and they are not amenable to
16 multistate litigation. A number of states have stayed
17 extremely active in protecting competition in local
18 health care markets. Just looking at matters over the
19 past few years, I found continued interest by state
20 attorneys general in continuing to review the
21 consolidation of hospitals and other kinds of providers
22 through merger and joint venture.
23 For example, in Connecticut versus American
24 Medical Response, the state settled with an ambulance
25 company by requiring it to divest ambulance licenses to

1 competitors, to sell ambulances at market prices and to
2 give up rights to certain primary service areas to
3 rectify concentration in the market caused by a series
4 of acquisitions. California challenged Sutter Health
5 System's acquisition of Summit Medical Center after the
6 FTC investigated and decided not to challenge the
7 transaction. Unfortunately, California was ultimately
8 unsuccessful, failing to prove a relevant geographic
9 market to the judge's satisfaction.
10 Other states that have actively reviewed
11 hospital physician and clinic mergers in the past few
12 years include Pennsylvania and Wisconsin, both of which
13 have crafted consent agreements that allow the
14 transaction to proceed, but placed restrictions on the
15 merged entity's future conduct. Such restrictions
16 usually characterized as regulatory by detractors and
17 creative by proponents typically require the new entry
18 to pass along to consumers cost savings from
19 efficiencies claimed from the merger and to maintain an
20 open hospital staff and finally to refrain from tying
21 certain services or acting in a discriminatory way.
22 Attorneys general generally appear more amenable
23 to reaching resolutions that they perceive to be in the
24 public interest. It may be for this same reason that
25 many offices resolve health care issues informally.

1 Instead or in addition to taking a litigation route, the
2 attorneys general may analyze market conditions and
3 report to the legislature or to an administrative or
4 executive agency.
5 In 2002, the Massachusetts Attorney General
6 issued a report to the legislature on the Springfield
7 health care market and the Arizona Attorney General
8 issued a report on prescription drug prices, for
9 example. However, price fixing remains a core concern
10 of the attorneys general.
11 In New York versus St. Francis Hospital, New
12 York successfully challenged the joint negotiations of
13 managed care contracts and allocation of services by two
14 hospitals in Poughkeepsie. The court ruled that the
15 hospital's joint negotiations were per se price fixing
16 agreements and the allocation of services were
17 horizontal market allocation agreements also per se
18 illegal. Interestingly, the hospitals tried to claim the
19 state action defense, which the court found was not valid
20 because state supervision was missing.
21 In addition to litigating cases, attorneys
22 general issue opinions. My own office in Maryland has a
23 board review program which advocates that licensing
24 board regulations be as procompetitive as possible,
25 commensurate with the board's mission to protect

1 consumers.
2 And since I'm out of time, I'm going to say,
3 finally, looking to the future, I believe that the State
4 Attorneys General will continue to focus on
5 pharmaceutical pricing issues, bringing cases under
6 antitrust, consumer protection, and fraud statutes.
7 Indeed, additional states may join Texas, Nevada,
8 Minnesota, and California in bringing or joining AWP
9 lawsuits based on various state statutory and common law
10 theories. However, continued consolidation in the
11 health care industry is certain to remain a concern, and
12 traditional core concerns about price fixing and other,
13 per se, antitrust violations are unlikely to diminish.
14 Thank you.
15 (Applause.)
16 MR. HYMAN: We'll continue commencing at 2:00.
17 (Whereupon, at 12:40 p.m., a lunch recess was taken.)
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20
21
22 AFTERNOON SESSION
23 MR. HYMAN: Thank you all for returning from
24 lunch. Our afternoon session will be two panels. I want
25 to begin by introducing Commissioner Sheila Anthony of

1 the Federal Trade Commission who will have some brief
2 remarks.
3 COMMISSIONER ANTHONY: Thank you, David, and
4 thank you for all of your hard work in organizing this
5 very important workshop. Throughout my five years as
6 FTC Commissioner, I've often predicted that tackling
7 health related competition and consumer protection
8 issues would be the Commission's greatest accomplishment
9 during my tenure.
10 As my term comes to a close, I think that
11 prediction has come true. I'm extremely proud of our
12 enforcement efforts, although we've had some disappointments in the
13 hospital merger area. We have really done our best, I think, for the
14 American public, especially in pharmaceutical cases relating to generic
15 drug competition. These cases have saved American consumers literally
16 millions of dollars.
17 As you've heard from our Chairman and our three
18 bureau directors this morning, we certainly aren't
19 resting on our laurels. Our health care agenda remains
20 full and varied. Given the Commission's broad
21 jurisdiction over many sectors of our economy, sometimes
22 our enforcement actions involve products and services
23 that seem esoteric or irrelevant to the average
24 American. In contrast, health care is something that
25 affects all of our lives and those of our loved ones.

1 When I talk to my family and friends about their
2 greatest economic concerns, you can bet that health care
3 is always at the top or near the top of their list,
4 Budgeting for increasingly expensive drug products,
5 securing a timely appointment with an over-booked
6 specialist, getting enough of a doctor's time to really
7 discuss a diagnosis or a proposed treatment, dealing
8 with the endless, health insurance paperwork
9 -- well, you and your parents have been there, and you
10 know what I'm talking about.
11 I'm assuming that we, in this room, are among
12 the lucky ones. We take for granted our access to
13 quality health care, our very ability to participate in
14 the health care system. For those uninsured Americans
15 who can barely afford basic care for themselves and
16 their families, and whose savings could be wiped out by a
17 major illness, the roster of concerns is even more
18 fundamental and frightening.
19 In short, while the American health care system
20 is, in many respects, the envy of the world, it is, by
21 far, not perfect. The many problems are too complex for
22 one discipline to solve alone.
23 In this building, the relevant question is, how
24 can the Commission encourage the use of competition
25 principles to improve the delivery of health care and

1 keep the health care market itself healthy? I'm quite hopeful that this
2 workshop will help focus the discussion and encourage a dialogue among
3 all interested parties.
4 As our work progresses, perhaps we'll be able to
5 find some answers. However, some relevant topics are
6 beyond the Commission's authority and beyond the scope
7 of this workshop.
8 For example, a doctor friend of mine, whom I
9 asked to review our proposed agenda, expressed regret
10 that the Commission couldn't do something about
11 Medicare, which accounts for a huge percentage of all
12 health care expenditures. Well, I have to admit, I'm relieved that we
13 can leave the Medicare reform to other parties. Personally, I do
14 remain very interested in consumer protection issues relating to
15 dietary supplements, weight loss products
16 and over-the-counter remedies, and I hope the Commission
17 will remain vigilant in those areas.
18 Having said that, the most critical health care
19 issues will be covered over the next day and a half, and
20 I look forward to a tremendous learning opportunity for
21 us all.
22 And now I turn the microphone over to the moderator
23 of this afternoon's panel, John Wiegand. John's a
24 senior antitrust attorney in the FTC's San Francisco
25 office. In his 14 years with the Commission he's

1 handled a variety of health care matters, including
2 mergers of hospitals, health plans and physician
3 practices. In addition, he's led investigations into
4 horizontal collusion among hospitals and among
5 physicians.
6 John?
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22 Panel 1, Health Care Services, Provider Integration
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24 Panel Members
25 Dr. Ellen Burkett, MedSouth

1 Henry R. Desmarais, Health Insurance Association of
2 America
3 Stuart Fine, Grand View Hospital
4 Warren Greenberg, George Washington University
5 Catherine Hanson, California Medical Association
6 Stephanie Kanwit, American Association Of Health Plans
7 Joe Wiegand, Federal Trade Commission, Moderator
8
9 MR. WIEGAND: Thank you, Commissioner Anthony.
10 The first panel will address the subject of provider
11 integration, and our first member of the panel is Ellen
12 Burkett from MedSouth in the Denver area. Ellen?
13 MS. BURKETT: Thank you. Just so you know, I'm
14 a little outnumbered here. I'm not an economist. I'm
15 not an attorney. I'm actually a practicing physician.
16 I'm the clinical director and vice president of
17 MedSouth, which is a physician group in the Denver area.
18 You've already heard about Denver.
19 Three of the five decisions this year were about
20 Denver, and I would reassure you that our group has been
21
22 working on our project for about three years.
23 Antecedent to some of these decisions, we've been
24 working very hard to find a way to do it the right way.
25 Our physician group has been in existence about

1 six years and reinvented itself about three years ago
2 with the idea that capitation was not the right way to do business for
3 physicians. So we looked for another way to do business, and I think
4 there are several ways that have been mentioned today.
5 We grasped the one that was probably the brass ring,
6 which is clinical integration. We are, as somebody described us in
7 their handout, the unicorn. I've also been described as Joan of Arc.
8 You know how both of these people ended up.
9 So we are still working on our project and
10 wanted to tell you a little about what we've done. We
11 have currently 315 physicians. About a third of those
12 are primary care physicians. We are physicians that are
13 in the south end of Denver, which strangely enough all
14 of the other FTC decisions that were done were in that
15 similar area or nearby. So we have been kind of under
16 the microscope, as everyone else has been in the south
17 area of Denver.
18 We have two competing hospital systems in Denver, that
19 currently have three hospitals. Sometime in the next two to three
20 years, they'll be five hospitals but two systems. We've undergone many
21 of the things that have been described here this morning, the hospital
22 consolidation, the health plan consolidation.
23 We have had a massive physician exodus from the
24 Denver area. It's very hard to recruit physicians in
25 to the Denver area because of the situation. We've

1 also had specialty groups forming and building separate
2 facilities. We've had all of those issues sort of going
3 on at the same time that we've been working on this
4 project.
5 We've had two partners, Quest Labs, which is a
6 national lab company, and MedPlus, which is a software
7 company. Those companies came to us to be their beta
8 site for this project and gave us the ability, I think,
9 to accomplish what we've done so far.
10 We have actually created a plan that does, we
11 think, the best job so far, which is the only job so far
12 presented to the FTC, in doing both clinical and
13 technology integration for our group. The clinical arm
14 uses clinical guidelines. These have been taken from
15 national guidelines, and they've been truncated and
16 measures added and benchmarks added, and those are
17 electronically available to the physicians, and the
18 physicians have signed physician agreements, which they
19
20 are accountable for the guidelines which pertain to them
21 in their specialty.
22 They've had to sign off of them, and they all
23 know they're responsible and accountable for how those
24 guidelines are going to be measured.
25 The technology arm is a large data repository

1 that's been created for our physician group, and data's
2 already been going in for about a year and a half now.
3 It's going to be ongoing historical data. It currently
4 shares labs and radiology, and we're working on adding
5 prescription information, hospital information and some
6 of the other pieces that go into the system.
7 We are not contracting as of yet. I'm sure lots
8 of people have questions about how we're doing. We're
9 not contracting yet. It's like a mine field. The FTC
10 reviewed our proposal in June of 2001, and we got the
11 answer back in 2002, and it was basically a yellow
12 light, and I think that was an appropriate response.
13 I think they made a thoughtful review of our
14 game plan, and to be real honest, those of you who
15 haven't seen it, it's very ambitious. I think it
16 encompasses a lot of things that we intend to do, but we
17 need to be fully and completely implemented before we
18 begin to contract.
19 I will say that we've met with some of the
20
21 health plans in the Denver area and have been met with a
22 very positive response. I think the health plans in our
23 area are interested in the physicians taking back some
24 of the responsibility for taking care of patients, and I
25 think that's one of the things that this health plan or

1 our clinical integration program does.
2 We see that there's benefits for the patients,
3 for the health plans and for the providers, all for
4 different reasons, but much of it revolves around the
5 ability to share the information that we use for patient
6 care.
7 I think what brought 315 physicians with us,
8 despite the fact that this was an extensive amount of
9 money, time and energy on our part, was that this was a
10 program that was patient-centric. It's not health plan
11 centric. It really revolves around how to better take
12 care of patients, and that's sort of the basis of why we
13 practice medicine.
14 We want to take better care of patients, and the
15 ability to do that has been hampered a bit by our lack
16 of technology. Most physicians, as we found out three
17 years ago, either didn't have a computer in their office
18 or only had a computer for electronic billing.
19 Part of this program is that every physician has
20 the link. Every physician has a computer. Everybody
21
22 has an Internet connection. We all are linked, and we
23 have the ability to communicate with each other and
24 share information.
25 The health plans really like this idea. We are

1 giving them a group of physicians who agreed, across the
2 board, to follow national guidelines, follow an
3 excellence of care pattern that we've established for
4 our community, and we are able to communicate amongst
5 each other about how we're doing, report back. We're
6 accountable, and so I think the health plans are in
7 favor of us doing this, at least in our area.
8 I think one of the concerns we have is we have
9 not yet gone out to contract because we want to be fully
10 implemented to do that. What we met with when we talked
11 and what we meet with when we go to contract may be two
12 different things. We hope not, but we will have to wait
13 to see.
14 Another concern of ours is we have a very
15 ambitious, complex plan. Our concern is that other
16 groups nationally may try to say, Well, we can Email
17 each other, therefore we're clinically integrated or
18 something not quite as ambitious, and that this could
19 sort of taint the atmosphere in the national community
20 for what clinical integration could do for physicians.
21 I think another issue that I would have is that
22
23 the burden of proof for us as a group on whether or not
24 we're improving quality is one that's going to be
25 difficult, and I think we can show some efficiencies,

1 but much of what we're doing to improve quality are
2 long-term issues. At least in the Denver area, the
3 turnover for patients is about every two years, they
4 change health plans.
5 For me to sell a health plan, I need to be able
6 to show that we're going to give some long-term benefits
7 to their patients for their diabetes, for their
8 prevention of cancer, those kind of things, so I think
9 that's an issue. That burden of proof that rests on us
10 for quality oftentimes will be long-term issues rather
11 than short-term, Are we going to do one less blood test
12 or one less x-ray.
13 I think probably the most basic, and I'll end
14 with this, is that this has been a very costly and time
15 consuming project for our physicians. We've worked on
16 this for three years. Basically we were told by the
17 FTC, and I'm sure there's people here looking for their
18 other IPAs to sort of start this road, during that
19 period we were asked not to do any contracting.
20 So for three years we've sat on some relatively
21 dismal contracts for physicians, and I think what has
22 been the best -- I mean, we went with 400 physicians,
23
24 and we've ended up with 315 physicians when the dust has
25 cleared, is that the physicians see that this is a

1 patient-centric program.

2 It really will improve the quality, and the

3 information sharing amongst physicians, which will

4 benefit patients and I think secondarily benefit the

5 health plans, but it was very costly and time

6 consuming. This was a pretty long haul for us all.

7 So when other groups are looking at this,

8 whether they approach the FTC or not, I think the

9 point is that if they have a game plan that's as complex and

10 ambitious as ours, it will take them some time and energy and

11 money to do this.

12 MR. WIEGAND: Thank you. Our next speaker is

13 Henry Desmarais from the Health Insurance Association of

14 America. Henry?

15 MR. DESMARAIS: Thank you very much. I'm

16 pleased to be here on behalf of HIAA. Our members

17 provide the full range of health insurance products to

18 over a hundred million Americans.

19 I would like to, in the interest of full

20 disclosure given the topic, to say that I am a physician

21 by training, although for the last 24 years, my

22 specialty has been health policy, and I've been working

23 in both the public and private sectors.

24

25 I would like to start by stating that HIAA has

1 been generally supportive of the statements of antitrust
2 enforcement policy in health care that were issued by
3 the Department of Justice and the Federal Trade
4 Commission.
5 However, we still remain somewhat concerned
6 about the implications of the MedSouth decision.
7 Clearly, the FTC staff broke new ground in issuing the
8 advisory opinion because MedSouth is going to be
9 clinically integrated and not a risk sharing joint
10 venture.
11 Now, both the FTC staff and individual
12 commissioners have certainly indicated that they recognize
13 the uncertainties and difficulties that exist in
14 determining if this new model is going to function as its
15 proposed.
16 We think there's three major challenges that are
17 faced in making that determination. First, in terms of
18 changing practice patterns, it does clearly require an
19 ongoing commitment of time, effort and expertise, and
20 it's going to be difficult to accomplish.
21 Whether the expected clinical efficiencies are
22 achieved is going to be difficult to determine in
23 evaluating the patient population. As you just heard,
24 they have a variety of specialties, and they're going to
25

1 be dealing with a whole range of health conditions.
2 Secondly, the efficiency enhancing integration
3 does establish goals that are important and make sense,
4 but Commissioner Thomas Leary himself said: "Those who
5 provide the best product are able to charge more for
6 it. They can charge a quality premium, so in the case
7 of MedSouth, if rates go up, how will we know if that's
8 the quality premium or a result of anti-competitive
9 practices?"
10 It really is not clear exactly how the
11 Commission is going to be able to determine whether
12 efficiencies have indeed been achieved that allowed them
13 to issue the advisory opinion in the sense of balancing
14 likely anti-competitive effects.
15 Thirdly, in terms of antitrust law, the issue is
16 going to rest on whether the arrangement, the network,
17 remains nonexclusive. Again the FTC staff has
18 already anticipated that in the advisory opinion, to
19 quote from it, "health plans appear to be vulnerable to
20 a threat by the group's members not to contract outside
21 the group unless the plans pay higher than prevailing
22 fees."
23 So again the issue is going to be with the large
24 number of physicians in MedSouth to be able to determine
25 whether it truly is a nonexclusive kind of situation,

1 and certainly as we've heard earlier today, there have
2 been now three consent agreements in the Denver area
3 itself, so the fact that we have a heightened
4 sensitivity about the potential implications of this I
5 think is certainly warranted.
6 Throughout the advisory opinion, the Commission
7 staff states that at this early point in time and based
8 on the information, they weren't going to make any
9 enforcement action recommendations, but they did imply
10 that they were planning to reevaluate based on the Rule
11 of Reason after MedSouth was operational.
12 Now, what we're hoping is that, in fact, there
13 will be a rigorous review and not simply waiting for
14 complaints to emerge. Again, Commissioner Leary has
15 himself said that complaints shouldn't be the only
16 vehicle here for monitoring the situation as it
17 continues to evolve.
18 What we're hoping is given the degree of
19 information systems that they're obviously putting into
20 place in MedSouth that they will be easily in a position
21 to provide information that the Commission staff might
22 find useful in continuing to monitor the situation.
23 A greater concern of ours is that while the
24 Commission's opinion, the advisory opinion, is the
25 problem that this could, in fact, cause other groups

1 simply to attempt to put in place an identical or a very
2 similar undertaking without the need to seek any kind of
3 review here at the Federal Trade Commission or any kind
4 of advance approval. We believe ideally there would be
5 more of a notification and some upfront scrutiny if, in fact, other
6 groups are going to allege that they are now using the MedSouth model
7 to put in place their own systems.
8 Now, this may require new legislative authority,
9 but I think it is again an issue that before too long we
10 could find a number of what I would call copycat groups
11 that again might not, in fact, satisfy the level of
12 integration that MedSouth is clearly trying to
13 accomplish.
14 Let me close by saying that we appreciate the
15 opportunity to participate in this workshop, and we look
16 forward to working with the Commission and the
17 Department of Justice, and we may, in fact, wish to
18 submit some additional written comments by the September
19 30th deadline. Thank you very much.
20 MR. WIEGAND: Thank you. Our next panelist is
21 Stuart Fine from Grand View Hospital in suburban
22 Philadelphia, Pennsylvania.
23 MR. FINE: Thank you. I'm located about 45
24 miles north of Philadelphia, due south of the Allentown
25

1 market, and just to give you a feel for the market
2 within which we operate, we have approximately 100
3 hospitals located within 60 minutes driving time of our
4 facility, so when we start talking about market power,
5 the impact of mergers, we have to look at many, many
6 things that come into play in a given market.
7 Again in our market, which is the one with which
8 I'm certainly most familiar, although I'm here today
9 representing the hospital community in the American
10 Hospital Association, we have the Thomas Jefferson
11 University Health System, which has nine member
12 institutions. We have the University of Pennsylvania
13 with its five affiliates. Tenet came into the market
14 following the demise of the Allegheny Health System. I
15 believe Tenet is now operating five institutions.
16 Five years ago there were no for-profit
17 institutions in our market operating general hospitals.
18 We now have approximately 11 percent for-profit market
19 share in Philadelphia, so things are very dynamic where
20 we're located and again very unique. If you look at one
21 hospital market, you've seen one hospital market.
22 We also have an unusual situation when it comes
23 to the third-party payors, in that we have what I, as a
24 non economist, would consider to be at least a duopsony,
25 if not a monopsony, with Aetna and an independent

1 BlueCross being the predominant payors outside of the
2 government.
3 At my hospital, we have approximately 50 percent
4 Medicare/Medical assistance market share. We have 67
5 percent of the remaining market share with BlueCross.
6 We have a situation where when you want to integrate
7 with another payor, or excuse me, with another provider,
8 we also have to contend with the Stark Rules. We have
9 Medicare fraud and abuse implications that actually need
10 to be looked at first and probably in most cases more
11 critically than some of the antitrust regulations.
12 They're harder for us to contend with at the
13 hospital level. We are severely and strictly limited as
14 to what we can do in cooperating and doing joint
15 ventures with other physicians and other providers in
16 our community. We have had some experience and some
17 success with integration. We've also had some failures
18 at Grand View Hospital.
19 On the success side, we have joined with 11
20 other hospitals to form a professional liability
21 insurance captive that has allowed us to continue to
22 access the professional liability insurance markets
23 where many of the hospitals and a very large number of
24 physicians in our market are not having that same level
25 of success.

1 Although our costs for professional liability
2 insurance went up 50 percent last year from $2 million to
3 $3 million, and although in the 89 year history of our
4 hospital we've never had a court judgment against it,
5 hospitals around us are seeing even greater increases in
6 their costs for professional liability insurance. Those
7 are costs that generally need to be absorbed by the
8 hospital since we have multi year provider contracts
9 with the different payors.
10 When we look at other more clinically oriented
11 things we were part of something called Penn Care.
12 Twelve hospitals that came together to accept risk with
13 one of the large payors that was trying to break in to
14 the Allentown market and had not been able to do so in
15 order to get a contract with some of the hospitals in
16 that area agreed to a risk sharing agreement where we
17 assumed risk for, at its peak, 110,000 covered lives.
18 We relied on the payor to provide us with
19 certain back office functions, and according to that
20 payor, we were doing tremendously well and operating
21 very profitably until they discovered a $13 million
22 accounting error that put us $11 million into the red.
23 We are now trying to figure how to unravel Penn
24 Care and how we can approach our medical staff members
25 from our hospitals in the future to talk about clinical

1 integration or integrating for business reasons and have
2 them not shy away, given the terrible result of the Penn
3 Care experiment.
4 We do partner with specialty hospitals in the
5 city of Philadelphia. We have the Children's Hospital
6 of Philadelphia at Grand View where they operate our inpatient
7 pediatric unit in a partnership with us, and we have pediatric
8 hospitals available in our community now 24 hours a day.
9 We lose money on that type of a venture, but
10 qualitatively, it's something that we felt was called
11 for and certainly benefits our community. We do not
12 receive the same payment rates that a Children's
13 Hospital would receive in Philadelphia, but we do, as I
14 say, help to fulfill our mission, especially given the
15 fact that in the suburbs, we're ten miles away from the
16 closest public transportation depot.
17 So out in our area, if you can't get your health
18 care locally, it's quite an inconvenience, although as I
19 said we have a hundred hospitals within 60 minutes
20 driving time, but you have to have a car.
21 Speaking about mergers generally, in the
22 Philadelphia market, mergers can be very beneficial.
23 Qualitatively there are tremendous improvements and
24 enhancements to be realized. I would hope that the FTC
25

1 will look not only at the cost savings issues but the
2 qualitative issues and work with health care providers
3 and academics to try to determine what those measures
4 should be.
5 Again in closing, the fraud and abuse Stark
6 regulations are the things with which hospitals have the
7 most difficulty contending. It is not at least
8 currently the antitrust provisions with which we're
9 asked to deal.
10 MR. WIEGAND: Thank you. Our next speaker is
11 Warren Greenberg from George Washington University
12 School of Public Health.
13 MR. GREENBERG: Let's look outside the health
14 care sector. It is 86 percent of the GDP, and for a
15 long time, the subject of this panel now is
16 integration. For a long time outside of the health care
17 sector, we've had a long history of vertical
18 integration, a linking of buyer and supplier
19 relationships such as in the petroleum industry where
20 large refineries such as Mobil and Exxon bought their own retail gas
21 stations and were subject, as a matter of fact, with six refineries to
22 a major suit brought by the FTC in 1973.
23 Firms have also had, outside of the health care
24 industry Per Se, and perhaps in the pharmaceutical
25

1 industry, firms have also had a long history of
2 horizontal integration. Mergers of basically the same
3 product such as in the pharmaceuticals, way before the
4 attention being paid today, were firms such as Warner
5 Lambert and Park Davis had merged and been subject to
6 FTC investigation.
7 My subject today, of course, is on health
8 services, and I would like to focus on vertical
9 integration in health services. I would like to say
10 that vertical integration, although we have a couple
11 panelists talking about physician involvement with
12 hospitals, that would also be included, but also
13 hospitals and HMOs, physicians and hospitals and HMOs or
14 any combination thereof, including long-term care
15 facilities.
16 These arrangements have mostly occurred over the
17 last 25 years, in large part because the more
18 competitive health care sector has forced firms to be
19 more efficient or look for alternative ways to achieve
20 greater revenues such as through monopoly power
21 arrangements.
22 Thus, the reasons for integration in the health
23 care sector are the same as outside the health care
24 sector, to realize lower costs, to realize higher
25 profits or prices or some combination of the two. Improvements in

1 quality care may also be a motive.

2 In a recently published paper the determinants

3 of hospital and HMO vertically integrated systems, we

4 found, using American Hospital Association data, that

5 hospitals integrated with HMOs when they had a higher

6 market share and a greater bargaining power to purchase

7 HMOs much more cheaply.

8 The modus for integration could be to reduce

9 transaction costs of hospitals attracting patients from

10 a large number of HMOs in order to primarily transact

11 with one HMO or fewer HMOs in order to achieve a

12 more dependable flow of patients, a lower average cost

13 and to reduce uncertainty.

14 We also found that hospitals, which have lower

15 occupancy rates also tended to merge, to increase the

16 number of occupied beds and achieve some economies of

17 scale from contracting with a single HMO or integrating

18 with a single HMO.

19 We also found that vertically integrated

20 systems, as we heard before, do not always work as

21 hospitals would want them to, and for example in 1997,

22 there were 353 hospital mergers with HMOs, yet 330

23 vertically integrated systems dissolved. There's been a

24 slight decline in vertical integration. In 1994, there

25 were 748 hospital HMO integrated systems compared to

1 353 in our 1997 data.
2 Getting back to antitrust and vertical
3 integration, BlueCross/BlueShield versus Marshfield
4 Clinic in 1994, there was ample evidence to suggest that
5 the vertical integration between the physician group,
6 the Marshfield Clinic, 500 physicians, the St. Joseph's
7 tertiary care hospital, a monopoly teaching hospital in
8 the relevant market and Marshfield Clinics HMO called
9 Security HMO created significant barriers to entry for
10 independent physicians and led to monopoly power of
11 Marshfield Clinic physicians.
12 Hospital staff privileges were not provided to
13 non Marshfield clinic physicians at the St. Joseph's
14 teaching hospital and its three smaller affiliated
15 hospitals. Marshfield Clinic physicians refused to
16 cover for non Marshfield physicians when the latter
17 physicians were unavailable due to vacations or
18 professional business meetings.
19 Security Health Plan HMO physicians would send
20 their patients needing specialty or tertiary care to
21 Marshfield Clinic physicians only. Security Health Plan
22 HMO only employed primary care physicians of the
23 Marshfield Clinic. Marshfield Clinic physicians refused
24 to participate with BlueCross/BlueShield indemnity
25 plan.

1 The Marshfield clinic physicians also agreed not
2 to affiliate with Comp Care BlueCross's HMO. The
3 Marshfield Clinic HMO Security Health Plan also agreed
4 to segment the relevant geographic market with North
5 Central Health Protection Plan eliminating any price or
6 non price competition between them.
7 High monopoly prices by Marshfield Clinic was
8 the outcome of the integration and anti-competitive
9 conduct by Marshfield, in addition to reduction in
10 choice of physician, reduction in choice of the health
11 plan.
12 The District Court agreed with BlueCross and
13 BlueShield in this case, finding that Marshfield Clinic
14 violated Section 1 and Section 2 of the Sherman Act, but
15 the decision was overturned by the Court of Appeals when
16 they appropriately defined relevant market to
17 third-party payors. The Section 1 charge, that's the
18 price fixing charge, that Security and North Central HMO
19 divided the HMO markets in northwest Wisconsin was
20 upheld.
21 Judge Posner sitting on the Court of Appeals
22 suggested the high market shares of the Marshfield
23 Clinic physicians also may be due to their higher
24 quality, but he could provide no evidence of this.
25 Thus, for the Federal Trade Commission, I would

1 suggest investigate the vertical integrations, examine
2 the sources of any monopoly power, if any, such as
3 monopoly hospitals denying staff privileges to
4 independent physicians, and be prepared to trade-off the
5 potential of lower cost against monopoly prices.
6 To all this, investigate the possibility of
7 increases or decreases in the quality of physician care,
8 hospital care or health care plans due to integration.
9 Volume of surgeries and case mix adjusting the mortality
10 rates have often been used as proxies for quality of
11 health care.
12 The costs or benefits of changes in quality,
13 therefore, must be weighed against the possibility of
14 lower costs or monopoly power or vertical integration in
15 order to arrive at the optimum degree of efficiency in
16 these health care markets.
17 That's it.
18 MR. WIEGAND: Thank you. Next speaker is
19 Catherine Hanson from the California Medical
20 Association.
21 MS. HANSON: Good afternoon. I am vice
22 president and general counsel of the California Medical
23 Association and am pleased to be here today to offer the
24 perspective of the American Medical Association and
25 practicing physicians on the application of the

1 antitrust laws to physician conduct.

2 We, who represent physicians, support efforts to

3 promote competition in the health care system.

4 Competition often leads to quality improvements,

5 innovation and enhanced access to medical services.

6 However, we believe it's time to take a fresh

7 look at some of the core principles that have guided

8 antitrust enforcement in the health care sector. In our

9 view, some of these principles simply don't hold up to

10 close examination. They are simply assumptions which

11 have never been proven and in which, in our view, have

12 outlived any purpose they once may have served and are

13 now counterproductive.

14 Today, I will identify some of these assumptions

15 and explain why we believe the Commission should revisit

16 them. Our central message boils down to this. When

17 physicians create a network to market their services

18 jointly to payors, the Rule of Reason rather than the

19 Per Se Rule should generally apply. The physician

20 network should not be required to do risk contracting,

21 to clinically integrate or to use the so-called

22 messenger model in order to avoid charges of price

23 fixing.

24 We believe the Rule of Reason is up to the task

25 of distinguishing between physician networks that are

1 truly harmful to competition and those which are benign,
2 and at the same time will allow greater flexibility,
3 more innovation and ultimately a better health care
4 system.

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

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

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

1 contracting on quality would have to be considered.
2 This alone is a highly controversial and unsettled
3 question.
4 An additional cost that is all too familiar to
5 those of us in California is the numerous physician
6 bankruptcies that have resulted from inadequate
7 capitation rates. In California where capitation has
8 been the norm rather than the exception, dozens of
9 medical groups and IPAs have declared bankruptcy since
10 1999, and dozen more are on the brink. These
11 bankruptcies have caused enormous disruptions in care,
12 jeopardizing the continuity and quality of care for
13 millions of patients.
14 Every time a medical group or IPA goes under,
15 patients lose access to their treating physicians and
16 must scramble to get their medical records. Patients
17 are forced again to establish a new therapeutic
18 relationship with a physician they hope they will
19 retain, assuming they can find any physician who can see
20 them.
21 Even if it were demonstrated that one form of
22 contracting is more efficient than another, there's a
23 more fundamental question to address, Is it the proper
24 role of antitrust officials to state a preference for
25 risk contracting versus fee for service?

1 Competition policy ordinarily does not take
2 sides on this sort of question. It usually lets the
3 market decide. To quote Clark Havighurst, "Antitrust
4 enforcers should not, without good reason, deny
5 physician designed arrangements a fair chance to compete
6 against lay controlled entities in finding efficient
7 ways to cope with disease at reasonable cost."
8 Havighurst went on to say that "the fact that
9 physicians are able to rely on professionalism,
10 collegiality and consensus rather than exclusively on rules
11 imposed from the corporate top down should give them a
12 competitive advantage."
13 Another assumption that the AMA disagrees with
14 is that joint contracting by physicians on a fee for
15 service basis offers no potential for transactional or
16 other efficiencies.
17 We believe that joint contracting by physician
18 sponsored networks offer transactional efficiencies that
19 can result in significant cost savings for both the
20 payor and for the physicians. For payors, efficiencies
21 can be achieved as a result of contracting with networks
22 that have already been developed by physicians.
23 Because physicians still practice predominantly
24 in solo practice or in small groups, creating a
25 physician panel can be a very time consuming and

1 expensive task for a payor seeking to enter or to expand
2 its place in a market.
3 For physicians, a network would enable them to
4 pool their resources to afford the necessary expertise
5 to evaluate contract proposals, just as large health
6 plans do now. This would lower costs and rationalize
7 pricing without restraining competition.
8 To illustrate, I'll describe a fairly typical
9 physician sponsored network. It includes a large number
10 of physicians in the community. All of the physicians'
11 credentials have been pre-approved by the network's
12 credentials community. The network is also truly
13 nonexclusive.
14 Payors thus have an option. They can build
15 their own network by approaching physicians individually
16 or they can approach the physician sponsored network and
17 obtain ready access to a panel of qualified physicians.
18 Assume too that payors have the additional
19 option of acquiring a physician panel by going to a
20 national or regional PPO that is not sponsored by
21 physicians but that has contracts with many of those
22 physicians that are in the physician sponsored network.
23 No threat to competition is posed by this
24 physician network. Because it is nonexclusive, the
25 physicians actively and independently consider contracts

1 presented to them outside of the network. A payor who
2 is unable to reach a package deal with the network can
3 go directly to its physicians or to the competing PPO.
4 Rather than restraining trade, the physicians have
5 created an additional option for purchasers, which is
6 pro-competitive.
7 In this sense, these types of networks can be
8 viewed as a new product under the Supreme Court's
9 decisions in BMI and Maricopa. Although some view
10 Maricopa as creating a strict Per Se prohibition for fee
11 for service contracting by a physician sponsored
12 network, the four to three decision in that case should
13 not be read so broadly, particularly since, because of
14 its procedural posture, there was no factual record
15 before the Court on the potential efficiencies of joint
16 contracting.
17 Ironically, while enforcement policy continues
18 to favor risk contracting, the market appears to be
19 shifting away from it and to discounted fee for service
20 networks. Many employers and patients want to eliminate
21 financial incentives for physicians to withhold care.
22 Should antitrust policy stand in the way of
23 physicians responding to this consumer demand? Should
24 our hypothetical physician network be prohibited from
25 competing on an even keel with the national or regional

1 PPO? The next assumption worth addressing is that
2 physician networks that want the flexibility to contract
3 on a fee for service basis can simply become clinically
4 integrated.
5 Although the MedSouth letter represents a
6 thoughtful attempt by the Commission to deal with an
7 innovative effort by physicians to provide new services
8 within the confines of antitrust restrictions, it
9 demonstrates how high the bar has been set. For most
10 physician groups, the level of investment called for in
11 MedSouth is simply not an option.
12 The letter is also laced with caveats that seem
13 to indicate the IPA will continue to be exposed to
14 significant antitrust risk. After years of work, a very
15 substantial investment, lots of physician and consultant
16 time, the IPA walked away with a luke warm conditional
17 go ahead. This leaves us with another assumption.
18 The messenger model represents a viable
19 alternative for physician networks that do not want to
20 become financially or clinically integrated. The
21 messenger model, although creative, is an invention
22 worthy of Rube Goldberg. It is purely a device for
23 maintaining antitrust compliance with no independent
24 business justification, and it is cumbersome and
25 difficult to administer.

1 Moreover, the messenger model leaves physicians
2 exposed to charges of boycott whenever a large number of
3 physicians in the network independently view a payor's offer
4 as inadequate. Consider the following scenario. A
5 payor offers a contract to the network messenger. The
6 messenger takes the contract to the individual
7 physicians, many of whom reject it as unacceptable. The
8 payor, who views its offer as eminently reasonable,
9 concludes that the physicians must have colluded and so
10 contacted the FTC.
11 In the end the machinations of the messenger
12 model provide little in the way of antitrust protection
13 for physicians while imposing significant administrative
14 costs on all parties.
15 Finally, we question the assumption that as long
16 as health care markets remain price competitive, quality
17 will take care of itself. When it comes to antitrust
18 enforcement in health care, quality is too often viewed
19 as a secondary consideration, or worse, a code word for
20 collusion.
21 The need to ensure quality is part of what
22 distinguishes medicine from other professions and other
23 industries. Subtle differences in approach may make a
24 life or death difference. Quality is the driving
25 consideration which guides medical decision making of

1 physicians and patients.

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

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

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

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

21 Our member organizations provide health care
22 coverage to approximately 170 million individuals
23 nationwide. AAHP member plans contract with large and
24 small employers, state and local governments as well as
25 with Medicare, Medicaid, the Federal Employee Health

1 Benefits Plan and the State Children's Health Insurance
2 Program, the SCHIP program, so it's both the public side
3 and the private side.
4 We most appreciate this opportunity to
5 participate in this important dialogue on provider
6 integration and important trends in the health care
7 system.
8 In an environment of rising health care costs,
9 it's important to take a step back and examine the key
10 factors shaping today's health care market. I would
11 like to talk a little bit about the trends in that
12 market.
13 According to the U.S. Department of Health and
14 Human Services, HHS, overall health care spending rose
15 6.9 percent in the year 2000, and that was the largest
16 increase since 1993. A number of factors, of course,
17 are contributing to this increase, but both HHS and the
18 non-partisan Center for Studying Health Systems Change
19 which you heard from this morning in Cara Lesser's
20 presentation, cited increases in hospital costs as the
21 largest single factor.
22 Moreover, a study commissioned by us at AAHP and
23 conducted by Pricewaterhouse Coopers just this past
24 spring, April 2002, found that rising provider expenses,
25 which is a category including hospitals, physicians and

1 others, accounted for fully 18 percent of the increase
2 in health care premiums from the year 2000 to 2001, in
3 that one year. All three studies identify hospital
4 consolidation as one of the prominent drivers of rising health care
5 cost.
6 Now, while it's clear that consolidation among
7 health care organizations has the potential to benefit
8 consumers by adding efficiency and affordability to the
9 market, in evaluating the impact of any consolidation
10 from an antitrust standpoint, the key question that
11 needs to be answered, and this was addressed by
12 Commission personnel this morning, is whether the test
13 is met. The test is, what is the impact on
14 consumers? Unfortunately, the evidence published to
15 date suggests that some consolidations may have had
16 unintended negative consequences.
17 I want to briefly review now five types of
18 market activity that we believe should be evaluated
19 closely. Number 1, increases in charges. In site
20 visits to 12 nationally representative communities in
21 2001, the Center for Studying Health Systems Change
22 found that consolidation has given hospitals
23 significantly more leverage in contract negotiations,
24 making it possible for them to gain substantially higher
25 payments from health plans.

1 An article in The New York Times from last year,
2 2001, reported that that as a growing number of
3 hospitals gained market power through mergers and
4 acquisition, they demanded rate increases as high as 40
5 to 60 percent for some services. These rate increases,
6 of course, are ultimately passed on to employers,
7 consumers and governments in the form of higher health
8 care costs.
9 Number 2, spill over effects. In some instances,
10 provider charges not only increased for the largest
11 player in a given market but also for all hospitals in
12 that particular region. This is because once the
13 largest player obtains a large increase, there's
14 significant upward cost pressure throughout the same
15 geographic area.
16 Number 3, the issue of all or nothing
17 contracts. In some markets, hospital systems force
18 health plans to contract with every facility affiliated
19 with their system, even if some of those facilities fill
20 no real need in the health plans network.
21 Number 4, termination instead of negotiation.
22 Some hospital systems are using a strategy of sending
23 termination letters to health plans as part of their
24 efforts to obtain higher rates. While termination used
25 to be the last resort in negotiations, in some highly

1 consolidated markets, it would appear that termination
2 notices are now being used as the first strategy. The
3 disruption in service this causes and the concern and
4 uncertainty these tactics pose for consumers should be
5 cause for concern.
6 Last but not least, number 5, increased leverage
7 through joint arrangements with physicians. In some
8 instances, hospitals are forming joint arrangements with
9 physician groups that have increased their market power
10 substantially and resulted in major rate increases for
11 provider services.
12 In a number of metropolitan areas, for example,
13 large hospital systems own or are affiliated with
14 physician practices. When large hospital systems also
15 own physician groups that represent the majority of
16 physicians in the market, the limits on consumer choice
17 as well as on the impact of consumer affordability are
18 of equal concern.
19 Now, increases in hospital and physician charges
20 have a ripple effect throughout the health care system
21 in both private and public sectors. As costs rise, it becomes more
22 difficult for both government and private employers, particularly small
23 businesses, to offer health care coverage to their workers.
24 Consumers ultimately pay the price in the form
25

1 of increased health premiums, higher cost sharing and in
2 extreme cases loss of access to employer sponsored
3 health care coverage. To promote policies and practices
4 that benefit consumers, it is critical that enforcement
5 agencies monitor the market closely and take steps to
6 address anti-competitive practices.
7 Finally, I would like to go over three
8 recommendations. In light of these developments in the
9 market, we need a renewed focus on ensuring appropriate
10 enforcement of the antitrust laws to ensure that
11 consolidation benefits consumers. Such an approach
12 could include the following three things.
13 Number 1, given recent press reports about how
14 consolidation is impacting health care negotiations, we
15 believe it is prudent for the agency, the Federal Trade
16 Commission, to proceed with its plans to evaluate the
17 impact of already consummated mergers as Chairman Muris
18 discussed this morning.
19 Such an analysis is critical to determine
20 whether existing mergers meet the test of benefitting
21 consumers by promoting efficiencies and affordability in
22 health care markets rather than adding another
23 administrative layer simply for negotiating purposes.
24 Number 2, in the past we believe that the
25 federal courts reviewing hospital mergers have defined

1 markets for acute care services as geographic areas that
2 are much too broad. We believe that the initial steps
3 in the agency's analysis should be to reevaluate the
4 definition of hospital markets and to assemble a more
5 appropriate definition that accurately reflects patterns
6 of utilization in the particular geographic area.
7 Third, we encourage the agency to continue its
8 important efforts in coordination with state and other
9 federal enforcement agencies to gather the facts
10 necessary to evaluate existing mergers and to analyze
11 proposed mergers through the prism of whether the impact
12 is positive or negative for health care consumers.
13 In the next panel, we will be addressing the
14 important issue of antitrust enforcement and how it
15 impacts quality of care. We believe that maintaining
16 competition in the health care market is critical to
17 create an environment in which policy makers, payors and
18 providers in both the public and private sectors can
19 develop effective strategies to bring health care costs
20 under control and provide consumers choice of affordable
21 health care options.
22 Thank you very much.
23 MR. WIEGAND: Thank you, and beginning with your
24 last point about quality of care issues, I would like to
25 raise that issue. I know that Warren Greenberg

1 expressed some skepticism about quality of care being a
2 motivation for integration, and I would like, if you
3 would, for him to expand on that a little bit, and then
4 I would like to invite Ellen Burkett to respond to that
5 because she emphasized MedSouth's emphasis on quality of
6 care. Then I will open it up to any of the other members of
7 the panel to discuss that particular point.
8 Warren?
9 MR. GREENBERG: Okay. This is an unrehearsed
10 question and unrehearsed answers, but I will give it a
11 shot.
12 I think everyone in the health care area has
13 good will to bring about as much quality as they can.
14 However, there are constraints on the incentives to
15 provide quality of care, mostly by health care plans,
16 and even perhaps on our providers such as hospitals and
17 physicians. Why do I say that?
18 The health care plan that advertises, we have
19 the best quality in the city, we treat HMO, we treat
20 cancer patients immediately and we'll send them to Sloan
21 Kettering if they have cancer at our expense or we'll
22 treat an AIDS patient and open up the doors with an 800
23 number, if you have AIDS, come in here, we'll treat you
24 with an infectious disease doctor in five minutes, the
25 next enrollment period that HMO will be flooded with

1 high risk individuals. What are the incentives of the
2 health care plans to provide quality under those sorts
3 of arrangements?
4 There's a problem with risk selection in the
5 health care market. It goes right up and down the line
6 from HMOs to physicians to hospitals. What incentives
7 do the hospitals have to be known as good quality hospitals,
8 maybe again being flooded with high risk individuals?
9 The incentives are I think people at hospitals
10 want to do a good job. They're professionals. I think physicians want
11 to do a good job. They're professionals. I think health plans want to
12 do a good job. They're run by human beings.
13 On the other hand, we have to be careful of the
14 incentives in the marketplace. When we talk about
15 quality, we have to really couple it with changes in the incentives.
16 I would ask Stephanie if she knows of any
17 health care plan in the country that will advertise,
18 this is our 800 number and if you're sick with heart
19 disease, we open up our doors to you tomorrow and we'll
20 fly you to the Cleveland Clinic.
21 MR. WIEGAND: Let's go to Ellen Burkett first,
22 and then we'll let Stephanie respond and any members of
23 the panel that would like to weigh in on this.
24
25 MS. BURKETT: She can go first, that's okay.

1 I think this quality issue is one that I raised
2 as well. I think it's going to be very difficult to
3 measure, and I think it really changes the paradigm for
4 physicians in our community to define what quality is.
5 I don't think health plans have actually done a
6 great job of that. I think probably the best measure of
7 quality in our community has been how well the health
8 plans achieve their HEDIS requirements, and they're
9 measured, and that's reported in this paper, and that's
10 sort of reported as quality.
11 I think the physicians in the past have been
12 incentivized, as Warren has said, on cost only. I think
13 it's much more difficult to define quality, particularly
14 in our community where it's a short-term goal of what
15 can you do for me in the next year that I can define as
16 quality? Did your 45 year old female get her mammogram
17 is defined as quality. I think it behooves the
18 physicians to show we're looking at a community of
19 patients over whom we're taking care of over maybe a 20
20 or 30 year career.
21 There isn't a lot of turnover physicians to
22 patients. I think there's a lot of turnover with
23 patients to health plans, so I think our definition of
24 quality is a longer term one, and one that I think as
25

1 physicians, it's really on our backs to define that.
2 That's what I said, I think it's on us to define what
3 that quality is, and I think that's just a different
4 take on it.
5 I think we have to define what that quality is
6 as a physician group rather than waiting for the health
7 plans to define that for us and not to have it be an
8 economic decision.
9 MR. WIEGAND: Stephanie Kanwit.
10 MS. KANWIT: Quality is an extraordinarily
11 important issue to health care plans, and I think we're
12 being a little bit too negative here, and we've made
13 great strides in the last five or six years, the last
14 decade, in quality issues. Just this morning, the
15 National Academy of Sciences Institute of Medicine
16 report was raised and went into all the quality issues
17 that are going into health care.
18 We're also underestimating employers with the
19 information out, that employers when they buy group
20 health care for their employees or arrange for group
21 health care are, in fact, very, very savvy consumers who
22 are working with HEDIS, JCAHO data, NCQA data about where
23 the best care is being given and the cost of that data.
24 Our health plans, on the quality area, are working with
25 disease management programs, proactive screening

1 programs, collecting and sharing medical information.
2 I think one of the things that we're proudest
3 of, John, is that we're partnering with the providers,
4 the hospitals and the doctors in terms of these disease
5 management programs and screening programs and using new
6 technology under HIPAA as well as just little things like
7 Palm Pilots and the technology that's out there, making
8 consumers more knowledgeable and savvy, making employers
9 as buyers of health care more savvy and in general
10 getting a healthier population as a result. I'm very,
11 very optimistic in this score.
12 MR. WIEGAND: Stuart.
13 MR. FINE: At least in the Commonwealth of
14 Pennsylvania we have an entity called the Pennsylvania
15 Health Care Cost Containment Council that publishes
16 mortality and morbidity information on each and every
17 hospital in the state. This is an annual report that
18 comes out. It also publishes information concerning
19 charges, not cost to reimbursement but charges that
20 pertain to each DRG category that's analyzed in the
21 report.
22 The report is far from perfect, but it's the
23 best thing that's out there right now. The frustration
24 that hospitals like my own have is that we'll have a
25 report that shows that we have superior outcomes, lower

1 than expected morbidity and mortality statistics. Yet
2 again the health plans don't modify the way in which
3 they contract based on that, and we've seen very little
4 public response, very little in the way of people
5 changing, how they shop for care based on the release of
6 this information.
7 MR. WIEGAND: Any other members want to say
8 anything on the subject of quality? Let me pursue the
9 point one step further. Suppose hypothetically that
10 MedSouth were to increase price over time and proceed to
11 contract with payors and proceed to increase price.
12 Let's suppose further that they claim that the
13 increase in price is due to the fact that they've
14 achieved a lot of the clinical integration that they
15 hoped and planned to achieve. How are we going to
16 measure whether that price increase is a result of
17 market power or is it really just a reflection of a
18 better product?
19 I will let Ellen take a stab at this and then
20 anyone who has any other ideas about how enforcement
21 agencies might address such a question.
22 MS. BURKETT: I think that's a very difficult
23 question. I think we haven't yet achieved what we said
24 we were going to achieve. I think it may take us a year
25 to have any proof of that know, any reporting

1 capabilities back, but I do think with the health plans
2 in consideration in contracting that we can give them
3 something that we have not been able to give them
4 before.

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

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

18 I think what we're really working towards is a
19 better product from the physicians, and I think there's
20 been this triangle between the health plans and the
21 hospitals and the doctors, and particularly in Denver
22 it's been kind of a vicious triangle, and we've been
23 sort of on the back burner for awhile, and I think the
24 physicians feel like we can provide a better product,
25 and I think that's sort of the hope, that we will in

1 turn give someone a health plan that may save them some
2 money, and in return some of that may come back to the
3 physicians as well.
4 MR. WIEGAND: Henry?
5 MR. DESMARAIS: Certainly it's possible that
6 MedSouth would be able to -- for example, they could
7 increase fees for physician services, but because of the
8 nature of the systems they've put in place, they're
9 actually saving money by reduced hospitalization or
10 other kinds of services, so there's certainly a lot of
11 theory here to support what they're trying to do.
12 I don't mean to suggest that we're throwing cold
13 water on the whole concept. However, I think the
14 question you asked, the whole Rule of Reason and how
15 these judgments will be made and the tools, what tools
16 does the Commission and others have to do that kind of
17 analysis and in particular, if there's thousands of
18 MedSouths that occur overnight.
19 I think there's some real significant issues
20 here to wrestle with, and I think we're anxious to see
21 as MedSouth continues to develop and become operational,
22 the kinds of information it is able to produce, both for
23 the plans that are involved there but also for the
24 Commission and others who are trying to learn really
25 from what is a very good experience.

1 MR. WIEGAND: Catherine?
2 MS. HANSON: If I could just add, I think one
3 thing that gets lost a little bit in the MedSouth
4 opinion, at least as I read it, was that they are a
5 nonexclusive network, so it seems to me that the market
6 is going to tell us whether the additional benefit
7 they're providing is worth more money because either
8 people will contract with them, and if they are paying a
9 premium, they'll be paying a premium.
10 If the premium is too high, then no one is going
11 to contract with them, and since it's nonexclusive,
12 they'll go around them and otherwise contract with the
13 doctors, so I think the MedSouth case actually provides
14 almost no or no potential for anti-competitive
15 problems.
16 I think the better concern with MedSouth is, as
17 I said, the bar is so high that there's a significant
18 concern about whether they're going to be able to
19 survive, whether they're going to be able to get past
20 three years of development without being able to
21 generate any revenue to support it, and I think that's a
22 very serious question for the Commission to consider is,
23 What are you doing to new entrants here and people who
24 are trying to do things that at least a lot of people
25 think theoretically may be a good thing to do?

1 The second point is that I do think there is a
2 lag time issue in these things. It costs a lot of money
3 to put together the kinds of information systems that
4 everybody is telling us are going to ultimately provide
5 tremendous efficiencies, and I personally believe that
6 those systems will provide tremendous efficiencies, but
7 somewhere there's got to be money to get those systems
8 in place.
9 So I think it's very possible that you could
10 have a MedSouth situation where the initial years, there
11 was a higher premium for that, and then potentially over
12 time, maybe there's still a higher premium for that, but
13 in terms of the overall cost of that network providing
14 care to the patient population, it's actually lower from
15 the standpoint of the system.
16 MR. WIEGAND: Warren?
17 MR. GREENBERG: I just wanted to hit the quality
18 point again. I think we've come a long way with this
19 quality question in antitrust. 20 and 25 years ago, we
20 never heard this word at the Commission. We only talked
21 about costs and monopoly prices.
22 Moving along, now there's been talk even by the
23 Commissioner himself this morning about quality in
24 health care. We never had rankings of hospitals in
25 Pennsylvania or New York state before. In the last ten

1 years we've begun to have these kind of rankings, and I
2 say that once we change these incentives, once we change
3 these rankings, I would also suggest this, that we'll be
4 able to measure quality.
5 It won't be easy. It will be tough, but compare
6 it with other industries of which there are differences
7 of opinion. Talk about the latest movie that you saw or
8 the last theater performance. You may have liked it.
9 Your friend didn't like it. Somehow we kind of agree
10 that this movie was better than another.
11 So again that's perhaps why I started off
12 looking at outside the health care box. There are other
13 things that we're buying all the time where quality can
14 be differentially rated among individuals, and yet we've
15 come up with market mechanisms, with government
16 mechanisms, with quasi government mechanisms to try and
17 evaluate quality. I believe this conference will
18 mark the start of exploring changing incentives to look
19 for other ways to measure quality in the health care
20 sector.
21 MR. WIEGAND: Henry Desmarais.
22 MR. DESMARAIS: Briefly just to avoid a danger
23 here. We don't have to have a MedSouth to work on
24 quality. Quality's being worked on today. We saw I
25 think it was Cara Lesser this morning showed us a chart

1 that spoke to the issue of appropriate drug management
2 after a heart attack, and the drugs we were talking
3 about were aspirin and generic drugs propranolol and so
4 on.
5 So it's not an insurmountable thing. There's a
6 lot of things that can get done. Clearly MedSouth
7 presents an opportunity, a more sophisticated
8 opportunity, but they're doing it in part because
9 they're also looking for the benefit of collective
10 negotiating, so I think that's another balancing act
11 that the Commission clearly has to consider.
12 MR. WIEGAND: I would like to follow up, if I
13 could, on a point that Catherine Hanson made about the
14 nonexclusivity provision and the MedSouth approach that
15 the Commission took in that letter and ask, I guess I'll
16 direct this first to representatives of payors,
17 Stephanie Kanwit and Henry Desmarais, if you would, how
18 do you find the concept of nonexclusivity to work in
19 practice?
20 Do we find that to be a real outlet for seeking
21 providers to participate in a network, or is it
22 sometimes more of an advertised portion of a venture's
23 planning but doesn't really exist in real life? How can
24 we at the FTC measure and examine the degree to which a
25 network is not exclusive?

1 MR. DESMARAIS: Obviously this is another issue
2 of where is the bright line. That's going to be
3 difficult, and obviously it's an issue of, Is it truly
4 nonexclusive or is it just in name nonexclusive, and we
5 were talking earlier today about the various forms of
6 coercion that may go on, refusing to cover for somebody
7 and so on, that can all be brought to bear to say, Oh,
8 yeah, you're free to do something, but subtly don't do
9 it or don't do it very often.
10 So I think one of the issues is going to be,
11 Well, is it 1 percent, is that enough to be nonexclusive
12 or should we be looking at some other tests, and I think
13 there will be some serious difficulties there.
14 MS. KANWIT: I agree with Henry. We're going to
15 have to look at this from a de novo standpoint because
16 MedSouth is such an unusual opinion from the
17 Commission. On the other hand we are encouraged by
18 MedSouth because of the Commission's flexibility in that
19 in terms of the doctors there I believe used good faith
20 in developing a novel method of delivering health care,
21 and I think the Commission's opinion is very well
22 balanced.
23 MR. WIEGAND: Ellen Burkett, how would we know
24 the degree to which the physician members of MedSouth
25 are contracting independently from MedSouth? Is there

1 going to be anyway that that information is going to be
2 monitored or collected, or are we going to have to go to
3 every doctor and say, How many contracts have you
4 signed, how many patients do you see pursuant to those
5 contracts?
6 MS. BURKETT: I think the administration of
7 MedSouth knows which of those physicians have contracted
8 outside. If we can't reach agreement with a health
9 plan, we probably will know who is or who isn't, but one
10 thing I would just like to add to this exclusivity/nonexclusivity that
11 is sort of the physician's perspective, sort of not as a MedSouth
12 person but as a physician, is that it's not all about price.
13 I think that's sort of been one of the basic
14 tenets here is if we can't agree on a price, and I
15 think in our group we've actually had some groups of
16 specialists join our group with the anticipation that
17 the price would actually be lower for them than it would
18 be if they contracted individually for two reasons.
19 One is the clinical integration program offers
20 them some benefits with the referring physicians and
21 clinically communicating with the other physicians. The
22 other is that as a group, we have a little more say in
23 contracting negotiations as far as wording of contracts,
24 and in Denver, that's been a huge problem is timely
25

1 payment, hassle factor and things like that.

2 When we get down to nuts and bolts, it's not all

3 going to be about price, so this exclusivity issue, it's

4 clear that the group is going to be nonexclusive, and

5 physicians will be sign outside of the contract. We've

6 already had that happen in the past, so I have no

7 concerns about that happening in the future, but I think

8 the physicians are motivated to do something beyond just

9 price.

10 I think we have a group of physicians that's

11 ready to sort of sit at the table with the health plan

12 and express some concerns over a lot of the hassle

13 factors which have driven a lot of our friends and

14 compatriots out of Denver, so I think we're actually

15 talking about something beyond just, how much are you

16 going to pay us for this service.

17 It's really about having a healthy dialogue as a

18 group with health plans in town.

19 MR. WIEGAND: Catherine.

20 MS. HANSON: If I can add a point, I think

21 certainly the practical reality for most physicians at

22 least in California is that nonexclusivity is the rule.

23 People are contracted with multiple networks, and in

24 fact that's part of the problem on the administrative

25 efficiency side is that they can't reconcile their

1 payments because they've got so many different contracts
2 with so many different terms with so many different
3 payment rates, even within one health plan which is
4 paying them this price for this company and that price
5 for that company.
6 It becomes an absolute nightmare, but I think
7 reality is that nonexclusivity has been the rule.
8 MR. DESMARAIS: To make a little point too, to
9 me it's not just MedSouth's responsibility to even be
10 tracking this. They certainly shouldn't be precluding
11 physicians to negotiate outside the MedSouth
12 arrangement, but I don't think they're supposed to be
13 sitting there and saying, Hey, you're too linked to us
14 so you better go out and get some business.
15 That's really not their responsibility, and
16 that's another issue I think just in monitoring this.
17 I'm not sure whether it's MedSouth that is supposed to
18 be collecting the data how frequently their physicians
19 are, in fact, entering into agreements with other
20 plans.
21 MR. WIEGAND: So would you say there would even
22 be some danger in MedSouth collecting such data?
23 MR. DESMARAIS: I think there could be, yes,
24 depending on exactly how it's used and what the
25 implications might be. So again, it's a challenge, and it

1 does put them in a difficult position because the
2 advisory opinion clearly was conditioned on seeing that
3 this truly was nonexclusive.
4 MR. WIEGAND: Any other comments on the value to
5 consumers through nonexclusivity of the provider
6 network?
7 I would like to follow up next on a point that
8 Catherine Hanson raised in her initial presentation,
9 really questioning the value of Per Se Rules, and I
10 would like, if you would, Catherine, to address whether
11 you would advocate eliminating Per Se Rules to all
12 industries or just to physicians, and if just to
13 physicians, if you have a kind of neutral objective
14 basis for advocating such position.
15 MS. HANSON: I protest no expertise with respect
16 to all industries, so I'll stay away from that one. I
17 think the concern in the health care arena is that what
18 we have seen, and again I speak primarily from
19 California since that's been my experience, is that the
20 FTC rules and guidelines have led the industry in a
21 particular direction which has proven not to be ideal,
22 to use somebody's wording here today.
23 I think it's not so certain that risk
24 integration, for example, is absolutely the best way to
25 go, and one of the things we found in California is that

1 in order for a physician group to take capitation, they
2 really have to become a little insurance company, and
3 that takes a huge amount of money and a huge amount of
4 expertise, which is not within the normal training of a
5 physician.
6 A number of physicians in California got into
7 capitation without knowing really what it meant and
8 without, in our view, getting adequate information from
9 the health plans about what kind of risk they were going
10 to be taking in any event, but the net result of all of
11 it was a huge amount of fall-out and disruption in the
12 community.
13 Under those circumstances, it seems to me that
14 it's time to say, we really don't know where things
15 should go. We need to provide some more flexibility.
16 Obviously I fully understand if a doctor group is
17 getting together not to be nonexclusive and simply to
18 boycott various arrangements, that's a whole different
19 kettle of fish, and clearly under the Rule of Reason,
20 that would be a violation.
21 I think the concern is when the Commission
22 starts setting rules and starts setting the bar high, as
23 it has in the MedSouth case, that you're both shutting
24 out a lot of innovation that may be beneficial and
25 you're potentially not even allowing an organization

1 like MedSouth to ever get anywhere because they simply
2 can't afford to get through all the hoops to get
3 clearance.
4 MR. WIEGAND: What do our other panelists think
5 about possibly eliminating Per Se Rules as they would
6 apply to physician networks?
7 MS. KANWIT: Not much. Basically as I
8 understand Catherine's proposal here, what this would be
9 would be a back door way to physician collective
10 bargaining. One of the issues in the recent Conyers/Barr bill that
11 came up before Congress this spring
12 was exactly that, was treating health care in a
13 physician bargaining in a different way and carving out
14 physicians out as an exception to the antitrust laws. This A, raises
15 prices for consumers in both the public
16 and private sector, and B, isn't necessary because they
17 already, under the health care guidelines, can talk to
18 each other about quality and treatment, et cetera.
19 So this is kind of a back door way to do that.
20 I think we also need to remember what Per Se Rules apply
21 to. They apply to price fixing, boycotts and market
22 allocations. I just cannot see the benefit to
23 consumers, again I harp on this, in a time of raising
24 health care costs of having the DOJ or the FTC spend
25 three years looking at a physician group to determine

1 under the Rule of Reason whether a certain arrangement
2 is or is not violative of the antitrust laws. That is
3 not going to benefit consumers.
4 MR. WIEGAND: How do our other panelists see
5 it?
6 MR. DESMARAIS: I agree with what Stephanie just
7 said. I'm not an attorney.
8 MR. FINE: Again from the hospital perspective
9 the issue becomes much more the Stark
10 Medicare fraud and abuse implications than the antitrust
11 implications.
12 If we have a Per Se illegal situation, if we
13 want to joint venture with physicians, we want to invite
14 physicians to participate in our MRI unit, but if they
15 do that, that will constitute an inducement for them to
16 refer. Instead, they can own their own MRI. They can put
17 one in an office and own it outright, but they can't joint
18 venture with us, so we are disadvantaged competitively.
19 So I know that that's not where you were taking
20 this, John, but we have the concern on the Medicare
21 side.
22 MR. GREENBERG: You can have an example of 20
23 physicians or a number of physicians sitting together in
24 perhaps a non smoke filled room fixing prices or attempting
25 to fix prices because there are so many of them that they feel they

1 have to sit in a non smoke filled room to attempt to fix prices.
2 That's going to fail. Physicians' behaviors are
3 different. Physicians are practicing differently. FTC or
4 Department of Justice can brings a case. There's no way
5 that these 20 physicians are going to be able to fix
6 prices with different types of practices and different
7 types of locations and so forth. If that case is
8 brought, perhaps it would be a waste of Commission
9 resources.
10 On the other hand, three physicians, not sitting
11 in a non smoke filled room, kind of following the
12 leader, following each other carefully, not violative of
13 Section 1 of Sherman Act, that may go right by the FTC
14 and where that may, in fact, become a scenario of higher
15 prices.
16 Given that, I think it's a tough good question
17 that you asked. I think there's such things as
18 transactions costs, as Stephanie pointed out, and
19 there's such a thing as length of trial, as Stephanie
20 pointed out, and I think on balance I think we ought to
21 look at Per Se and keep that Per Se approach, but with
22 the cognizance, let's be smart about which cases we
23 bring about in the Per Se area.
24 MR. FINE: John, I will add one other thing, and
25 that's not on the physician side but on the hospital side.

1 If we can't work with hospitals with which we're not
2 integrated or merged to rationalize services in a way
3 that makes sense from a public health perspective, then
4 we are left with no option but to seek the merger
5 alternative. We're sometimes forced, due to failing
6 concern issues or other complicated issues, to look at
7 alternatives that we might prefer not to pursue but
8 then we're forced in the direction that I believe
9 FTC would rather not see us go.
10 MR. WIEGAND: So you're really saying that
11 there's situations in which you would like to do a joint
12 venture collaboratively with competing hospitals, but
13 you feel constrained due to the fact that you might be
14 caught into the Per Se dragnet.
15 MR. FINE: Exactly.
16 MR. WIEGAND: Catherine.
17 MS. HANSON: Just to follow up, I think there
18 are other places where the Commission and certainly the
19 courts have looked at joint sales agencies and have
20 found pro-competitive justifications that allowed them
21 to go forward, and I think what we're saying is that
22 when you look at certainly networks, physician networks,
23 they are out there.
24 They're being developed by for-profit
25

1 entrepreneurs because there are employers particularly
2 that are very interested in being able to access a
3 physician network, and they don't want to have to go
4 through the cost of developing that network.
5 It clearly is a product. It's clearly out
6 there, and yet because of, in our view, the weird way
7 that the Maricopa case came up, none of those issues
8 really were in front of the Court, and so the Court
9 suggests that all physician network activity is
10 inherently Per Se illegal.
11 So I'm not saying that you have a number of
12 doctors who sit down and do something that has no
13 pro-competitive justification, that ultimately you might
14 conclude that that's totally illegal, you probably
15 would, but the question becomes in this area of
16 physician networks where you have purchasers for that
17 product, i.e., they want something more than just access
18 to a single physician, that there are clear
19 pro-competitive values in that. At a minimum,
20 the Commission ought to hold hearings on that question
21 and reassess whether every one of those is inherently
22 anti-competitive or ones that have some level of
23 clinical integration that doesn't meet close to what
24 MedSouth has done but are moving in that direction given
25 limited financial resources, that there ought to be a

1 second look at what's happening out there and what might
2 be ultimately in the benefit of consumers.
3 MR. WIEGAND: Anyone else on this point?
4 Let's talk for a moment about the legal form of
5 the network. I don't think this issue has been raised,
6 but it occasionally appears in real life. If the
7 network is itself a corporation composed of all the
8 physicians or partnership composed of all the
9 physicians, should it be immune from antitrust
10 scrutiny?
11 Say an organization like MedSouth was created
12 not as an umbrella entity but as a merger of all the
13 physician practices into a single partnership or a
14 single shell corporation, should such an entity be
15 granted immunity just because it's a single entity?
16 Warren, do you want to speak to that first?
17 MR. GREENBERG: No, but I'll leave it to my
18 colleagues to expand on that. I don't quite see the
19 reasoning why it should be granted immunity. I would
20 say no. I think they should be investigated.
21 MS. HANSON: I don't think I understand or I'm
22 not sure I understand your hypothetical.
23 MR. GREENBERG: Just say no.
24 MS. HANSON: Are they integrated, or just it's
25 an IPA that's set up as a professional corporation.

1 MR. WIEGAND: It's the latter.
2 MS. HANSON: Well, that's the current
3 situation. If they're not a single entity, then they're
4 going to be, now in our view, too strictly under the Per
5 Se Rule, whereas they should be viewed under the Rule of
6 Reason depending on whether what they're doing has
7 pro-competitive justifications that outweigh the
8 anti-competitive effects.
9 MR. WIEGAND: Sure. The concern is when they
10 are legally, from a legal point of structure, a single
11 entity and arguing that they're incapable of conspiring
12 with one another because they're in a single partnership
13 or a single corporation, but economically they're not
14 integrated in any way at all, and whether that kind of
15 arrangement is a problem to payors, whether it's
16 something that's commonplace in the industry.
17 MR. GREENBERG: I think payor would have a
18 problem with that, wouldn't they? A single entity
19 combined together, wouldn't you have a problem with
20 that, Stephanie?
21 MS. KANWIT: It's hypothetical.
22 MR. WIEGAND: Sure.
23 MS. KANWIT: I really can't answer that. I'm
24 trying to remember, John, if we're talking about are
25 they risk bearing? Is it clinically integrated in any

1 way? What is the network?

2 MR. WIEGAND: No. There is no clinical or

3 economic integration. The member physicians have put

4 all their practices into a common partnership, haven't

5 changed anything else as to what they do, except they

6 might change their prices, but they haven't changed

7 anything about what they're doing as far as financial

8 risk sharing or clinical integration.

9 They've just created either a shell corporation

10 or a shell partnership that covers all of their

11 practices and created a single legal entity, and my

12 question is: Is that an entity that ought to be exempt

13 from application of the antitrust laws generally or the

14 Per Se Rule specifically?

15 MS. HANSON: Yes, it should be exempt from the

16 Per Se Rule, and it should be reviewed under the Rule of

17 Reason.

18 MR. WIEGAND: Anyone else?

19 MS. KANWIT: Let me just add payors, are not

20 always in the best position to know exactly how an

21 entity like that, John, is constituted so you're asking

22 a payor representative a difficult question here.

23 MR. WIEGAND: Okay. Are there any other

24 questions, the panelists would like to raise?

25 MR. DESMARAIS: One of the things I wondered

1 about, MedSouth clearly has come forward and dealt with
2 the Commission staff and received an advisory opinion,
3 but to the extent other groups begin or think they can
4 rely on that opinion to set up similar entities and then
5 they in turn begin to negotiate collectively with plans.
6 I'm beginning to wonder, absent some notification of
7 what's going on, that we are clinically integrated and
8 so on, whether plans are going to begin to report to the
9 FTC some suspicious activity believing that, well, these
10 aren't risks, they are not a risk sharing arrangement,
11 and so they really shouldn't be doing what they're
12 doing.
13 So I think it could potentially cause some
14 confusion out in the market.
15 MR. GREENBERG: John, may I ask a question of
16 you, and that is, let us say the FTC does the right
17 thing, as it usually does work in the public interest.
18 What does the FTC expect to see, a drop in the increase
19 in rising health care costs, a one-time drop in health
20 care costs, a continual curve of rising health care
21 costs?
22 MR. WIEGAND: I can only speak for myself. I'll
23 give a standard disclaimer.
24 MR. GREENBERG: You asked me a question.
25 MR. WIEGAND: I can't speak for the Commission

1 or Commissioners or Bureau Directors or anybody else. I
2 think that from either financial integration or clinical
3 integration, what we hope to see from it is ongoing
4 efficiencies being achieved, and ongoing improvements in
5 the delivery of care.
6 Over time, as those benefits are achieved,
7 there's also going to be affecting the marketplace cost
8 increases, so if you're just looking at price, I think
9 what you'll see is an initial benefit, and you might
10 even see prices go down or the rate of increase take a
11 dramatic hit.
12 I don't think anyone's suggesting that an
13 improvement in efficiency is going to be a cure all to
14 price increases over the long haul because as technology
15 advances and medical science, people want access to
16 that. It's a story about everyone wanting 1970 prices for
17 2002 medicine. Well, that's not going to happen, and I
18 don't think anyone at our agency is suggesting it will.
19 We're going to take about a five-minute break.
20 MS. MATHIAS: Actually the next panel is set to
21 start about 3:50, so if we could just make it 3:45, give
22 you all a little bit more than a five-minute break,
23 about a ten-minute break. We'll start on time at 3:45.
24 Just two quick reminders. If you didn't see the
25 MedSouth opinion, it is in the brown handout under the

1 Bureau of Competition section in the handout. If
2 anybody wants to review that, it's in the handout.
3 Also if you go out and use our cell phones,
4 please turn them off when you come back in. Thanks.
5 MR. WIEGAND: I would like to thank all of our
6 panelists.
7 (Applause.)
8 (Break in the proceedings.)
9 MS. MATHIAS: Let's go ahead and get this
10 started again. Please turn off your cell phones. They
11 do interfere with the sound system. Let's get this
12 rolling so everyone hopefully can get out of here.
13 I would like to take this opportunity to
14 introduce Mark Botti. Mark is the chief of Litigation I
15 in the Department of Justice which handles all health
16 related antitrust measures at the Department of Justice.
17 I'll hand this over to Mark.
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1 Panel 2, Health Insurance, Payor/provider Issues
2
3 Panel Members
4 Helen Darling, Washington Business Group on Health
5 Henry R. Desmarais, Health Insurance Association of
6 America
7 Stuart Fine, Grand View Hospital
8 Stephanie Foreman, Pennsylvania Medical Society
9 Donald J. Palmisiano, American Medical Association
10 Lawrence Wu, NERA
11 Mark Botti, Department Of Justice, Moderator.
12
13
14 MR. BOTTI: Good afternoon, everyone. I think
15 the best way to do this, since we've been here awhile
16 today, is to launch into our panel. We're going to use
17 the same objective criterion of the alphabet in deciding
18 which order we'll go.
19 Helen Darling from the Washington Business
20 Group, can I ask you to start us off with your remarks.
21 MR. DARLING: I will, thank you. Thank you very
22 much. I come from the Washington Business Group on
23 Health which is the national voice for large employers
24 dedicated to finding innovative and forward solutions to
25 health care problems.

1 Our membership includes 175 mostly large
2
3 employers, Fortune 100, Fortune 500, representing about
4 40 million retired and active employees and their
5 families.
6 As employers we would, of course, not
7 surprisingly like to see a health care marketplace that
8 competes on the basis of quality, innovation, service
9 and price as other goods and services do.
10 Unfortunately, as I'm sure everyone in this room
11 knows, the health care marketplace doesn't function very
12 well, and it falls far too short on many of those, in
13 fact I would say virtually all of them.
14 Employers and consumers, which you also know,
15 it's in the paper almost daily, have been facing double
16 digit health care cost increases. Over a five-year
17 period we had 50 percent increases. This year, meaning
18 2002, are looking at 13 to 14 percent on top of the
19 50 percent. It's estimated that 2003 will be another
20 13 or 14 percent depending on whose numbers you use.
21 In effect, health care has indeed become more
22 unaffordable than ever, and of greater concern is
23 there's absolutely no end in sight. All of the
24 underlying forces currently driving health care costs
25 are there, and there's no reason to believe that they're

1 going to change any time soon.
2 Unfortunately, overall the growth in health care
3
4 cost, the spending has been associated in the last
5 couple of years with hospital costs. Up until 2000, the
6 main driver of health care cost increases were
7 prescription drugs. That changed in 2000. It will
8 change again in 2001, and given what we've seen in some
9 of the markets around the country and some of what you
10 all have heard, and you heard this morning from Cara
11 Lesser from the Center for Health Systems Change, we
12 have no reason to think that is going to change at all.
13 Provider consolidation, particularly hospital
14 consolidation, is we believe strongly aggravating these
15 cost increases. In a growing number of geographic areas,
16 urban and rural, northern California, Long Island, other
17 places, consolidation has left us with either a single
18 hospital or a few dominant systems, and they have in turn
19 chosen, for whatever complicated set of reasons, in some
20 instances to demand and essentially receive payment
21 increases of up to 40 percent in a single contract year.
22 We've also seen that there are hospital systems,
23 we've put that in quotes, that join together for cost
24 price negotiation purposes with no apparent evidence of
25 any other integration of services, resources or

1 referrals or anything else that might directly benefit
2 patient care.
3 We believe, not surprisingly, that these actions
4 hurt consumers and make it more difficult to institute
5 programs that improve quality and moderate cost.
6 We have had a number of highly public so-called
7 contract showdowns, again you heard about that this
8 morning, between hospitals in some communities and
9 payors reflecting the increase in the market power of
10 hospitals. Some of the most dramatic ones of course
11 were in Boston. I know we have someone here from the
12 Boston area.
13 I can tell you that I have many members who are
14 directly affected by what happened in Boston. It was
15 pretty amazing, really nothing like anything we've seen
16 in this country at least in my entire career. So things
17 have really changed rather dramatically.
18 We also know that consolidation which at least
19 in theory might provide some benefits for volume
20 referrals and some other things that we might value in
21 quality, what we have seen is no evidence that that
22 happens, and we could talk about some of the
23 trade-offs. The reality is we're not seeing any
24 trade-offs of any kind, other than increased cost and
25 virtually no changes in quality and certainly no changes

1 or no ability for health plans or employers to have any
2 ability to negotiate or frankly to even get some kind of
3
4 flexibility to talk about quality matters.
5 Also we know that hospital consolidation may
6 actively harm quality and certainly purchasers' and
7 consumers' ability to reward hospitals that compete on
8 quality and innovation and transparency in the health
9 system essentially is impossible if there's only one
10 hospital or one dominant hospital system.
11 So we don't even have the ability to do some of
12 the really important innovations, such as tiered
13 networks where we begin to change the dynamics of the
14 health system by empowering consumers with money, their
15 own money or the belief it's their own money because
16 they have choice. When choice goes away, all of our
17 ability to try to drive the system towards quality
18 innovation essentially goes away.
19 On prescription drugs, just to shift subjects,
20 employers support fair market rules that promote access
21 to affordable medicine as well as promote the
22 development of tomorrow's innovative therapies. We
23 believe that playing by the rules stimulates innovation
24 and promotes robust and fair competition that benefits
25 consumers.

1 Anti-competitive abuses and unwarranted delays
2 to market entry harm employers, employees and all
3 consumers, and we find that pretty unacceptable at this
4
5 point. Employers would also be very concerned about
6 efforts to ease or waive health care antitrust
7 regulations in general and for any specific segment of
8 the health care industry. Such a change is likely to
9 reduce access and competition and lead to higher costs,
10 particularly for some services or in some geographic
11 areas.
12 We urge you to carefully assess any proposal to
13 ease health care antitrust regulations to determine who
14 will really benefit. In an increasingly consumer driven
15 health care world, which is what we're already in, will
16 be more so as consumers pay an increased share of their
17 own health care costs, there must be clear benefit to
18 the consumer.
19 Employers applaud recent efforts by the FTC to
20 step up antitrust enforcement efforts in health care and
21 increase staffing in this area. We cannot say that
22 strongly enough. We are very pleased by what the FTC is
23 doing and feel that it's extremely important at this
24 time that they continue with that very impressive
25 effort.

1 In addition, employers believe that post merger
2 follow up and continuing oversight is essential to
3 determine whether hospital mergers have actually
4 benefitted consumers or simply allowed hospitals to
5
6 charge more and importantly resist efforts to improve
7 quality and patient safety.
8 And if I may, I would just like to make one
9 quote from an article in Health Affairs by Spange,
10 Bazolli and Arno, they concluded "The position that
11 hospital mergers should be presumed beneficial for
12 consumers, unless they pose severe threats to
13 competition, is not well supported." And we certainly
14 agree with that.
15 Finally, our point on information is that
16 transparency in the health system is an essential
17 ingredient for a truly competitive health care
18 marketplace and is essential if consumers are going to
19 be able to navigate and negotiate the system, which they
20 will have to do whether we do anything else or not.
21 Providers should be making information on
22 quality, utilization and performance easily available to
23 all consumers. In many cases a lot of information, very
24 valuable information is already publicly reported and is
25 not proprietary and does not risk any confidentiality

1 issues.

2 We believe that all hospitals should pose all
3 publicly reportable information in a user friendly way
4 on their web sites so that consumers can use it to
5 select on quality, efficiency and service.
6
7 Thank you.

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

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

20 Obviously we have a long way to go in
21 recognizing this hope, but our current president, Don
22 Young is a physician. Last November our board approved
23 a resolution strongly supporting open communication and
24 collaborative working relationships between HIAA and
25 organizations representing physicians and other health

1 care professionals. In approving this resolution,
2 the board heard that such relationships are necessary to
3 establish trust and to further the shared goals of
4 strengthening the physician and patient relationship and
5 encouraging high quality affordable health care.
6 Obviously we all recognize here that the Federal
7
8 Trade Commission is ultimately there to protect and
9 benefit the consumer, and if relationships between
10 physicians, health insurance plans and employers are not
11 functioning appropriately, consumers will be the ones
12 affected the most. If access to needed physician
13 services is compromised or if health insurance coverage
14 becomes unaffordable for employers, individual consumers
15 are the ones that are affected.
16 The issue of affordability is certainly an
17 important one, especially at the time of rising health
18 care cost. We've heard quoted earlier today recent
19 studies showing that employer based health insurance
20 costs rose 12.7 percent from spring 2001 to spring
21 2002.
22 I think quoting further from that study, they
23 said that this high rate of growth appears to have been
24 driven primarily by rapid inflation and spending for
25 health care services. Some people like to think that

1 it's rising premiums and with the assumption somehow
2 that insurers are the only ones that are involved or
3 explain the increase in costs, but again it's the
4 services and the cost both in terms of increased price
5 and increased utilization that are key here.
6 The report also, by the way, went on to say that
7 monthly employee contributions for health insurance rose
8
9 from $30 to $38 for single coverage, and from 150 to 174
10 for family coverage, and finally the study found that
11 employers responded to the rising cost by increasing
12 employee deductibles and copayments, reducing covered
13 benefits and even in some instances dropping health care
14 insurance coverage all together.
15 So in this context it's important to
16 consideration the implications of potential changes in
17 public policies on access, cost and quality.
18 The issue of whether consumers benefit when
19 providers combine to form what they call a
20 countervailing balance is one that is brought to the
21 forefront by physicians seeking to bypass antitrust law
22 and form cartels to collectively bargain with health
23 plans on fees.
24 HIAA, it's not secret, is strongly opposed to
25 any federal or state effort by physicians to gain this

1 kind of an exemption. A recent study by Charles River
2 Associates show that enacting physician antitrust
3 regulation would increase health care costs by 5 to 7
4 percent.
5 A more recent study by Charles River Associates
6 also states, "There are no economic principles that
7 support the argument that bargaining between two parties
8 that both possess market power leads to a superior
9
10 outcome for ultimate consumers, in this case patients,
11 than bargaining between one party with market power and
12 one without."
13 In our view physicians and providers currently
14 have significant market power and the ability to legally
15 negotiate with health plans. In addition, employers
16 have expressed the desire for less restrictive managed
17 care plan designs and access to large provider networks
18 through their employees, so this is another factor that
19 puts physicians and other providers in the position of
20 power in negotiations with health insurance plans that
21 need to contract with large numbers of physicians or
22 even with specific must have physicians in order to
23 satisfy consumer did he hands.
24 Testimony by Paul Ginsburg, the President of the
25 Center for Studying Health System Change, shows that one

1 likely factor resulting in an increase in the cost of
2 health insurance is hospital consolidation.
3 Physicians argue that health insurers that have
4 a significant health insurance market share possess
5 monopsony power or the power to suppress the purchase of
6 physician services and therefore suppress physician
7 fees.
8 While the insurance and physician service
9 markets are interrelated, they are not identical, and
10
11 the competitive characteristics of each market must be
12 analyzed separately. There is a great deal of
13 competition among health insurers in purchasing
14 physician services. As noted in one recent report "any
15 attempt by a single plan to decrease the rates it pays
16 providers below the competitive level would be offset by
17 its competitors taking the opportunity to augment their
18 provider panels and thereby grow their businesses at the
19 expense of the plan attempting to reduce its fees paid
20 to providers. Even if health insurers possess
21 significant market power, they might not have market
22 power in purchasing physician services."
23 Physician groups can use consolidation to increase
24 their bargaining power. Physicians can capitalize on
25 their good reputations or powerful presence in local

1 geographic areas to achieve leverage with insurers. In
2 addition physicians have other sources of income, including Medicare,
3 Medicaid, federal and state employee plans and
4 also obviously a big presence in the market, the
5 self-insured plans.
6 As Catherine Hanson reminded us earlier today,
7 the average physician has contractual or other business
8 arrangements with multiple private plans, and has she
9 told us, even if they contract in the case of a single
10 payor, then they have multiple payment arrangements with
11
12 different payment schedules.
13 It's also I think important to recognize that
14 insurers are subject to intense governmental scrutiny of
15 their business practices. Some examples of regulatory
16 oversight include the following: Regulation of
17 insurer's financial statements, regulation of insurer's
18 investments, financial examinations, review and approval
19 of premium rates and policy forms, regulation of form
20 and substance of disclosures, regulation of
21 discontinuance and replacement of policies,
22 investigation of consumer complaints, performance of
23 market conduct examinations, investigation and
24 prosecution of insurance fraud, and finally regulation
25 of trade and claim payment practices.

1 Indeed, there are few business activities an
2 insurer can undertake without having to consider
3 compliance with an existing law or regulation. This
4 includes issues relating to mergers, acquisitions and
5 antitrust. While actions taken by federal authorities,
6 both the Department of Justice and FTC, against insurers
7 for antitrust concerns are not common, this lack of
8 activity is not attributable to a lack of scrutiny.
9 Certainly this morning Deborah Majoras from the
10 Department of Justice told us a great deal of how they
11 were looking at the issue of consolidation and also
12
13 collective activity by insurers.
14 In addition to the national antitrust
15 enforcement agencies, State Attorneys General are also
16 very active, and we heard Ellen Cooper echo that early
17 today.
18 I would like to emphasize that the insurance
19 business is extremely competitive. There are multiple
20 pressures on insurers from purchasers of the product,
21 both individuals, and remember there are 16 million
22 individuals in this country who purchase their own
23 health insurance, as well the remainder of the population
24 that's covered obtains their coverage through their
25 employers.

1 There's also obviously pressure from providers
2 and also individual consumers. It's a difficult
3 business. It's a business where risk has to be managed,
4 and this is not easy, and you've heard about the
5 physicians in California who entered into risk
6 arrangements and who had difficultly.
7 Well, it's not easy to manage risk, and with the
8 cloud of bioterrorism hanging over us, it makes it even
9 more difficult, so once again, I would like to close by
10 thanking the Commission for providing HIAA this
11 opportunity to participate in this important forum.
12 Thank you very much.
13 MR. BOTTI: Thank you, Henry. And Stuart Fine,
14 Grand View Hospital.
15 MR. FINE: I'll just pick up where we left off
16 with the prior discussion. In the Philadelphia market,
17 we have a rather unique situation in that we have a
18 particularly concentrated payor market that creates
19 formidable barriers to entry to any insurance company
20 that might want to try to break in.
21 I've already described our situation at Grand
22 View Hospital where we have one insurer who has 67
23 percent of the non Medicare, non Medicaid market. I can
24 only imagine what it would be like, the deep pockets it
25 would take for an insurance company to come in and try

1 to position themselves to do business in such an
2 environment.
3 We heard comments in the previous panel having
4 to do with hospitals and hospital networks demanding
5 that people take or, excuse me, that insurance companies
6 accept all or nothing contracting, that each of those
7 networks must be taken as a network in full rather than
8 as individual facilities, should that group want to
9 contract with the insurance payor.
10 In Philadelphia we have the converse of that.
11 We have a situation where the predominant payor requires
12 all products be accepted. We have no option to say,
13 well, we would prefer not to participate in your
14 Medicare HMO product.
15 In our county, the only non government Medicare
16 product is provided by one entity that has 99.7 percent
17 market share. That is not something someone else can
18 come in and easily contend with.
19 We've heard from a couple different people
20 earlier today about hospitals involved in contract
21 showdowns where, rather than try to negotiate renewals
22 or changes to contracts, it's been made to sound like
23 there would be unilateral termination on the side of the
24 hospital. What wasn't stated was that the hospital
25 contracts all contain within them Evergreen provisions,

1 automatic renewal provisions, that if cancellation or
2 termination is not effected within 60 or 90 days prior
3 to the expiration date, that contract automatically
4 rolls over for another three to five year term.
5 My hospital was one of the hospitals that was
6 involved in such a situation in the Philadelphia market,
7 and for a period of five months, we worked to try to set
8 up meetings, face-to-face meetings, and we were denied
9 for five months. So we had no option but to submit a
10 notice of contract termination, and then it was made to
11 sound as if we had acted in a very Machiavellian way.
12 We have a situation with the health insurers
13 where we have market segmentation. In the situation
14 with BlueCross, we have county lines that BlueCross
15 plans won't cross, so we happen to sit in the very
16 northern end of Bucks County, Pennsylvania. We're
17 within the Independence Blue Cross territory, where if
18 we were just a few miles up in the world we would be in
19 the Capital Blue Cross territory.
20 We are not allowed to negotiate with Capital, to
21 have a contract with Capital. We have to do our
22 contracting through IBC, so there's market segmentation
23 that works one way but again can't work another.
24 What we're looking for is a road that runs both
25 ways, a level playing field, and we're very frustrated

1 that from the perspective of the hospital, we don't have
2 that.
3 When it comes to the issue of cost, in our
4 contracts, the standard in the Philadelphia area is an
5 inflation index tied to the Mcgraw Hill DRI. If we have
6 increased costs, for example, the professional liability
7 insurance costs that I mentioned a little while back that
8 went up a million dollars, we can't pass that through. We
9 get the DRI, and if you're lucky you get the DRI plus a
10 fraction of a percentage point, but you do not get to pass through
11 things like Zygrous, the new drug that costs over
12 8,000 dollars per course of treatment, the coated stents that we've
13 heard mentioned earlier today, the labor costs with
14 which we're all confronted, given the nursing shortage
15 and the shortage of pharmacists and radiation techs and
16 things like that. This is very, very frustrating.
17 We have an average age of plant that requires
18 attention. I know at my facility we're looking at a 30
19 million dollar enhancement to plant. Hospitals have
20 deferred and deferred acting on plant, but now we have a
21 situation with the baby boomers coming through where
22 demand for services far outstrips our ability to meet
23 that demand.
24 Nationwide, hospital spending has grown at a
25 slower rate than health care spending overall. We've

1 heard some inconsistent data here on this morning, and I
2 find that confusing myself, but I can only tell you that
3 the data that I've been reviewing and that I reviewed
4 even just this past Friday showed that up until at least
5 the year 2000, spending on health care increased 6.9
6 percent overall, but on hospitals it was 5.1 percent.
7 Hospitals account for 33 percent of the total health
8 care spending, but only 25 percent of the growth in
9 health care spending.
10 We have unfunded mandates with which we need to
11 contend, HIPAA, the Privacy Act is expected to cost
12 hospitals 22 billion dollars over the next five years;
13
14 disaster readiness, another 11 billion dollars over the
15 next two to three years.
16 We are working to improve quality and patient
17 safety. Those are not things for which we receive
18 direct compensation. We have Medicare and Medicaid
19 payment shortfalls.
20 Since the implementation of the Perspective
21 Payment System back in 1987, Medicare has passed through
22 less than their calculations concerning cost to
23 increases by a cumulative 21 percent. That's a very,
24 very hefty gap when in our case, as I've already stated,
25 Medicare and Medicaid provide 54 percent of our

1 revenues.

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

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

13 Access to capital, is very very problematic. In
14
15 2001, bond downgrades for hospitals exceeded upgrades by
16 six fold. We are an A 2 credit by Moodies, and we have
17 been told that if we go to the bond market this year, it
18 is unlikely that we'll be able to get bond insurance
19 because we happen to be situated in the Philadelphia
20 market. It has nothing to do with our balance sheet,
21 nothing to do with our credit rating. It has to do with
22 our geographic location.

23 Wrapping up, we have increased competition from
24 other providers. The merger activity around us has
25 actually slowed over the past five years, at least in

1 the market with which I'm familiar, but we still have
2 issues in some states with Certificate Of Need laws
3 being barriers to entry. In Pennsylvania, CON has gone
4 away, and we've seen a proliferation of things like open
5 heart surgery programs. We've seen 16 new programs
6 developed in the five county Philadelphia area in the
7 past two years, but the number of surgeries being
8 performed has not increased.
9 So we're seeing that segmented more and more.
10 We have the difficulties with Stark that I've made
11 mention of previously relative to inducements to refer.
12 We have specialty or niche providers such as cardiac
13 hospitals, heart hospitals, bariatric hospitals being
14 developed around us.
15
16 In the nation, we have one-third of our
17 hospitals operating with a negative operating margin.
18 In the Commonwealth of Pennsylvania that number is
19 two-thirds, so that's pretty much our situation. It's
20 pretty ugly.
21 As I say, what we would hope to see from FTC
22 activity is a leveling of the playing field, a situation
23 that not only looks at hospital alignment but one that
24 looks at the market power of insurers as well.
25 Thank you.

1 MR. BOTTI: Thank you, Stuart. Steve Foreman of
2 the Pennsylvania Medical Society. PowerPoint?
3 MR. FOREMAN: PowerPoint. Good afternoon. I'm
4 Steve Foreman. I'm director of Health Services Research
5 for the Pennsylvania Medical Society. I'm here to
6 present a bit of a different view than you may have
7 heard earlier today.
8 Many of our constituents see, at least think
9 they see a gradually disintegrating health care market
10 in the State of Pennsylvania. In fact, there's some of
11 us who are concerned that one or two random events might
12 cause that disintegration to accelerate rapidly, a
13 disintegrating screen, too. We're concerned about a
14 rapid disintegration in these markets and a total
15 unwinding to be totally blunt.
16
17 I'm just a poor North Carolina lawyer, so I
18 brought some pictures. We have four markets as defined
19 by BlueCross firms in Pennsylvania. I'm going to
20 present some figures from one of them, but we believe
21 they generalize. We conduct our analysis, we've been
22 doing this for about six years now, in what I will call
23 a comparative context.
24 We don't think that you can look at any one
25 segment of the market and reach conclusions about

1 competition or market power. We look at the relative
2 position of all the players in the market, so what I
3 mean very specifically is that in the market for health
4 insurance, that part of the segment, we look at the
5 relative power of insurers compared to employers, who
6 are the major purchasers here, and then in the other
7 segment, the market for medical care, we evaluate the
8 market power of providers like hospitals and physicians
9 compared with health insurers. We think this is the
10 best way to look at these markets.
11 Obviously we're using a structure conduct
12 performance analysis in doing this. We have actually
13 built some demand curves in, and we have found a number
14 of downward slopping demand curves, and we think that in
15 terms of ongoing research, that's an area where the
16 Commission might make some strides.
17
18 Our first picture in terms of the structure, I
19 said we're going to do this in a comparative context.
20 It's unnamed, I took the names out so we're not talking
21 about specific times, an unnamed market in Pennsylvania
22 with an insurance HHI of 6139, a 77 percent competitor
23 competing mostly with a 19 percent competitor. This is
24 all private commercial products, and we try to use this
25 in its broadest sense.

1 Employers, by contrast, are almost all smaller
2 than 250 employers. Employers do not bargain on an
3 equal level playing field in terms of the bargaining
4 between employers and insurance companies, at least in
5 terms of size.
6 In terms of hospital shares, we've seen rapid
7 consolidation in the last ten years. The HHI for
8 hospitals is 1464. I didn't have a number for
9 employers, by the way. It's 50. So hospitals have an
10 HHI here of 1464, and physicians, by and large, half of
11 the physicians in this market -- this goes back to 1980,
12 and I heard some facts and figures earlier today.
13 In 1980, about 45 percent of physicians were
14 engaged in practice, 16.4 in group practices. Take a
15 look at the change in the last 20 years. We're at 32.7
16 for physicians, 29.6 for group practice. In other
17 words, there's a structural change undergoing with
18
19 physicians. One of the things that we really believe
20 is that we can deal with the countervailing power issues
21 through the market. The market will evolve and one of
22 the concerns we have is what's going to happen when all
23 physicians are employed.
24 How does structure translate into conduct? We
25 look at conduct in three realms. One is operating

1 results. The other is process, do people negotiate or
2 do they dictate. The third part of that is what's in the contracts,
3 I'm going to focus on some of the results.
4 The contracts are highly illuminating. I used to
5 use them for my health law class. This is the dominant
6 insurer premiums per member per month going back to
7 1990. On average the increases have been at double
8 digit rates. That ties in with our question about the
9 relative power of employers and the dominant insurers
10 here.
11 This is the profits of the dominant insurer
12 going back to 1990, the blue line tied back to the blue
13 on that other chart, the red to the red. We think this
14 situation is not long-term sustainable.
15 Something that's not been talked about today are
16 reserves and unpaid claims, although it's been mumbled
17 about. In Pennsylvania, our insurance firms have rather
18 substantial reserves. These are well run companies.
19 These are actually good firms, most of them nonprofit,
20 but here's the reserves.
21 And one of the questions we have to ask in a
22 full market analysis is, how are reserves being used?
23 Why do we care about large reserves? Well, various
24 barriers to entry comes to mind immediately, also
25 efficiencies in terms of operation. Then unpaid

1 claims. Between reserves and unpaid claims, that's a
2 rather large sum of money that firms can use to invest,
3 and they can use it in terms of entry barriers.
4 What about hospitals? We saw the comparative
5 market power of hospitals. This is the same market.
6 That red arrow is the profits of system hospitals.
7 System hospitals made more in profits than the health
8 insurers in that market. The health insurer made a
9 little over 200 million dollars before tax. The
10 hospitals in that market made 280 million dollars. So
11 countervailing power may make a difference here.
12 What about physicians? Well, those two light
13 blue lines at the top -- this is seven selected
14 specialties. We didn't do a weighted average. We just
15 weighted all codes for these specialties. The light
16 blue lines at the top are the national averages, the
17 national means for these specialties.
18
19 Medicare is there in red and Medicaid in
20 orange. Medicare pays less than half, sometimes even a
21 third of national averages. Medicaid pays less than
22 that in Pennsylvania. In fact I go into these meetings
23 and I even mention Medicaid, and I have some physicians
24 get up and yell and scream, and I can't finish.
25 The dominant payor that I talked about there

1 pays less than Medicare in this market. That is not
2 market power.
3 So what are we saying here? First of all, the
4 structure and conduct of these markets has some obvious
5 impact on the industry. You've heard reports about
6 diminished coverage, as employers respond to increasing
7 health care premiums and even some employers that are
8 dropping coverage all together. We wonder whether
9 that's evidence of an unwinding market.
10 In addition, we see substantially increasing
11 concentration in markets across the state, even across
12 the country, unrelated to economies of scale.
13 Physicians, physicians really would like to work
14 well with everybody in the system. I will tell you in
15 my travels about the State of Pennsylvania, the biggest
16 physician concerns these days are departures, early
17 retirements, unwillingness to come to practices in the
18 State of Pennsylvania. We see situations where
19
20 residencies aren't filled. Medical school applications
21 are down, and out just in Claring, Pennsylvania, last
22 week, these situations are hitting hardest and fastest
23 in rural areas of Pennsylvania. Again we wonder about a
24 market unraveling.
25 What do we do? I think that our constituents

1 would be first in line yelling and cheering if we were
2 to restore full competition to health insurance in
3 medical care markets. That would be a first best
4 solution that everyone I think would really go along
5 with. In every area, it would not necessarily mean
6 physician fee increases, mark that.
7 In fact in some ways, as I said, I had a doctor
8 explain to me, this is a tragedy of the medical commons
9 in a way. We have a number of entities in this system
10 playing out self interests in a way that is unhealthy
11 for the whole system. Everybody needs to make some
12 contributions to dealing with it, and I think everybody
13 means everybody.
14 If we can't restore full competition to these
15 markets and given where we've evolved, that might be a
16 tall order. If we think Microsoft was difficult, this
17 might be of a magnitude bigger. Then we need to think
18 about some countervailing power responses to it.
19 As I said earlier, we can either that do by
20
21 regulation or by legislation, or we can let the market
22 do it. You will see employer buying cooperatives and
23 you will see employee physicians coming out of this if
24 there's a really countervailing power imbalance.
25 Third, I suppose the state menu, the menu of

1 state action, could come to play here, although we heard
2 this morning about the enforcement problems that come
3 along with that.
4 Get ready for a single payor system. I think
5 we'll see another national campaign waged on this issue
6 if we don't deal with market breakdown in health care.
7 Finally, and near and dear to my heart, I think
8 we need a whole range of much better research on where
9 we are and where we're headed in this industry, simple
10 things like optimal sizes of firms, providers, more
11 complicated issues like countervailing power.
12 Let's really research countervailing power, get
13 the vitriol out of all this and take a look at where
14 this all heads. Other items like tracking state action
15 doctrines where they're implemented. I'm talking about
16 a whole research agenda, although I must say I'm not
17 sure we have a big window of opportunity here.
18 I'm quoting Fran Swoisman who runs Health
19 America in Pennsylvania. I was on a panel with him a
20 couple weeks ago. He said, This system is broke. This
21
22 system is very broke, and if we don't, insurance
23 industry providers, employers, find a way to craft a
24 solution to this, we will have the solution imposed
25 on us.

1 Thank you much.
2 MR. BOTTI: Thank you, Stephen. Stephanie
3 Kanwit of the American Association of Health Plans.
4 MS. KANWIT: Thanks very much, Mark. Well, on
5 that downer note, Stephen Foreman, I won't introduce
6 myself again since this is a reprise.
7 In terms of the payor-provider issues that are
8 the subject of this panel, AAHP and its member plans
9 strongly support both competition and cooperation among
10 all participants in the health care delivery system.
11 Competition creates incentives for health care providers
12 to increase their efficiency, lower their cost and
13 improve quality.
14 Competition among health plans spurs them to be
15 innovative and efficient and assures that the savings
16 they obtain through their negotiations with health care
17 providers will be passed on to consumers through lower
18 prices to employers which pay for the bulk of the
19 premiums and ultimately to all of us, the employees.
20 Cooperation between health plans and provides
21 promotes payments for services that are timely and
22
23 appropriate for properly submitted claims as well as a
24 better system wide integration of evidence-based
25 standards into the practice of medicine, very important,

1 evidence-based standards.

2 Simply put, competition and cooperation are
3 necessary ingredients for a health care system that
4 ultimately puts consumers first so that as many as
5 possible have access to affordable health care that is
6 of the highest quality.

7 When standards for competition are loosened or
8 when cooperative efforts are hindered, consumers lose.
9 Their health care costs rise. Ability to afford access
10 to the system declines, and quality and safety
11 improvement efforts are undermined.

12 Any consideration of altering existing antitrust
13 laws or the statement of antitrust enforcement policies
14 in health care should start with one key question, one
15 fundamental question, Does this proposed change help
16 consumers or does it hurt consumers?

17 As Helen Darling noted on this panel, health
18 care costs are rising at the fastest rate in a decade.
19 Consumers today view affordability as the single most
20 important problem in health care today.

21 The second most important problem, and this is
22 according to consumer polling, is the high number of
23
24 uninsured, which tends to rise, of course, with the cost
25 of health care. In fact, one recent study suggests that

1 with every 1 percent rise in health care costs 300,000
2 more Americans lose access to health insurance.
3 All of us, whether representing providers or
4 payors, have a crucial task to accomplish in the
5 immediate future, to work together to address these very
6 serious concerns while continuing our best efforts to
7 integrate the latest and best medical science into the
8 practice of medicine.
9 In terms of that best medical science, I would
10 remind you of recent information regarding Hormone
11 Replacement Therapy, HRT, and arthritic surgery. These are
12 two examples of areas where assumptions about medical
13 efficacy were simply proven wrong, to the detriment of
14 patients and the health care system as a whole.
15 Preserving standards for healthy market
16 competition among all members of the health care
17 community is an indispensable part of these efforts.
18 Now, health care antitrust guidelines, you have
19 asked for our views on the current statements of
20 antitrust enforcement policy issued by the Commission
21 and the Department of Justice. First, we reject the
22 contention that the guidelines need to be amended to
23 allow providers to collectively negotiate regarding
24
25 price.

1 The current guidelines, as we discussed somewhat
2 in the last panel, provide sufficient flexibility for
3 providers to create new and alternative ways of creating
4 delivery networks to provide patients quality care.
5 At the same time, the guidelines unfortunately
6 may have had the unintended consequence of giving
7 providers more opportunity to form cartels. Several
8 years ago when changes were made to the guidelines we
9 raised this concern, 1996.
10 Unfortunately, the activities we are beginning
11 to see in certain parts of the country now suggest that
12 these concerns were warranted. The FTC's MedSouth
13 advisory opinion, which again we discussed extensively
14 in the last panel, we believe allows flexibility to
15 create new alternatives that can lead to improved
16 quality of care.
17 Notwithstanding MedSouth, some physicians have
18 continued to argue that the guidelines and current
19 antitrust laws prevent them from communicating about
20 such issues as quality, utilization management or
21 contract terms. The rhetoric doesn't match the
22 reality, and moreover, it continues to be used as a
23 device to justify a long standing effort to seek changes
24 to the antitrust laws in the form of exemptions or other
25

1 special treatment for providers. Were the FTC to
2 provide this type of special treatment, consumers would
3 certainly pay the price.
4 The antitrust laws have always permitted, always
5 permitted health care providers to join together to
6 provide more efficient health care and negotiate with
7 health plans. For example, by forming group practices,
8 which can often include groups of a hundred or even a
9 thousand or more, physicians can create substantial
10 economies of scale. These arrangements provide a lawful
11 means by which physicians can achieve efficiencies and
12 negotiate collectively with health plans.
13 While providers have argued that alternatives to
14 these arrangements are needed to create a "more level
15 playing field for competition," in fact their proposals
16 would do just the opposite. They would create large
17 powerful provider cartels which would both restrict
18 consumer choice and hinder the ability of health plans
19 and employers to manage escalating health care cost.
20 In 2000 the consulting firm LECG estimated for
21 us at AAHP that enactment of physician collective
22 bargaining legislation would increase health care
23 expenditures by 141 billion dollars over a five-year
24 period, 141 billion, or 8.6 percent private health care
25 costs during its peak year.

1 According to a separate LECG study, that would
2 result in almost 17 million people losing insurance over
3 the next five years and 855,000 people losing their jobs.
4 For consumers, that is simply too high a price.
5 Now, there have been several recent settlements
6 between provider groups and the FTC that highlight these
7 concerns regarding collective bargaining and the harm
8 that befalls consumers when providers are allowed to
9 negotiate the terms that include price fixing.
10 One example, which many of you are probably
11 familiar with, is the recent Dallas Fort Worth Physician
12 Groups settlement. In that case, the FTC determined
13 that the physician groups management company's actions
14 restrained price and other forms of competition. As a
15 result physician fees rose significantly and health
16 care costs for consumers, employer and payors in the
17 public and private sector increased.
18 These activities by providers reveal the
19 significant problems that anti-competitive activities
20 cause for consumers. We commend the FTC and the
21 Department of Justice for their consistent opposition to
22 any special exemption for physicians or other health
23 care professionals, and we continue to believe that
24 providers should be allowed to negotiate as permitted
25 under the existing laws and guidelines.

1 Penultimately here, I want to talk about the
2 uniform model contracting and class action litigation.
3 Very briefly these are two additional strategies that
4 providers currently are using to advance their arguments regarding the
5 need for a more level playing field, number
6 one, advocating for a uniform contract with all payors.
7 Number 2, joining with plaintiffs' attorneys in filing
8 class action lawsuits to force disclosure of health plan
9 fee schedules and rate payment information.
10 In fact, we believe that disclosure of contract
11 terms and payment rates to all players in a market would
12 eliminate the opportunity for negotiating to keep prices
13 affordable for consumers.
14 Essentially such disclosure would lead to a rate
15 setting process in which providers have the opportunity
16 collectively to drive rates to the highest possible
17 level. As a result competition in the market would be
18 eliminated.
19 Lastly some recommendations. We've all been
20 talking this afternoon and this morning as well about
21 the purpose of the antitrust laws, in a nutshell, to
22 promote and preserve competition for the benefit of
23 consumers, not individual competitors.
24 To that end, we believe that the FTC and the
25 Department of Justice can make a positive contribution

1 by, number 1, continuing their work in an active
2 enforcement of the existing antitrust laws; number 2,
3 working with the state and local levels in a unified
4 collaborative approach to antitrust enforcement
5 throughout the health care system; and number 3,
6 facilitating an open dialogue about what are and what
7 are not permissible negotiating parameters under the
8 existing statements of antitrust enforcement policy in
9 health care.
10 In sum, we believe it's a time to build bridges,
11 not fences, and to work together in addressing the
12 problems facing our health care system.
13 Thank you.
14 MR. BOTTI: Thank you. Donald Palmisiano of the
15 American Medical Association.
16 MR. PALMISIANO: Thank you. Good afternoon. My
17 name is Donald Palmisiano. I'm a surgeon from New
18 Orleans, Louisiana, and I'm president elect of the
19 American Medical Association. It's a pleasure to be
20 here today on behalf of the AMA to address the Federal
21 Trade Commission regarding antitrust issues involving
22 physicians and third-party payors.
23 We approach the topic of antitrust enforcement
24 before this Commission with great respect and serious
25 concerns. To put it bluntly, we believe that federal

1 antitrust agencies have placed physicians under far
2 greater scrutiny than is warranted by our comparative
3 economic strength in today's health care system.
4 In recent years, physicians and physician
5 organizations have been the subject of approximately 50
6 enforcement actions. Virtually all of the physician
7 organizations in these actions have been small in
8 economic and practical terms. It is no wonder that
9 every one of these organizations settled with the
10 Commission rather than commit to a time consuming
11 struggle which likely would have depleted the
12 organization's resources before reaching decision.
13 By contrast, we know of no single FTC action
14 against a third party payor ever. We are very
15 encouraged to hear today by the Department of Justice's
16 Deborah Majoras that the Department of Justice will give
17 close scrutiny to the competitiveness of payor markets.
18 The absence of enforcement activity on the payor side to
19 date is puzzling because there are plenty of reasons to
20 be concerned about the competitiveness of payor
21 markets.
22 In the latter half of the 1990s, managed care
23 organizations consolidated at a record pace. Today
24 we're seeing double digit increases in health premiums
25 and in health plan profits. At the same time consumers

1 have expressed deep dissatisfaction with managed care,
2 and physicians have found themselves vastly over powered
3 in their dealings with payors.
4 In any other industry, a merger wave followed by
5 an abrupt rise in prices would cry out for an
6 investigation, but so far these conditions have only led
7 to renewed calls by the Commission "to get tough against
8 physicians and other health care providers." Something
9 is amiss.
10 Our suggestion today is that the time is right
11 for the Commission to consider a fundamental shift in
12 how it deploys its resources within the health care
13 field. As I just indicated, in the latter 1990s, it was
14 a period of unprecedented consolidation among health
15 insurers. Between 1995 and 2000, there were over 350
16 mergers.
17 Today, the ten largest health plans control over
18 half of the commercially insured persons. The effects
19 of consolidation are most clearly seen at the local and
20 regional levels. Last year, the AMA conducted the most
21 comprehensive study ever undertaken of competition in
22 health insurance.
23 What we found was staggering. Out of the 40
24 large metropolitan statistical areas or MSAs across the
25 country, approximately 70 percent of HMO markets were

1 highly concentrated. 87.5 percent of PPO markets were
2 highly concentrated, and nearly half of the combined HMO
3 PPO markets were highly concentrated.
4 Moreover, in roughly half of these highly
5 concentrated MSA market, a single payor had a market
6 share in excess of 40 percent, and in a quarter of these
7 markets a single payor had a market share in excess of
8 50 percent. The study confirmed what patients,
9 physicians and employers already knew. In many parts of
10 the country, health insurance markets are dominated by a
11 few companies that have significant power.
12 We also looked beyond market concentration at
13 other characteristics of payor markets. In doing so, we
14 found further cause for concern. Payor markets are
15 characterized by significant regulatory barriers to
16 entry. To enter a market, a payor most invest millions
17 of dollars to comply with state regulations governing
18 insurance companies. The payor must also invest time,
19 labor and money to establish relationships with
20 physicians and other providers in the market.
21 These costs and regulatory hurdles facing a new
22 entrant make it possible for an existing dominant payor
23 to increase premiums without concern that it will lose
24 its market share. Even worse large payors often use
25 contractual devices to lock in physicians and keep out

1 new rivals. The large companies are clearly in the
2 driver's seat.
3 On the supply side, physicians face unique legal
4 and ethical responsibilities that enhance the ability of
5 payors to exercise market power. Unlike suppliers in
6 most areas of the economy, physicians can't rapidly
7 switch customers in response to changes in price.
8 Physician's decisions are driven by their relationships
9 with their patients.
10 The combined effect of these conditions is to
11 enable an insurer with a large market share to increase
12 its premiums while also reducing physician payments.
13 Dominant plans can wield enormous bargaining
14 power, often driving payment rates well below the level
15 needed to provide medically necessary care, and in some
16 cases forcing medical groups into bankruptcy. From the
17 consumers' perspective the result has been chaos, higher
18 out of pocket expense, longer waiting times and reduced
19 access to physicians.
20 If the late 1990s were a period of mergers and
21 acquisitions in managed care, the years since have been
22 characterized by increasing health plan premiums and
23 profits. Again let's take a look at the facts. From
24 2000 to 2001, premiums increased by 11 percent, the
25 fifth consecutive year of increases, outpacing overall

1 inflation by a wide margin. Preliminary results of a
2 recent survey indicate that HMOs expect to implement
3 double digit premium increases in 2003.
4 These recent increases have not been primarily
5 driven by increases in medical costs. Data also
6 indicate that premiums have been rising at a faster rate
7 than administrative costs and claims expenses. Further,
8 recent reports on payor profits refute any notion that
9 claims expenses are driving premium increases. Profit
10 margins of the major national payors have been steadily
11 rising, despite a slow down in the general economy.
12 In 2001, health insurers reported a 25 percent
13 increase in profits. In the second quarter of 2000,
14 most national insurers posted increased profits and in
15 one case an increase of more than ten fold. To the
16 extent that premium increases are attributable to rising
17 costs of health care, physicians costs have not been one
18 of the major drivers.
19 The federal government's own data shows growth
20 in spending for physician services decreased from 1991
21 to 1996. Then after a few years of slight increases,
22 payments leveled off in 2000. However you cut the pie,
23 physician costs today are simply not a significant
24 factor driving growth in overall health care costs.
25 Why is it then that the Commission continues to

1 focus on physicians rather than payors? Is there
2 something about physician markets that justifies the
3 Commission's extraordinary vigilance in policing them?
4 Alternatively, is there something about payor markets
5 that justifies a hands off attitude?
6 One perspective is that payors are simply
7 purchasers of health care services whose interests are
8 closely aligned with consumers. Under this view, when
9 payors prevail in fee negotiations, the ultimate winner
10 is the patient. This view is terribly naive. Patients
11 don't buy the idea that their interests are aligned with
12 their health plan, witness the "managed care backlash"
13 of recent years.
14 Patients do share an interest in avoiding
15 unnecessary expenses, but they also have an intense
16 interest in receiving high quality medical care, an
17 interest that health plans do not necessarily share.
18 Furthermore, payors are not merely purchasers.
19 They're also sellers. Employers who negotiate premiums
20 with health insurers know this fact all too well.
21 Payors don't simply pass through expenses. Premiums
22 reflect administrative expenses in profits, not just
23 claims expenses, so competition in the health insurance
24 sector really matters.
25 When health premiums rise due to lack of

1 competition, some employers providing coverage or reduce
2 the scope of benefits provided. Lack of coverage places
3 enormous pressures on other segments of the health care
4 system. It also leads to increase expenditures for
5 emergency treatment.
6 Further, as the Justice Department recognized in
7 the Aetna matter, a lack of competition among health
8 insurers may also open the door for health plans to
9 exercise monopsony power, often leading to physicians
10 leaving the market and reducing access to care for
11 patients. These are precisely the effects that are
12 being currently observed in a number of markets that are
13 dominated by large payors.
14 In short, the Commission should care about
15 competition in the health insurance sector. There is
16 simply no justification for a one sided enforcement
17 policy that puts the sole burden of compliance on
18 physicians.
19 In closing, we respectfully ask the Commission
20 to reconsider its approach and take a serious look at
21 competition on the payor side. In our written
22 testimony, we offer numerous issues that we think merit
23 particular attention.
24 Thank you for the opportunity to participate in
25 these proceedings. The American Medical Association

1 hopes to continue a dialogue with the Commission
2 regarding these important issue.
3 Thank you.
4 MR. BOTTI: Thank you very much. Lawrence Wu
5 with NERA.
6 MR. WU: Thank you. I want to thank the FTC for
7 hosting and organizing this workshop and for inviting me
8 to speak.
9 I am encouraged to see the FTC's continuing
10 interest in fostering competition in health care
11 markets. Competition is not just an antitrust issue. I
12 believe competition can help us control the rise in
13 health care cost, which has long been an important
14 public policy goal.
15 My perspective is a little bit different from
16 the others on this panel. As an antitrust economist, I
17 am interested in understanding the sources of market
18 power in an industry and in measuring its effects.
19 As a health economist, I'm interested in the
20 public policy questions related to health care cost
21 containment, and as an empirical economist, I have a
22 natural interest in numbers, and when it comes to health
23 care, there are some pretty big numbers that caught my
24 interest and the interest of others on this panel as
25 well.

1 So let me start there. A recent survey found
2 that employers' health insurance premiums increased
3 almost 13 percent from 2001 to 2002, the largest
4 increase since 1990. This is higher than the inflation
5 rate, which was 1.6 percent. Increases in premiums for
6 small employers are even higher, and experts believe
7 that the average premium will rise anywhere from 12 to
8 15 percent from 2002 to 2003.
9 Spending on health care services and
10 prescription drugs has increased around 7 percent per
11 year recently. Sound small? Not compared to the 2
12 percent growth rates that we had in the mid 1990s. To
13 give you a little more perspective, spending on hospital
14 in-patient care actually declined from 1994 to 1998, and
15 that's not the case anymore.
16 By most accounts we are headed for significant
17 increases in health care spending, and as a result the
18 demand for cost containment will be stronger than ever.
19 So what can we do to control cost?
20 In broad terms, we have three strategies. One,
21 we can reduce prices paid to providers; two, we can
22 manage health care utilization better; and/or three, we
23 can accept a lower quality of care.
24 I want to talk a little bit about each of these
25 cost containment tools, but more importantly, I want to

1 talk about the role that competition can play and has
2 played in developing innovative ways to control the rise
3 in costs. Because competition is so important, I will
4 include a few observations on the vital role that
5 the FTC has and will continue to have in preserving
6 competition in this industry.
7 What can health plans do to control cost?
8 First, health plans could continue to try to reduce the
9 prices that are paid to providers. In the past, this
10 has come about through HMOs, who use selective
11 contracting with providers as a way to negotiate lower
12 provider reimbursement rates.
13 Will this continue to work? Not without some
14 major change because the HMOs have lost quite a bit of
15 bargaining power in recent years. If the past five
16 years is any indication, employers have shown that they
17 prefer PPOs and health plans that do not limit
18 coverage to certain hospitals and physicians. But,
19 limiting coverage is the backbone of selective
20 contracting.
21 Health plans also could reduce cost by managing
22 health care utilization better or by reducing the
23 quality of care that is provided or covered by a plan.
24 Again, if the past five years are any indication, it
25 isn't clear that employers and employees will embrace

1 more controls that will restrict the amount of medical
2 care that is provided and paid for. Consumer concerns
3 about the quality of care provided to HMO enrollees have
4 already made HMOs reluctant to further manage access and
5 use of health care services.
6 Now, if we can't count on the traditional tools
7 of managed care and if consumers are not willing to
8 accept a lower quality of care, are we destined for
9 double digit inflation? I don't think so, but we have
10 to allow competition to take its course.
11 Here's what I mean. If you go back to the
12 basics, it's pretty clear that managed care was able to
13 reduce the rise in health care spending by doing two
14 things, encouraging competition among providers and
15 encouraging consumers to shop for a health plan on the
16 basis of price.
17 What happened? The market evolved. Using
18 selective contracting, HMOs proceeded to negotiate low
19 reimbursement rates with providers, with lower cost.
20 The HMOs went to the marketplace and sold low price
21 insurance. Employees and employers loved the low
22 premiums and enrolled by the millions, and this only
23 served to give HMOs even more leverage to negotiate even
24 lower prices with providers.
25 In this way, managed care changed the nature of

1 competition so that market forces could be used to
2 control costs. Managed care wasn't perfect, but it
3 worked. Total health care spending stabilized as a
4 percent of the gross domestic product, and the rise in
5 premiums and provider cost slowed.
6 Then consumers started to express their
7 dissatisfaction with some of the restrictions that came
8 with managed care. We wanted more freedom of choice,
9 and we didn't want to have to get a referral before we
10 were allowed to see a specialist. What happened?
11 The market evolved, and we saw the introduction
12 and proliferation of numerous types of health plans that
13 varied in terms of copayment rates, benefits coverage
14 and access to care. By the mid 1990s, enrollment in
15 HMOs started to fall, and HMOs began to lose their
16 ability to negotiate low rates with providers. Not
17 surprisingly, provider costs and premiums are again
18 raising at levels not seen since 1990.
19 Where will it end? I don't know, but the market
20 is evolving. For example, more and more health plans
21 are starting to introduce triple tiered pricing, which
22 is a fancy word for charging consumers different
23 copayment rates depending on their choice of provider.
24 The hope is that by charging different copayment rates
25 for say different hospitals, consumers will pay more

1 attention to price.
2 Just as important, the expectation is that
3 tiered pricing to consumers will lead to tiered pricing
4 to providers, which should help stimulate price
5 competition among providers for contracts for health
6 plans.
7 This sounds like old-fashioned competition, and
8 it is, but as the financial incentives become more
9 complicated, it is likely that the contracting and
10 reimbursement arrangements between payors and providers
11 also will become much more complicated.
12 Providers have not and won't be standing still
13 to make themselves attractive to health plans. Providers
14 have found, with varying degrees of success, new ways
15 to reduce and control the rise in cost. MedSouth,
16 an IPA of south Denver that was the subject of a recent
17 FTC staff advisory opinion, is a great example of a
18 physician group that is trying to find innovative
19 solutions that will help patients and lower costs.
20 Will tiered pricing and providing integration
21 eliminate concerns about cost containment? Again I
22 don't know, but what I do know is that the market will
23 evolve. The solutions that will survive will not be
24 driven by the health plans, and they will not be driven
25 by the providers.

1 The solutions that will survive will be driven
2 by what employers and employees want and by the tools
3 that consumers want to put in the hands of the health
4 plans.
5 What does this mean for the FTC? First the
6 Federal Trade Commission will probably have an important
7 role in commenting on physician collective bargaining
8 laws and legislation such as the Patient's Bill of
9 Rights. Many, if not all, of the proposals for
10 collective bargaining have included provisions that
11 would allow some physicians to price jointly without
12 integration.
13 And second, the FTC will continue to play an
14 important role in evaluating the competitive effects of
15 mergers, contracts and other changes in ownership and
16 organizational form. These organizational changes,
17 especially if they involve complex contracts, will
18 likely affect the way contracts between payors and
19 providers are written, which will change the way health
20 care is delivered, priced and paid for.
21 The task facing the FTC will not be easy, one,
22 because it is likely that the responses of health plans
23 and providers to consumer demands for cost
24 containment could have pro-competitive as well as
25 potentially anti-competitive consequences.

1 For example, in evaluating the buyer power of a
2 health plan, we will need to be careful to distinguish
3 sensible and pro-competitive cost controls from the
4 exercise of market power that also lowers the amount that
5 is paid to providers. It is not always easy to separate
6 the two theories but we must try.
7 The dynamics of competition also complicates
8 matters by making it harder to conduct a forward looking
9 antitrust analysis. In this context, I like the FTC's
10 recent initiative to take a retrospective look at
11 consummated hospital mergers because this approach to
12 merger analysis is premised in the belief that in the
13 first instance, the market is capable of sorting things
14 out.
15 Post merger reviews, if they can be done well,
16 and if we have the patience to let the market sort
17 things out, lessens the pressure to forecast the future.
18 This is probably helpful in this industry, which is
19 complicated and needs extra understanding and
20 flexibility in times of change.
21 So in summary, competition is an important part
22 of the cost containment process. It is the dynamic that
23 encourages providers to find new ways to develop high
24 quality cost effective medicine. It is also the dynamic
25 that's encouraged payors to find ways to slow the rise

1 in health care costs of employers and employees.
2 The challenge for the FTC will be to protect and
3 preserve competition without discouraging the
4 marketplace incentives that are helping payors,
5 employers and employees control the rise in health care
6 cost.
7 MR. BOTTI: Thank you. Let me start off by
8 thanking each and every one of you for some very
9 thoughtful and provocative comments to get this panel
10 started. There's a lot of diversity of opinion that's
11 just been expressed, but there is some uniformity, and I
12 think one of the uniform themes is we're seeing
13 increasing health insurance premiums, increasing costs
14 in this system, and questions of what's the cause of
15 that are dividing some of you.
16 If I can comment briefly, I've sort of heard
17 three different things come out as primary themes. One
18 is that the payors are consolidating or somehow
19 exercising market power.
20 Two is the principal focus on the hospital
21 segment of the industry. The third is Lawrence's
22 comments, that there's evolving consumer preferences
23 that are perhaps affecting the way in which the system
24 is operating and allowing some increase in the prices.
25 I want to focus for a moment on one factual

1 issue, and that is payor consolidation, and I would like
2 to turn to our payor representatives and get your
3 comments on that. Henry, if I could start with you,
4 you've had a chance to rest for awhile since you started
5 first, and ask your views, has there been a
6 consolidation among payors? Is it a healthy thing? Is
7 it counterproductive in some areas? Can you comment on
8 that, please?
9 MR. DESMARAIS: Sure. There has been
10 consolidation. We heard this morning actually that a
11 lot of it was not at the local level but was across
12 geographic regions, so if a payor in California chooses
13 to purchase a payor in Maryland, that's consolidation,
14 but I would be hard pressed to show how that's
15 anti-competitive and could produce problems.
16 There's certainly been consolidation with
17 companies, and we know that the federal and state
18 officials, there is oversight. In fact when two payors
19 tried to merge, they were told they needed to divest
20 themselves of certain issues in the State of Texas,
21 so people were looking to see what the impact would
22 be of the merger.
23 So again I think people are watching. There is
24 some consolidation going on, but not always at the local
25 level which I think is significant here. I think too we

1 hear a lot that the single payors in a state have a huge
2 market share of at least a small part of the market we
3 want to look at, so I think that's another issue.
4 We also have to ask ourselves, What's the
5 denominator before we look at what the numerator is, but
6 a lot of that is honestly the Blues Plans, and there's
7 historic reasons for that, how they came about, how they
8 were formed involving both hospitals and physicians and
9 their initial formation, how many of them remain not for
10 profit, how many of them have certain obligations placed
11 upon them by state government in terms of insurer of
12 last resort.
13 So there's a lot of complex issues I think that
14 as we look at the market -- I don't know if Stephanie
15 wants to add anything.
16 MR. BOTTI: Stephanie if you would like to pick
17 up on it, and let me ask you in particular, accepting
18 Henry's point that some consolidation may be across
19 localized geographic areas, has there been consolidation
20 on a local level, the type concentration that may or may
21 not be anti-competitive, but is the type of thing we
22 look at in antitrust?
23 MS. KANWIT: I'm not aware, Mark, of any
24 competitive consolidations by health plans, and I think
25 the Department of Justice has made statements to that

1 effect, certainly the former chief Joel Klein, et
2 cetera. I mean, there's really two questions. One is
3 do health plans after consolidation have monopsony
4 power, and are we looking at, as Henry says, the right
5 denominator.
6 I think one of the many factors that goes in the
7 mix that people forget is that the bulk of health care
8 dollars in the United States are spent for Champus,
9 Medicare Medicaid, FEHBP, the other health plans and
10 they're not the commercial insurance market, so we have
11 to be careful.
12 But the other really big point, and Helen made
13 this just a little while ago, is consumer choice. You
14 saw some slides this morning that I thought were
15 excellent, I think they were Cara Lesser's slides, where
16 she pointed out that the majority of employees, health
17 care consumers in the United States have a choice of two
18 or three health plans right now. 60 percent of them
19 have a choice of two or more, and 40 percent have a
20 choice of three or more, so that's really the bottom
21 line.
22 When we start talking about consolidation in the
23 abstract, again we have to come back to what is the
24 impact on consumers, and I certainly am not seeing any
25 competitive impact out there.

1 MR. BOTTI: Stephen. Please, go ahead.
2 MR. FINE: I'm sorry. Part of this may be an
3 issue of definition when we talk about consolidation.
4 Again in the Philadelphia market, most consumers do have
5 a choice between multiple plans. They could, for
6 example, have independence BlueCross Keystone,
7 independence BlueCross PPO, BlueCross Commercial,
8 Independence BlueCross I believe it's Blair Mill
9 Administrators. There are five or six different
10 products.
11 The parent BlueCross is a not-for-profit
12 entity. Most, if not all, of the other health plans
13 that are subsidiaries are for profit entities. So we
14 need to look again at each market individually, but make
15 sure that we don't focus on, Was there a merger of two
16 existing plans or did one plan create alternatives but
17 in an effort to potentially dominate that market.
18 MR. BOTTI: Fair enough point, that we need to
19 get underneath the statistics and see what's meant by
20 that. Stephen, you've taken a pretty close look at
21 Pennsylvania markets, it sounds like, and gave us some
22 statistics on market share of health plans.
23 Can you address whether that's the result of
24 some type of consolidation? Is that a historical number
25 that's been consistent over the years? Has it grown,

1 and if there's been growth, what's the source of it?
2 MR. FOREMAN: In Pennsylvania we've had two
3 factors that have contributed to this. One is, as Henry
4 mentioned, the historical role that the BlueCross firms
5 have played in the state, and at one point in time back
6 in the 40s and early 50s before other entry, they were
7 the only plans.
8 More recently there's been a merger of BlueCross
9 of Western Pennsylvania and Pennsylvania BlueShield. As
10 part of that merger, Independence BlueCross gained sole
11 control of Keystone East Health Plan so merger and
12 acquisition activities played a role here.
13 One thing I would like to sort of point out as
14 an overview on this is that, number 1, it should be the
15 concentration that we look at in the market that exists,
16 not necessarily what's historically gone before, and
17 then number 2, if there is a concentrated market, what
18 do we do with it? In other words, how is that
19 concentration been used?
20 Just sort of as an overview so we don't get side
21 tracked, it's pretty clear that in a lot of these
22 concentrated markets, the health plans are not price
23 takers. In other words, the touchstone of competition
24 that we're arguing about here would be price taking
25 behavior. We have price making firms, and we have

1 prices that are being set by negotiation. That's not
2 competitive either. That's a game theoretic, and we
3 haven't really studied the application of game theoretic
4 to what's going on here, but I think it has a lot of
5 applicability.
6 MR. BOTTI: Helen, in terms of this
7 concentration if it is occurring on a local level and
8 it's to a significant degree, it would seem like
9 employers would have concern over that vis-a-vis whether
10 they're getting competition among health insurers. Do
11 you have a concern? Can you address this?
12 MS. DARLING: Yes, and I'll do it from two
13 perspectives, from my current job and my prior job where
14 I used to buy health care for Xerox Corporation around
15 the country, so I got to know 240 markets real well in
16 that process.
17 I would say first a couple things. First, I
18 think it's very important, it's the way you all operate,
19 but it's the way we have to think about it, you cannot
20 answer most of our questions one way. You have to say,
21 What's the market and what's the year you're talking
22 about.
23 For example, we had about four or five years
24 where underlying medical costs were actually higher than
25 what was being charged by some insurance companies, not

1 much to be sure, and you had other years where the
2 underlying medical costs, which is where we are right
3 now, was considerably below what's being charged in
4 premiums where there's a premium. So looking every year
5 at every market is extremely important to answer those
6 questions.
7 Our concern and some of my concerns at Xerox was
8 that you're going to have problems in lots of markets
9 much of the time, and you're going to have to deal with
10 them market by market. There was a time period I guess,
11 I have to think a second about what the years were, when
12 a number of the large health plans were buying each
13 other, and in fact we had a chaotic time in places like
14 Texas where you had companies like (inaudible) being bought
15 by -- I'll probably get the names wrong because you lose
16 track of it, but you had sort of a mess going on because
17 at the local level you had problems, service problems,
18 delays, physicians weren't being paid and that kind of
19 thing. In other markets it was working perfectly well
20 so it varies enormously around the country both by time
21 and by location.
22 I think in terms of whether or not the
23 consolidation, now I just said don't make a
24 generalization and I'm going to make one, but right now
25 there's still in most markets sufficient competition and

1 choices for employers, but we certainly think everything
2 ought to be watched.
3 I mean, nothing should be left untouched in
4 terms of analysis and information, and what's so
5 important about I think what you all are talking about
6 doing now and a number of organizations like the Center
7 are doing is watching these things very closely, so we
8 have an empirical basis. We knows what's happening at
9 every time and as quickly as possible, and we also know
10 what's happening market by market, and you all can act
11 accordingly.
12 MR. BOTTI: Your comments earlier, I believe you
13 told us you were concerned about rising premiums, and if
14 I'm interpreting what you just said properly, you're not
15 attributing that to consolidation among payors.
16 MS. DARLING: No, and actually most of our
17 employers don't even pay premiums. Most of our
18 employers are self funded, so right frankly they're
19 worried to death about claims. What's driving their
20 costs right now are claims. There's some concern
21 sometimes when there's consolidation, the companies are
22 able to charge more or try to charge more for the
23 services they provide.
24 MR. BOTTI: Is one of the services they provide
25 negotiating better rates for you among the hospitals?

1 MS. DARLING: Absolutely.
2 MR. BOTTI: Let me ask how you view the
3 competition among payors to provide you that service.
4 Do you have enough payors trying to do that? Are they
5 trying to do it hard enough, and are they being
6 successful or not?
7 MS. DARLING: A couple things I would say. Up
8 until recently they were trying at the level they try,
9 but for the most part there was plenty of competition to
10 encourage them to do as well as they could and always to
11 do better.
12 More recently, however, meaning in the last
13 couple years what's happened with these so-called
14 contract showdowns is no matter who's out there trying
15 to negotiate what we would consider a reasonable price,
16 and we can debate one I'm sure endlessly, and by the
17 way, we're talking about cost too. We believe that it's
18 reasonable to have a reasonable number of costs and also
19 perhaps some payment for additional services.
20 There's a huge debate, as you might know right
21 now, in the hospitals feeling that they are underpaid
22 because their full costs are not paid, so that's a whole
23 other debate, which we could probably have another
24 workshop on and might be worth doing because that's a
25 major problem.

1 Some of the markets where the worst contract
2 showdowns have occurred are the markets with very large
3 numbers of teaching hospitals, academic medical centers,
4 medical schools, sometimes five or seven in a given
5 geographic area.
6 So they feel they must have their cost
7 reimbursed for a very expensive system, so that's one of
8 our big concerns.
9 MR. BOTTI: Thank you. Lawrence, do you want to
10 say something?
11 MR. WU: I think Helen is right that in many
12 cities employers and employees do have choice, and I
13 want to tie this back to some of the charts that we've
14 seen that describe payor concentration in various
15 marketplaces.
16 There's one dynamic that falls out of employer
17 and employee choice, and that is employer and employee
18 choice facilitates the entry and exit of health plans,
19 and that is one dynamic that isn't easy to show on a
20 PowerPoint slide, and that is over time, there is a lot
21 of entry of new health plans, and at the same time
22 there's a lot of exodus of health plans, and it does
23 make sense because if you look at the profits of health
24 plans, health plans are not doing as well as you might
25 think they're doing.

1 So there is this dynamic of entry and exit, and
2 it makes a difference because if one were to do a study
3 of says 50 or 60 top MSAs, that is Metropolitan
4 Statistical Areas in the U.S., and look at who the
5 leading health plan was say in 1994, and then ask the
6 question four years later, Will the leading plan in 1994
7 still be the leading plan in 1998? If you do that
8 study, you will find that the leading health plan in
9 1994 in general was no longer the leading plan in 1998.
10 And that is a dynamic in the health insurance
11 industry that I think it's easy to forget, but a very
12 important one in evaluating the market power of the
13 health plan.
14 MR. BOTTI: Okay, Don, let me ask you to give us
15 some comments somewhat picking up on what Helen said,
16 and that is she had expressed a concern over hospital
17 costs, and I think most of us in this room know that
18 physicians and hospitals interact quite a bit, and
19 physicians should have a good sense of what's been going
20 on in the hospital sector, whether that's driving the
21 cost of these premiums or not.
22 One thing that has struck me, that is, if we've
23 had consolidation of hospitals, and we have vigorous
24 competition in health plans, and I'm not purporting to
25 say any of this is right or not, but let's just work on

1 that proposition, we should have seen reduced costs in
2 hospitals and costs being passed through to employers
3 and consumers, and maybe you can give us the physician's
4 perspective on whether hospital consolidation has
5 delivered on its promises or has it led to an exercise
6 in market power?
7 MR. PALMISIANO: Well, thank you, Mark. On
8 behalf of the American Medical Association, I'm not the
9 person to talk about hospitals and what they delivered
10 other than the fact that we operate in hospitals, and
11 what we would like to stress is that when you look at
12 health care cost, we need to go one layer down and break
13 it up as we did in our testimony.
14 You need to divide out of the physicians. You
15 need to divide out the hospitals. You need to -- health
16 care cost, what the insurers are charging, how much goes
17 to profits so that you break all that up. Our point is
18 is that physicians -- and I have the advantage of
19 traveling all over the country to meet physicians on
20 behalf of the American Medical Association and listen to
21 their complaints of what was said earlier, physicians believe
22 the system is broken.
23 I also have the advantage that I continue to
24 practice when I go home to New Orleans, and my surgical
25 partners will greet me and say, What have you been doing

1 now up there, did you tell them what's going on, we can
2 hardly keep the practice going under these
3 circumstances.
4 When I heard a moment ago that there was no
5 monopsony power, and even if it existed, it didn't make
6 any difference. I would submit to you that no rational
7 human being would sign a contract that contains, if they
8 had any equal bargaining product, all products clauses
9 most favored nations clauses, it's on page 15 of our
10 written testimony, undisclosed fee schedules.
11 We don't even know, they can change fee
12 schedules at will. So how do we budget to buy
13 equipment, to hire staff, to deal with all the turn
14 backs when you send the insurance in, Oh, it's not a
15 clean claim, please fill out this form and do this, oh
16 the line's busy, you'll have to call back at another
17 time, we can't admit the person at this time.
18 We've gone through a paper morass and there's a
19 feeling of hopelessness. We do need to work together.
20 We need to cooperate, and AMA believes maybe the
21 long-term situation, we won't need the Federal Trade
22 Commission to do as much work in this area, is when we
23 have defined contribution individual ownership and a way
24 to make it happen, but that's perhaps the future.
25 Unilateral amendment of the contract by payor,

1 slow pay, a big problem, restrictive definitions of
2 medical necessity. It's not my job as a physician to
3 ration necessary care, and if the insurance company
4 promises a product, they should deliver on the product.
5 If they want to exclude a product or service, they ought
6 to say so in bold print.
7 The indemnification clauses for patient privacy
8 violations, now I submit this is evidence on behalf of
9 the AMA. If an insurance company violates the privacy
10 of the patient, the medical record confidentiality, we
11 have submitted in to Congress contracts that say we are
12 responsible for indemnifying the insurance company. We
13 are responsible for their defense costs. What rational
14 human being would sign a contract like that if they had
15 any bargaining power?
16 And you don't have any power when you deal with
17 these folks. They say, Take it or leave it, doctor, so
18 that's the problem.
19 As far as the hospitals, you have people here
20 who can better answer whether hospitals are delivering.
21 What I'm saying is that this system is broken.
22 Physicians want to do ethical science based medicine.
23 In a previous panel you talked about quality. I
24 want to get in to the record AMA has a lot of quality
25 efforts. We're involved in the National Guidelines

1 Clearinghouse. We're involved in the Physician
2 Consortium for Performance Improvement. We're involved
3 in the Practice Guidelines Partnership. We're involved
4 in so many entities, the JCAHO. We have commissioners in
5 there. We're involved in NCQA, working with them.
6 We founded the National Patient Safety
7 Foundation before the Institute of Medicine came out.
8 We founded that in 1997, and safety as you know is a
9 major component of quality, so there are so many things
10 going on, and I would just hope that the Commission and
11 the Justice Department would go beyond these words and
12 do their own independent gathering of data and then let
13 all the experts get together and see if this system
14 allows us to do quality medicine for our patients.
15 MR. BOTTI: Let me ask you to take it a step
16 further in terms of getting us guidance is where you
17 would like to see us go, and I will accept for purposes
18 of talking about it the proposition that physicians
19 don't have bargaining power and that payors do.
20 Who role does antitrust have to play there? Is
21 your proposition to give physicians this countervailing
22 market power? Is that where the AMA would like to see
23 antitrust enforcement go, or is there some type of
24 response you would like us to make to existing market
25 power by payors?

1 I understand that if there's consolidation that
2 aggregates it, sure, people would like us to stop that,
3 but we're talking about the situation as it is. What
4 are your thoughts on this?
5 MR. PALMISIANO: I think earlier you heard Ms.
6 Hanson talk about the Rule of Reason approach rather
7 than automatic Per Se treatment under Section 1 of the Sherman Act.
8 Also on page 15 of the written testimony, we would like
9 you to look at each one of those items as well as
10 additional comments that we have in there and put your
11 sharp eye on that and say, Does this violate antitrust.
12 In other words, does this power prevent true
13 competition in the marketplace. We would like you to do
14 that.
15 Of course the American Medical Association is
16 working in many directions, both at the state level. We
17 talked on the state action doctrine, and in Congress we
18 talk about the bills that deal with antitrust. You
19 heard about earlier the Barr/Conyers bill, which by the
20 way, that bill is different from the original Campbell
21 bill 1304 in the previous session, and what this bill
22 does is just make the Rule of Reason the standard, and it
23 has two demonstration projects.
24 One demonstration project is basically the
25 Campbell model in a small number of states and the other

1 model is the one that basically acts like a state action
2 doctrine, like they do with certain fisheries and
3 certain things where you have oversight, some
4 governmental oversight. We think the system needs to
5 be changed because we're heading for chaos.
6 Overhead for physicians continues to go up.
7 Pennsylvania is a particularly hard hit state. It's one
8 of our crisis states, 12 crisis states in the nation
9 with professional liability premiums, and so as the
10 overhead goes up and reimbursement goes down, 5.4
11 percent decrease with prediction of another 20 percent
12 over the next several years, if they don't do something
13 in this Congress, what you're going to have is a quality
14 problem because if you can't access a physician when you
15 need a physician, if you go to Wheeling, West Virginia,
16 you can't get a neurosurgeon to do trauma.
17 So that means when your child is involved in a
18 soccer game or football game and gets hit on the head
19 and is unconscious for a brief moment, they won't even
20 keep the child. They send the child away to Columbus,
21 Ohio, to Pittsburgh, and the helicopter can't fly in 30
22 percent of the time because there's fog or other adverse
23 weather conditions.
24 This system is broken right now, and we do need
25 to go beyond our words, everybody comes in good faith

1 trying to present their position and the role of
2 government, as we see it, is to be that objective entity
3 that looks at all of this so that we have true
4 competition. The bottom line is what's in the best
5 interest of the American public and our patients.
6 MR. BOTTI: Thank you. This idea of refereeing
7 the competition and making sure it's fair I think is a
8 good one, and I'm going to take your comments and turn
9 them over to Stephen Foreman, because, Stephen, I think
10 when I asked you the question about consolidation, you
11 said, Let's look at the current situation and where do
12 we go from here.
13 Let me ask you to talk about that. We're
14 talking now about if payors have some type of market
15 power, and I say if, I don't know that they do, but if
16 they have it and they're exercising it, what's your
17 proposition in terms of what role antitrust can play in
18 addressing that?
19 MR. FOREMAN: I think that ideally we would want
20 to get to a first best solution on this. If we could
21 restore competition to these markets and there's
22 mechanisms to do that, we would all be better off. Ruth
23 Givens here, she has an article, and Doug Holland has an
24 article, but the optimal size of health insurance firms
25 is not 4 million members.

1 There's things to think about there, so if we
2 can restore competition at every level of this industry,
3 we would all be better off.
4 If we're not going to do that, if we're going to
5 leave a monopolist in place, and I'll start at the
6 health insurance level, to presume that monopolist can
7 pass through costs presumes that the monopolist is not
8 currently monopoly pricing.
9 If the monopolist is monopoly pricing as
10 rational monopolists should do, then they're charging as
11 much as the market will bear. They're not going to pass
12 through any more cost. If we give employers
13 countervailing power in that kind of setting, you may
14 get a welfare improving result. I said a minute ago we
15 should do some research in this. There's good
16 countervailing power theory on the books that isn't
17 widely known to people.
18 The second part of that is that if a monopoly
19 payor is deriving monopoly rent, to give countervailing
20 power to hospitals or to physicians means that you'll
21 reallocate this monopoly at random. You're not going to
22 charge more to the employer if you think about it, so I
23 mean, to think all of this through in the countervailing
24 power setting is one way to go on this.
25 The other one is we can throw up our hands and

1 give up and go to single payor and say, Look, the
2 consolidation in this industry is too much for us to
3 bear.
4 Again, some of this is a generalization off of
5 some premises about some markets. Not every market is
6 consolidating at the payor level. Some markets have
7 competition. Other markets don't, and in those markets
8 we have payors dictating price. Small businesses don't
9 negotiate with health insurers in Pennsylvania.
10 Private physician practices in Pennsylvania with
11 some exceptions don't negotiate with the payors. They
12 have a fee schedule, and in fact there are letters from
13 the payors in Pennsylvania saying, we don't negotiate
14 with physicians, we can't do it administratively.
15 That's probably right.
16 So I think we have a list of preferences or
17 priorities that we ought to go down here before we give
18 up but restoring competition ought to be real high on
19 our list.
20 MR. BOTTI: Helen, let's assume we have a market
21 where we have payors with market power. Is
22 countervailing market power by physicians and hospitals
23 the solution that employers would prefer or what would
24 they have the agencies do in terms of antitrust, or is
25

1 it an antitrust question?

2 MS. DARLING: I'm not sure I can answer it, but

3 let me back up a second and see if I can take it from

4 where he has ended. Most employers with more than 500

5 employees, which is a lot, are self funded, and so they

6 do in fact use networks, and they can shop around. They

7 have multiple networks throughout the country that you

8 can use. You can buy this PPO network or that PPO

9 network. There are a lot of options.

10 Now, it's true that very small employers have to

11 deal with an insured product, but there are multiple

12 insured product in many places, and then there are more

13 things coming down the road, so I'm not sure it's quite

14 -- that piece of it isn't as grim at least as I see it

15 and live it as it sounds like.

16 I think there is definitely the feeling that

17 right now, and this is why the timing is so important,

18 and this is the first time I've been in this my entire

19 adult life, the first time that large employers feel

20 that their biggest problem right now is provider

21 consolidation, and that has not been true in the past.

22 They generally are not -- again, this is a

23 generalization, it may vary by market, but it is not

24 the absence of competing plans. They do have that.

25 They have ways that they can pull out of dealing with a

1 particular plan.
2 Now, you could in some markets, especially the
3 Blues, do have some advantages. States where they used
4 to have advantages, they no longer have the advantages,
5 and so they're having to change on that so there's
6 movement in all of them. It's like many moving parts
7 simultaneously, and that's why you have to get back to
8 the market.
9 If the FTC's role is to make certain that in
10 every market and in every situation you have the optimal
11 opportunities, and I know I'm not using the language of
12 economists, I'm not an economist, but the maximum
13 opportunities, the optimal opportunities for competition
14 in all of the areas you need to have it in, that's what
15 we need to make this system work.
16 I mentioned earlier, but I'll mention again, how
17 important the consumer is today. We are already in a
18 much more consumer driven health system than we have
19 ever been in. We are going to be in it for at least the
20 next three to five years. Maybe there will be some
21 grand solution in our country, but I lived through
22 Catastrophic Coverage Act which got repealed, so I don't
23 know even if you get something passed, it will
24 necessarily remain in law when people discover they have
25 to pay for it. So, we may have a few more years to work

1 at some of these problems.

2 I think in the meantime, there's plenty of
3 opportunities for the FTC to do what it's talking about
4 doing and has done, and the dynamics have changed so
5 dramatically that perhaps some of the unfortunate track
6 record that you all have suffered from because you tried
7 and the courts didn't let you move will be changed when
8 they look at the new dynamics.

9 MR. BOTTI: Lawrence, I'm going to come back to
10 you because you made a comment I want to follow up on.
11 How do we tell the difference between good payor
12 negotiation and bad payor negotiation of lower prices
13 from physicians and hospitals?

14 MR. WU: That was actually going to be my follow
15 up to the comments here, which is to answer your
16 original question, I don't think there's an easy answer
17 or a single answer to your question, whether we want to
18 stop the exercise of market power and the existing payor
19 or whether we should give physicians and other providers
20 more bargaining power because in the end, as an
21 economist, what I want to look for is what is happening
22 to prices and what is happening to quality.

23 If prices go up and quality goes up and that's
24 what the employers and employees want and are willing to
25 pay for, then I would view that whatever is being

1 investigated as being a response to what employees and
2 employers want.
3 It's really problematic if there are increases
4 in price without a corresponding increase in quality,
5 and/or no change in price and a decrease in quality, and
6 this is nothing new for the antitrusters in the room,
7 but again I think that is ultimately the guiding
8 principle.
9 MR. BOTTI: I think with that, we should
10 probably wrap up, David?
11 (Applause.)
12 MR. HYMAN: Some very quick announcements.
13 First, I want to thank all the speakers, panelists and
14 moderators for today, all of us have benefitted
15 greatly by their insights. Second, we start tomorrow at
16 9:15 a.m. promptly. You have to clear through security
17 again, so please allow an appropriate amount of time for
18 that.
19 Your property rights for today do not translate
20 into property rights for tomorrow, so it's a license.
21 Here at the Commission we adhere to our contracts, so at
22 5:30, it's time to stop.
23 (Time noted: 5:27 p.m.)
24
25

1 C E R T I F I C A T I O N O F R E P O R T E R
2
3 CASE TITLE: Healthcare and Competition Law and Policy
4 Workshop
5 HEARING DATE: September 9, 2002
6
7 We HEREBY CERTIFY that the transcript contained
8 herein is a full and accurate transcript of the notes
9 taken by us at the hearing on the above cause before the
10 FEDERAL TRADE COMMISSION to the best of our knowledge
11 and belief.
12
13 DATED: September 16, 2002
14
15 Sally Bowling
16
17 Debra L. Maheux
18
19 C E R T I F I C A T I O N O F P R O O F R E A D E R
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21 I HEREBY CERTIFY that I proofread the transcript
22 for accuracy in spelling, hyphenation, punctuation and
23 format.
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