FEDERAL TRADE COMMISSION

HEALTH CARE AND COMPETITION LAW

Thursday, February 27, 2003

9:30 a.m.

Federal Trade Commission

601 New Jersey Avenue, N.W.

Washington, D.C.

For The Record, Inc.
Waldorf, Maryland
(301)870-8025

FEDERAL TRADE COMMISSION

I N D E X

P R O C E E D I N G S

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MR. HYMAN: We're going to get started today. For those of you who were not here yesterday and didn't check the website this morning, which includes me, my understanding is the web site accurately reflects that we've canceled the Friday afternoon session on Little Rock. So, we'll do the Friday morning session on Boston, but we won't be doing a Friday afternoon session. We're planning to reschedule that. There were ice storms in Little Rock and people were unable to come.

The basic framework for today is there are going to be short introductory remarks by Bill Kovacic followed by presentations by two academics, Professor Peter Hammer and Professor Jim Blumstein, and then we're going to have a panel discussion, short presentations from five members of the panel, followed by a moderated panel encompassing pretty much everybody who's spoken so far, except for Bill, who somehow weaseled out of it.

Bill's an academic, so he gets a very short introduction. Bill is General Counsel at the Federal Trade Commission, on leave from George Washington University Law School where I met him when I visited there, and he was foolish enough, after that experience, to hire me to work here. Bill is a long time scholar on

competition law and policy, here to offer us his perspectives on competition policy in the health care marketplace.

MR. KOVACIC: Thank you, David, and on behalf of the Federal Trade Commission and Department of Justice, I want to welcome you back to the second day of our major initiative: hearings on competition policy in health care.

What I'd like to do this morning is, once again, to just briefly acknowledge the contributions of our many staff members who have put these hearings together to give you a sense, again, of who's made this all possible. To say a few words about the rationale for the hearings, why we've made a major commitment of resources to this undertaking, and then to simply identify what we see to be some of the major objectives of this enterprise.

In doing this, I just want to remind you, again, I'm giving you my own views and not those of the Commission. I had occasion soon after I came to the FTC to have that disclaimer delivered through a translator in a somewhat garbled way and the audience laughed out loud. That's usually not a big applause line, but later I was told that the translator had said, Kovacic is not speaking for the Federal Trade Commission and it's not

clear that he has any of his own ideas.

(Laughter.)

MR. KOVACIC: So, though I do speak for myself, let me give you a couple of thoughts about what we're attempting to do and why we've made this commitment.

I want to simply highlight for you, again, the types of resources and talent in the agencies that have been brought to bear on this. I do want to thank our colleagues at the Department of Justice. You heard Hew Pate yesterday and I just echo his comments about the enormous value in having a collaboration between the two agencies in doing this work. My own pleasure in getting to work with Hew on this project with two friends from my wife's law firm, Debby Majoras and Leslie Overton, with Bill Berlin and the entire team from the Department of Justice.

Let me also simply highlight closer to home, because I have the pleasure of working with them much more extensively, the contributions of our own colleagues at the FTC. First, the folks you met when you came through the door, Angela Wilson, Julia Knoblauch and Mizuki Tanabe, who are responsible for all of the infrastructure that makes the event possible. Nicole Gorham, who sits in the back, who's also provided vital support in simply the preparation of the materials, the

distributed materials. Sarah Mathias, who came to us in September from Jones Day.

And as just a wonderful introduction to one of my favorite corridors in the building, when I walk by our little Policy Studies Group on the fifth floor, I feel as though I'm walking through the locker room of the 1961 New York Yankees and seeing names like Maris, Mantle, Howard, Skowron, Ford, on the lockers. It gives me confidence that every day at the agency is going to be a success.

And last, I do want to salute David Hyman. To use another baseball analogy, I once had an occasion at a social event to talk to Jim Palmer, the Hall of Fame Baltimore Orioles pitcher, and Palmer was talking about the 1966 season, which was a championship season for the Orioles, and over the off-season, they had picked up Frank Robinson from the Cincinnati Reds in one of the greatest one-sided trades ever in the history of professional baseball. And Palmer talks about how in his rookie year that year, watching in spring training Frank Robinson hit a 450-foot home run with one hand, having been fooled by a pitch. And Palmer turned to Paul Blair, who was a star outfielder on the Orioles, and said, we're going to win the World Series this year.

The day that David decided he'd come and work

with us on this project, I knew we were going to win the World Series of hearings. So, thanks to the entire team for putting this together.

Why dedicate the amount of time we have to this? Why make this a focus of 30 days of hearings? First, a bit about the rationale. For the Federal Trade Commission, having compiled a data set of the FTC's competition policy work since 1960, the field of health care, both the provision of health care services, and if you expand that to include pharmaceutical products, health care accounts for more FTC enforcement actions in the past 40 years than any other single sector of the Commission's work. This is simply, far and away, the central and most important area of the FTC's competition policy work in the past 40 years, especially since the filing of the path-breaking American Medical Association case in 1976.

It's not an exaggeration to say that this is the single, most significant area of FTC competition policy work and the area in which, starting with the tetracycline investigation in the 1960s, carrying through to the revival of enforcement in several fields of health care, simply the most important competition policy arena of FTC work in that period. And these hearings reflect our own interests. I think if you did a similar profile

of the Department of Justice, you would likewise be struck with the amount of civil merger and non-merger work that the Division has done since 1960 in this field.

A second respect is what I call competition policy research and development, and this is a phrase that I borrow from a recent speech of Tim Muris. Those of you who have spent some time in academia -- and happily, we have a number of you here -- those of you who haven't, I'll simply give you a bit of insight into how academics work. There are two ways to come up with ideas in academia and phrases. One is to develop them on your own. That tends to be painful and difficult. The other is to take them from someone else, which is much more pleasing and a much more effective shortcut.

So, I take them from Tim Muris, another academic. He'll understand the ritual, that I've done it. Tim has developed the phrase "Competition Policy Research and Development." What do we mean by this? We mean all of the intellectual development and foundation building that goes into sound enforcement and policymaking.

Soon after coming back to the Commission and seeing the amount of effort that we and the Justice Department had dedicated to our intellectual property hearings and to a variety of other non-case enforcement

matters, I have an acquaintance on the outside who said, that's interesting, but why don't you get down to the serious work of bringing cases, why spend time on this stuff.

And I could imagine that same person going to a pharmaceutical company and saying, why do you have an R&D lab, why don't you just fire all the scientists and just put drugs out into the marketplace. Indeed, why test them at all? Trials? Tests? Simply have someone come up with an idea about a new drug and put it out there, see how it goes. People live, people die, it doesn't matter. Tests? Ahh, it's expensive, difficult. Why have an R&D lab?

I think what you're seeing, in many respects -- and this is part of an evolution that's taken place over the past decade in particular, you're seeing an increasing recognition on the part of the federal competition agencies that investing in the development of a knowledge base is every bit as important as developing the cases that ultimately show up in the courtroom, the consent decrees or other matters.

What we're seeing is a fundamental recognition that the capacity of the agencies to do good work requires investment in what Tim has called competition policy R&D. And the pay-off, the significance is the

last point I have on this slide, what I call intellectual leadership.

In a world in which competition policy authority is shared, not only across the federal level with two competition policy authorities, but many other federal institutions, as we heard yesterday, that shape the competition policy environment and 50 state governments and public utility regulators at the state level and dozens of competition policy authorities overseas, all of whom have concurrent, non-exclusive authority, how do you make your voice heard? How do you get people to pay attention to you?

Intellectual leadership, as Tim has said, is the currency of exchange in the modern world of policymaking. And those who invest in developing the ideas, those who develop the high ground, have the capacity to shape the way people think about competition policy. Thus, the rationale for spending 30 days on hearings.

What do we hope to get out of this? Let me simply finish by turning to a couple of specific objectives we have for this undertaking. The first is to improve our understanding of the institutional arrangements through which health care is delivered and through which pharmaceutical products, through which

health care providers operate, through which the field functions.

Here -- again, my second bit of academic theft -- I turn to a speech that Tim gave about a month and a half ago in Washington called Improving the Economic Foundations of Competition Policy. In this speech, Tim spent a great deal of time focusing on how good economic analysis today increasingly demonstrates an appreciation, developed from the work of Ronald Coase, Oliver Williamson and a number of other scholars, Mancur Olson, Douglas North, that to make sensible judgments about the appropriate content of public policy, one needs to know more about the institutions through which the commercial activity in question takes place.

What are these institutional arrangements? First, a host of commercial phenomena that we'll be looking at in great detail. How is the marketplace itself changing? What is the changing relationship among the principal participants in the health care field? And last, a point that several of our contributors yesterday mentioned in here, starting with Tom Scully's comments, but Mark Pauly, Paul Ginsburg and Marty Gaynor’s comments yesterday, you have to know more about the regulatory environment, and if you don't focus on how the regulatory environment shapes competition policy outcomes, you've

really missed a crucial ingredient of the health care competitive field.

I will say that this, again, reflects something we are seeing in other areas. In the work we've done with the Department of Justice in the IP area, we've spent lots of time in our IP hearings looking at collateral government institutions, the work of the Patent and Trademark Office, the work of the Food and Drug Administration.

In our work in electric power, in our work in the communications sector, we're also observing how decisions of collateral public institutions shape outcomes. And, indeed, the work we've done in the defense field, which has some striking similarities with health care, both with respect to the price control mechanism that Tom Scully talked about yesterday, the tremendous interface between regulatory design, regulatory intervention with a significant area for private activity and reliance on private service providers.

Part of what we hope to do in these hearings is bring to bear and to draw out from our participants observations about how the regulatory environment operates. And, indeed, how it might be changed to improve outcomes in the field.

The second key objective is to improve our capacity for formulating policy itself. And the first ingredient of this is to improve the conceptual foundation on which we work. Notice these are called competition policy hearings, not antitrust enforcement alone. That's a deliberate effort to signal our interest in a broader array of policy responses beyond the bringing of specific cases and to take into account, again, the institutional arrangements that shape commercial outcomes and shape government policy that affects those outcomes.

Indeed, we intend to focus on consumer protection issues, especially involving the information concerns that our academic panelists addressed in great detail yesterday. And, yes, indeed, where appropriate, to make adjustments in the regulatory arena, to propose those adjustments to improve outcomes in the marketplace. This has an important implication; namely, picking the right policy instruments. I would be surprised if at the end of this process, all we have to say, certainly in the report that we offer, focuses exclusively on the prosecution of antitrust cases through the traditional litigation mechanism.

Indeed, selecting the right policy instrument increasingly is going to involve not only the work of the

division and the Commission, but the work of state governments in a host of different settings and, indeed, other federal agencies that we don't usually think of as being competition policy agencies, but nonetheless, have an enormous influence on the competitive environment. And here I simply offer, as Tom Scully suggested yesterday, one example, and that's the Department of Health and Human Services.

Final observation for this morning and that simply involves improving the empirical basis for policymaking. Again, one of the most encouraging, for me, developments that we are seeing in the competition policymaking environment at the national level today is a greater dedication of resources to improving our understanding of the effects of what we have done and what we have not done in this area. The FTC's hospital retrospectives are, perhaps, the best example.

If you use a health care analogy and you apply it to the antitrust world, you see some interesting anomalies in how the agencies have done business before. These are, we bring cases and typically we don't go back and look at what happened. Imagine a hospital or a physician -- a hospital that performs surgery pushes the patient out the door and says, don't come back. In fact, don't talk to us again, we don't want your address, we

don't care how things turned out. We're going to assume, as a matter of faith, that you're better.

And, indeed, if you were simply to study our press releases and our competitive impact statements, you would believe that we have the most magnificent group of competition policy doctors on earth because we always do better by the patient. We operate, we take out the bad stuff and the patient lives well, so we say.

I think what we're seeing now is an increasing willingness to go back and test these propositions empirically in a number of different ways, as well as to do basic empirical research that bears upon the operation of existing regulatory structures, and I simply highlight here our generic drug study, which involved a major commitment over a two-year period to doing this kind of R&D.

And, last, we'd really like to continue the momentum that's developing to do more empirical work in this area. And I simply think back to Marty Gaynor's presentation yesterday. Notice how many places where Marty has taught us something. Not only was it a wonderful tour through the field and, again, we're so grateful that our witnesses are devoting this kind of heavy lifting to giving us a fresh look on what's happening. But notice how provocative the presentation

was, both in terms of telling us what we know, but what we don't know. And I think part of what we would like to do over time is, indeed, to press the field more in the direction of doing a greater amount of empirical work in this area.

So, to finish up, really three things that we hope to take away from these hearings. We want to know more about the institutions. Again, as Tim and Hew put it yesterday, in a non-adversarial setting where we're listening. These are hearings, not talkings. So, you won't hear a lot of -- indeed, you'll hear very little more from me in another 15 seconds. To listen more and to learn more.

Second, to use the hearings to formulate strategy in a broad sense. And last, to improve the empirical foundation on which we work.

So, again, my thanks to my colleagues of the Division and the Commission for their work in doing this. My thanks to all of the participants for contributing to this vital initiative and my thanks to all of you for coming and participating in the process. Thank you.

(Applause.)

MR. HYMAN: Thank you, Bill. I'd like to introduce Professor Jim Blumstein now who's going to talk for about 25 or 30 minutes. Jim is the Centennial Chair

in Law and the Director of the Health Policy Center at Vanderbilt University. He has written at length about a range of issues in health care, as co-author of one of the leading textbooks, at least I use it for my classes, and for some unaccountable reason, he has also chosen to write at length about constitutional law.

DR. BLUMSTEIN: David, thank you. It's a delight to hear Bill talk about the goals of this set of hearings and the analogy to the drug company getting rid of its R&D department. It's nice to see that the Federal Trade Commission is still in the hands now of good academics, and that's a relief.

David, thank you for organizing all these programs. It's a pleasure and I'm privileged to be here to participate. I must say, I had a little bit of trepidation this morning as I was sitting in the taxi and totally gridlocked and worried whether we'd make it here. I thought I had left ample time and then the lights kept turning green. I said, why isn't anyone moving. And, of course, you don't understand Washington. I forgot my origins in New York, having lived in Nashville for so long.

Debates about health care and the role of competition sometimes take on a very heated dimension and sometimes they really have almost a religious fervor to

them. Some advocates of competition thought that competition and that the result of competition would look a certain way when things sorted out and they have been disappointed with the way that the industry has responded. My colleague and sometime mentor, Clark Havighurst, has just recently written a paper that shows great angst about how the system has worked.

Some, on the other hand -- and I think Tim Muris' talk yesterday mentioned this -- view competition as a process which is to preserve a structure, set up a system of incentives for competition, look at empirical evidence where that informs, but also look at structure and incentives quite independent of empirical evidence, and not to have a stake in how the system or how the institutions develop or evolve, but to focus on the process.

I was thinking of a story, and it's always risky, but the Internet just is so tempting these days. You get all these stories. And I was thinking of a story that would kind of capture the problem of prayers being answered. This is a story of a woman who goes to her rabbi and has a serious problem. She has two parrots, female parrots, and they've picked up a terrible habit that's very embarrassing to her. Whenever she has visitors, the two parrots say together, hi, we're

hookers, we want to have some fun, do you want to have some fun.

To her surprise, the rabbi breaks into a smile and explains that he has two parrots that he's been training religiously and that they pray a lot and that they're dressed up in religious garb and they have a prayer book and so forth. So, the rabbi has a solution. He tells the woman to bring her parrots over to his house and he would introduce her parrots to his parrots. And so, she does that. She sees the parrots, introduces her parrots into the cage, and immediately her parrots say, hi, we're hookers, want to have some fun. And one of the rabbi's parrots immediately turns to the other and squawks and says, Moisha, put the book down, our prayers have been answered.

(Laughter.)

DR. BLUMSTEIN: So, I think some people saw the introduction of competition much like those parrots saw the introduction of the other parrots to the cage. And I think we have to be careful and have more modest expectations about what is going to come from or has come from competition, and within the time frame, what realistically can happen and to realize that this is not going to be a win or a lose situation, but an ongoing struggle, and I'm going to talk about that over the

course of my presentation.

I want to organize my comments around five points or five areas. First, again, taking comments from the Chairman seriously, to talk about some first principles and some background. I want to walk through some of these introductory points about different ways of thinking about health care and the importance of understanding those core differences and differences in values that are involved in the debates.

Then I want, secondly, to focus on some substantive areas of inquiry, some thoughts that I want to present about areas that need some additional thought. In this area, bundling and monopsony, I'm going to talk about as major issues.

Third, I want to talk about some doctrinal issues. I'm going to make the case against doctrinal exceptionalism. That is to say, I'm going to make the argument that the antitrust law does fine in coping with the specific kinds of concerns that some critics of the antitrust law have brought out and that there's not a case to be made for doctrinal exceptionalism and that we should follow the old-fashioned strategy, which is, that if the values that inhere in antitrust are incompatible or need to be modified in a certain small segment of the health care industry, then the right way to do that is to

get legislative exceptionalism rather than doctrinal exceptionalism.

Fourth, enforcement issues. I want to talk a little bit about the educational role -- Bill has mentioned this -- for government. I'm going to propose that the Commission do some work in the area of judicial education. And I don't mean that tongue in cheek. I mean in the sense of sponsoring programs that will be oriented towards judges to understand some of the issues. As David knows, for many years, we did judicial education at Vanderbilt. He participated in the program. Those were State Court Justices, but we've also done it for Federal Appellate Judges.

And then, finally, the importance of the research mission, which I will talk about as fifth and finally.

All right, let's go back to the background. Key health policy issues differ, and how one even identifies issues in the area differ based upon some normative assumptions. This is why the area is so contentious. This is not purely a question about resource allocation, but it's also a question about a normative overlay of why health care is different. Why do we care about access to health care in ways that we don't care about access to certain other things?

We worry about it because of our concern about, broadly speaking, redistributive values and some notion of egalitarianism. If one looks at this from a traditional viewpoint, there's an egalitarian objective of access to health care. The access agenda is driven by this egalitarian ethic. Value judgments are critical, but in these debates, they're often -- usually submerged and they're not discussed. Antitrust law has a way of bringing these debates to the fore and requiring that they be addressed quite directly.

Also, traditionally, health care has been an area of professional or scientific prerogatives. A notion is that these are scientific judgments, there's a single right way of doing things, and that build together with the egalitarian ideal that there should not be stratification, that there should not be differences within the market, that there's a single right way of providing medical care, and if there's divergence, that we should do what we can to overcome those divergences. Whereas in markets, we know that there's room for lots of different levels of quality, different tastes, and so forth in the market.

So, the introduction of markets and market thinking requires some degree of normative change within the traditional vision of how health care is provided.

If you ask for customization in a market, that's understood. But customization is a difficult sell now in medical care, although it's beginning to happen, we heard yesterday, from Paul Ginsburg. But it's a difficult sell because doctors have been trained traditionally to think that there's a single medically correct standard of care. What is the standard of care? And it applies to everyone alike. That's a scientific judgment, not an economic judgment.

For market-oriented folks, the issues focus not so much on access or on professional prerogatives and judgments but on individual choice and the use of incentives to shape decision making. That is, how do we introduce economic factors into the decision making process. Basically, how much care is provided and who decides? Those kinds of questions.

The professional model shifts the authority to the professional decision maker and away from consumers and insulates, to a large extent, those decisions from economic factors.

So, the different models, the different ways of thinking are important. Let me talk about those different ways of thinking. The professional or the market oriented models or paradigms are broad categories and we talk about these as if they're very different.

But, in fact, elements of both must exist. We're not talking about one or the other. It's a continuum that we're looking at and the issue is, where along a continuum must we be. Traditionally, I would argue that we've been at one end of the continuum, traditionally up until, say, 15 years ago at one end of a continuum, and now we're moving more into some middle ground. The question is, where along this continuum will it lie?

Bill was talking about baseball stories, but let me tell you my analogy. Yogi Berra was once asked, what's more important in baseball, physical ability or mental attitude. He thought a moment and said, 90 percent of the game is mental, the other half is physical. In the health care arena, one might say that 90 percent of the issue is professional, but the other half is economic.

What are the assumptions and implications of the professional model? It reflects an approach to perceived market failure. We've heard a lot in the literature about market failure. The professional model observes the lack of knowledge on the part of consumers and the scientific expertise of physicians. The professional model substitutes professional controlled decision making for that of consumers and, as a result, vests tremendous authority to determine quality and

volume of services and, ultimately, costs on professional providers.

The assumption is that patients are uniformed and that the market cannot function in the face of such consumer ignorance. When we had an election, the last election cycle in Tennessee, there was kind of this person on the street interviewing this -- this fellow was being interviewed and he was asked by the reporter, what's the worst problem today regarding the political process, voter ignorance or voter apathy. And the guy thought for a moment and said, you know, I don't know and I don't care.

That's basically the assumption of the professional paradigm, which has, as I said, vested enormous authority in professionals to make fundamental decisions about medical care.

A further assumption of the scientific approach is that diagnosis and treatment decisions are not influenced by financial incentives. Financial incentives do not affect professional judgment. I remember being told early on by a doctor, that’s a nice young man, that you think economics has some role to play in medical decision making, but it's not like candy. Economics has nothing to do with medical decision making. It's a scientific process.

We've come a long way from that. I don't think doctors would say that quite in as extreme a position today, but I think there's certainly a kernel of that -- more than a kernel of that belief that still exists. The lack of influence of financial incentives allowed us to develop a system of third party payment with a blank check and with minimal oversight, which we heard about from Tom Scully yesterday, Medicare, and to some extent, Medicaid. We assume that the flow of dollars would not affect levels of utilization despite the fact that economists have told us that that is completely contrary to what we normally expect in economic thinking.

The bottom line was that doctors controlled the system because of their scientific expertise, because of the respect that flowed from that expertise, and to some extent, because they controlled patients and this gave them economic leverage. The hospitals were beholden to doctors and competition, to the extent that it existed, was for doctors, and that's how we got the medical arms race hypothesis -- that hospitals were catering in their competition to doctors. And we heard about some of this yesterday, about how competition in a regulatory environment can lead to some perverse outcomes.

The market paradigm challenges many of these assumptions. The assumption and implication of the

market model is that the appropriate market oriented response to consumer ignorance is guess what, education and improved flow of information. We've seen this all around us. We now have shared decision making models being developed jointly by Al Mulley at Harvard and Jack Wennberg at Dartmouth with an increased flow of information. The Internet is a font of that information and we now see that in many areas -- and the AIDS victims really were the pioneers here, where the patients know more about the illness that they have than their physicians because they have an incentive to learn about that.

The market model contemplates a greater role in decision making for the patient, either directly or through information intermediaries. Payers or consumers control decisions about quality and levels of service and quantity produced.

And, bear in mind this riddle. If you have a -- which is the case for the market approach. If you have a donkey race in which a person puts up $1,000 and the owner of the donkey that finishes last -- there are only two donkeys. The owner of the donkey that finishes last gets the $1,000. So, the donkeys are told -- the owners mount their donkeys, the whistle blows and neither one moves. They go through a whole bunch of explanations,

they appeal to their better nature, to the fact that the rules require them to try their hardest, and they keep blowing the whistle and no one moves. Can someone suggest a solution?

What's the solution? Well, next thing you know, the donkeys are mounted and the whistle blows and they go as fast as they can to the finish line. And the question is, how did they solve this problem? And the answer is, that they had the owners switch donkeys. All right? It changes the incentives.

Basically, the goal is to develop a system where incentives are properly aligned and where private decision makers make both self-interested and socially appropriate decisions. The goal is to get a solution like having the owners switch donkeys.

Now, why has the market model developed? My punch line here is that the antitrust law is the engine of the market paradigm, but let me go through three or four other -- quickly, other examples, other reasons.

We've seen the evidence that financial incentives in medical care influence medical decision making on both the demand side and the supply side. We've seen evidence of that. We've seen a cost escalation that was linked to third party payment that suggested that financial incentives made a difference.

We've seen that when we encourage people to have outpatient facilities, they build outpatient facilities. When we encourage them to have dedicated programs, we heard about this yesterday, they tend to build dedicated programs. Paul Ginsburg recounted that example as well.

Third, clinical uncertainty. Again, Jack Wennberg at Dartmouth published this eye opening atlas. When you present this to judges and you just see their eyes pop out of their head to see the clinical uncertainty, the different levels of procedures that are being provided and performed in different jurisdictions when the researchers control for everything imaginable. And so, the scientific claim for medicine has been somewhat undermined and suggesting a greater role for consumer choice.

And then, of course, in the '80s, the shift is payment systems to the DRGs and more through managed care with capitation, all basically push towards a different vision of medical care suggesting that economics had a role. But I've argued that the antitrust doctrine is the engine of the market model.

And now, I want to talk about application of the antitrust law and why it's so important in this transformation, moving down that continuum from a pure professional paradigm to a mixed model that includes a

heavy dose of economic thinking.

I would argue that antitrust doctrine is substantively and symbolically important. First, it applies to trade or commerce. So, at the threshold, we're thinking about issues that are trade or commerce. It's not purely a professional delivery system, a social services delivery system.

It shifts the vocabulary. Things that old-time health planners talked about about how coordination is a good thing all of a sudden becomes conspiracy, not such a good thing, collective action. The old-time hospital managers were told to eliminate wasteful duplication. The plan is to eliminate this, and filtered through the prism of antitrust, this becomes territorial market division. You don't want to say you do services on the west side of the river, we'll do services on the east side of the river. In the health planning model, that's a good thing. In the antitrust world, that's probably five years or more in prison.

So, substantively, antitrust evaluates conduct on grounds of a competition and efficiency. It encourages competing away excess profits and cross subsidization. This is something that the health system has lived on for many years, but it is hard to do when super-competitive profits are being competed away and

that many monopolies are being targeted. In the old days, the opponents of this would call this cream skimming and pro-competition types would say, competing away super-normal profits.

It also has eliminated the worthy purpose defense, that anti-competitive conduct is not justified in the pursuit of laudable goals. And, again, this undermines, to some extent, and explains the hostility to antitrust, in some quarters, the professional commitment to quality at any cost. It also challenged the egalitarian ideal that money should not matter in medical care, that money is just not part of our thinking.

So, in summary, with respect to the antitrust agenda, antitrust focuses on efficiency and competition and it necessarily submerges concerns about equity that are the concern of access-egalitarians and quality and autonomy that are concerns of the professionals. And so, one can understand how this would upset folks who are steeped in the traditional professional paradigm.

But, ultimately, the potential for antitrust liability is an impetus to a shift in the culture. It limits the traditional guild-oriented collective conduct by professionals and it provides an impetus for hospital managers to make in-roads on professional control within the hospital because of certain kinds of fears of

behavior by the institution itself.

So, from the perspective of market reform, it's important to maintain the role of antitrust. This has helped to change the way policymakers think about medical care and the way people in the industry think about medical care, to include an economic focus and to empower consumers.

Now, let me turn secondly to some areas of inquiry that I want to highlight and to think about. And here, I want to focus on three areas. Bundling is the first, especially as a pricing strategy. U.S. competition law has been, in my view, insufficiently attentive to the potential effect on competition of bundling. It's difficult because bundling can have pro-competitive virtues. It's a requirement to look at the context in which this arises. Pro-competitive virtues include economies of scale in production and economies of scope in marketing or one stop shopping.

Where market power exists, however, there is a risk to quality and a risk to innovation. The Microsoft case and insights from the Microsoft case suggest that there can be pro-competitive virtues from bundling, but also there can be adverse effects on competition as well. And I think a fair analysis has to look at both the pluses and the minuses of bundling.

But where bundling is primarily a pricing strategy, and that's what I want to focus on, the production economies tend to wash out, the economies of scope are what you're left with, and in Microsoft, there were some clear virtues to the bundling strategy. But when it's limited to pricing and scope economies, I think that it can inhibit entry and it can hamper quality and technological innovation.

The Third Circuit is now considering, en banc, an important bundling case, the LePages (phonetic) case involving a pricing strategy by 3M. An earlier Third Circuit case, the SmithKline case, dealt with the question of blocking the introduction of a new competitive drug through a bundling pricing strategy, and the SmithKline case has not had any progeny, but it's one that's worth looking at, and we'll see how the Third Circuit handles the issue in LePages. The panel had rejected the plaintiff's bundling claim, overturning a District Court judgment. That was vacated and is being heard en banc. It was heard en banc earlier this year.

Second, insurer or health plan monopsony. This is something that's worth thinking about. It's a paper I'm working on now in the context of the introduction of Tenncare in Tennessee. We heard a lot about countervailing power and antitrust law tends to frown on

countervailing power as a vehicle for overcoming anti-competitive conduct, and I support that.

The Commission has pursued physician organizations that have been developed for countervailing power reasons. I think that's appropriate.

Monopsony, however, can result in the mis-allocation of resources in the long run. For example, if the price signal to the labor market suggests lower prices for labor supply, that suggests, in the long run, that there will be an under-supply of labor, with shortages, bottlenecks and associated queuing.

Courts have treated insurers as purchasers with the prerogative to drive a hard bargain. This is the prevailing view. But when you talk to doctors, this is a peculiar area to doctors. They drum up the David and Goliath image and they see themselves as David, not Goliath, although most people tend to see physicians as having some authority. But this strikes hard at their self-concept.

Does the reaction of the doctors suggest maybe some tentative thoughts about reconceptualizing what's going on? And I offer this only tentatively because I haven't fully worked this out. We're doing this in a paper.

To the extent that insurers are purchasers of

provider services, the now conventional view, the argument is in cases like Kartell and Ball Memorial that Blue Cross or the insurer is the purchaser for the account of others. This is the language of Judge, now Justice Breyer in the Kartell case.

Are they financial intermediaries or purchasing agents? They're acting on behalf of others. But insurance companies actually have little control over if, when or how services are provided. Patients initiate purchase transactions. But if you look at insurance companies as purchasers on the account of others, what do we do about their subscribers? What role do we attribute to them? Is this a purchasing co-op, are they acting as agents on behalf of their subscribers? And if you look at this, it's the aggregation of buying power that creates the irritant here with respect to insurance companies. So, they are maybe buyers, but they're a different kind of a buyer than we normally think of as buyers because their clout comes from the aggregation of powers of their customers.

So, it may be that we have to be a little more modest in how we think about what's going on in this exchange, and I thought about a certain resemblance to the collective conduct by doctor groups that the Commission has prosecuted because of the anti-competitive

distortion of the so-called messenger model, where the messengers are coming and negotiating on behalf of the doctors. Under those circumstances, maybe the messenger model distortion that the Commission has looked at with respect to doctor groups is applicable, to some extent, with respect to insurance companies as well.

There's another way of thinking about this whole exchange transaction, not that insurance companies or health plans are buyers, but, in fact, are sellers of access to patients. We know that access to patients is very important. Hospitals vertically integrate and become durable medical equipment suppliers and they have an inside track to provide services and it gives them great competitive advantage.

The anti-kickback law is concerned about giving special advantage to folks who have access to patients. So, selling of access gives great clout in negotiations and antitrust enforcement and analysis needs to be open-minded to the competitive consequences of this power of selling of access, if that's how we conceptualize this. Again, I haven't fully worked my way through on how to look at those issues, but I think if we listen hard enough to the doctors, we may be sensitive to the fact that what is really irritating them is something that irritates us when we look at it in different contexts,

such as when the doctors get together and have these messengers acting in ways that we don't approve, rather than ways in which we do approve.

The third area that I want to just present for thinking is standard setting as a tool of defeating competition. Now, on the demand side, standard setting can be pro-competitive, where it facilitates consumer choice, and we've seen that in the California Dental case, which I want to come to, if I have time.

But on the supply side, this can inhibit competition and can limit innovation. It's especially important when it's linked to the adoption of standards for which one firm has a monopoly, a patent. So, I think we need to be very careful about private companies using technical features of their patents as a way of inhibiting entry and inhibiting access to new technology. We should insist on some link to quality or cost efficiency; in other words, some pro-competitive justification that would support the standard rather than having kind of a game of gotcha.

All right, let me quickly run through -- I'm getting the hook, so let me quickly run through. David has a hard job, so I want to respect that.

First, on doctrinal issues, I make the claim for no doctrinal exceptionalism. I've talked about the

worthy purpose argument. The Courts have tended to reject this. There's some exceptions to that. I think that it's important to hold the line on no worthy purpose defense.

The role of non-profit institutions, the Butterworth case, the merger case is a good whipping boy. It substitutes the rule of noblesse oblige for the rule of competition. That's not what the antitrust laws are. That's everyone's kind of poster child for doctrine run amuck, and I think it's important that we not give up. That's one case, preliminary injunction stage, that I think that it's worth looking at and I'm glad to hear that the Commission is doing research.

Market imperfections, I think that the goal here, again, should be to perfect the market, not to substitute the market. I don't see a reason for doctrinal change. Market imperfections can be dealt with within conventional antitrust law.

The fourth area, quality. Again, quality can be dealt with within conventional antitrust law. It is a method of non-price competition that is traditionally recognized in competition policy, in competition law. There's no need to develop doctrinal exceptionalism to deal with quality. What it requires is a change in rhetoric. It requires a change in the views of doctors,

what they're doing when they're pursuing quality. They're pursuing quality for market share. They're pursuing quality because it's consumer-justified, not because it's their professional prerogative to impose quality standards on willing consumers. And I think it's important that doctors justify their quality rationale in pro-competitive terms. It's hard sometimes to do.

Finally, in doctrinal, I want to talk about Cal Dental and then I'll conclude. I'll try to do this in one minute. The Cal Dental case, I think, has caused a great funk among marketeers in some circles. I think that one has to be loyal in looking at Cal Dental and I think that one has to look at this in terms of the procedural posture and also, that it was argued within an antitrust framework. It was good lawyering on the part of the victors in that case, the Dental Association.

The claim of improved quality of information to consumers is perfectly consistent with a pro-competitive justification. A standardization on the demand side is something that's totally compatible with a market approach. The problem was that we saw that a procedural shortcut, the so-called quick look analysis was being disapproved in that case. But I think the argument is that what we have to do is do a better job of educating the judges and not taking the procedural shortcuts at the

first instance.

The per se rules all developed over time where the Courts said, oh, gosh, we've seen these price fixing cases, we've seen a lot of them, we know that they're not pro-competitive, we're going to have a procedural shortcut to do that. You don't do that at the start of the process. One does that strategically as a culmination of a series of cases, of good cases.

So, what I would urge, again, is through the enforcement mechanisms, not to get a funk about that case, but to go back and build huge records, big records that show that what was really going on in that case was what Justice Breyer said in his dissent, is that they were creating these barriers so that there was no information flow going forward. The problem was that the result of those restraints on advertising were such that there was -- it was too expensive and there was no communication going forward.

So, I think that we should take a better -- maybe I'm a Pollyanna on this, but take a more sanguine view of the Cal Dental case and treat it as a challenge to explain what we're doing, make our case and then eventually get the procedural shortcuts that we want to have after we've won a few of these cases at the Supreme Court level and move forward from there.

Basically, I'm going to support the research agenda that's going forward. The one area that I would look at in terms of research, with respect to non-profits, is bidding. I think that there's lots of hope, good prospects for encouraging pro-competitive alternatives by a bidding strategy and I would encourage -- and I'll talk about this in the discussion afterwards -- about developing the strategies for bidding as a vehicle for getting cost consciousness into health plans.

Thank you very much.

(Applause.)

MR. HYMAN: Thank you very much, Jim. Our next speak is Peter Hammer who is an Assistant Professor of Law at the University of Michigan, School of Law, who's written a significant number of articles about this particular subject, many of them with Bill Sage, including a major empirical study of health care antitrust litigation since, I think, 1985 to 1999. That's my vague recollection.

So, Peter.

DR. HAMMER: I'm a neophyte with this brand new technology. So, bear with me.

This is the slide -- to sort of give you the warning from the airlines, that this is not the plane that you expected to be flying, that you're at the wrong

FTC competition hearing. We're charged today to try to talk about perspectives on competition policy and the health care marketplace.

My title or the focus I want to think about is competition in the context of failure. The law school just got done with a large building campaign and there were these cheesy slogans about from excellence to excellence and strength to strength. The problem about trying to build a competition policy, it only gets interesting in light of market failures. So, you really have to be thinking about how to build upon failure and that's the kind of challenge that I'm going to be talking about today, how you successfully develop a competition policy in light of substantial market failures.

I'd give deference to the funders. A large part of this is an outgrowth of work that I've done with my colleague, Bill Sage, at Columbia Law School and funded by the Robert Wood Johnson Foundation.

As I read the little precept that David circulated about what we were supposed to talk about in this session, I distilled it down to two observations and one question. The first observation is that simply health care markets are very complicated, right? We sort of have the litany of factors making it complicated, an interesting combination of private markets, regulation

both at the state and federal level and substantial public subsidies, which is not what you normally find in competitive markets.

Second observation that we are charged to discuss is that there's multiple market failures here. And the question then is how you build a competition policy in light of these facts.

When I'm done, I hope that you will see that these are actually consistent. You wouldn't expect to find anything other than substantial public-private cooperation, sometimes competition, sometimes inconsistencies in the light of market failures. And, in fact, any time you're going to have substantial market failures, it is going to invite and, therefore, you're going to observe interesting combinations of public and private non-market institutions and the objective of a competition policy then is to try to calibrate how those market and non-market institutions actually work together as opposed to against each other.

I'd like to build a general sort of analytic framework for thinking about a competition policy in the context of market failures, and this dovetails very nicely into what Mark Pauly and Marty Gaynor were talking about yesterday, and I approached this problem as an economist and from the perspective of general equilibrium

theory. If you go back as far as Arrow and DeBreu, you have the proof of the efficiency of competitive markets, which is sort of the analytical infrastructure supporting a lot of antitrust analysis.

But to get to the efficiency of private markets, you have a tremendous number of very restrictive conditions, conditions that aren't always satisfied in the real world, which leads us to the point of market failures. One way to understand market failures is simply going point by point down the set of restrictive assumptions necessary to establish the efficiency of a competitive equilibrium and say, well, this one is not satisfied here, this one is not satisfied there, and at the end of the day, you have a long list of market failures.

The problem is, and this was alluded to again yesterday in work coming out of Lipsey and Lancaster back in the 1950s, is that if you have multiple market failures, you absolutely don't have any compass left to guide you as to what appropriate policy is. In the face of multiple market failures, you have the world oftentimes being turned upside down on itself and sometimes actually having less competition might get you a higher level of social welfare. The sort of implication is that close is not good enough. Once

you're dealing with market failures, you have to have a more open conceptual mind to what might be proper policymaking.

This has led a number of people to sort of go in the lines of what I call sort of economic nihilism. And a number of people who want to sort of be anti-markets will latch on to the theory of second best as a justification for simply getting rid of economic thought as being useless, or -- and I don't want to put necessarily Richard Markovits as an economic nihilist -- try to devise very sophisticated and sometimes difficult to understand prescriptions on how to then address the problem within an economic framework.

I'm going to propose a different approach to the problem of second best, and it's building upon further work by Arrow, done in 1963, where he contemplates an interesting economic rule for social institutions. Although Arrow doesn't use the language of second best in his article, he says, well, when you have market failures, and Arrow's talking about the medical industry back in 1963, you have these optimality gaps. You have the sort of gaps between what a competitive equilibrium would provide you and a level of welfare optimality that you get with failed markets.

Sort of building on that, I call it sort of the

social analog to the coase theorem. When that happens, people respond. Institutions respond, policies respond, professionals respond, and you have the sort of natural emergence of a variety of social institutions that help to bridge the optimality gap and then he tries to justify and look through a number of traditional medical institutions, circa 1960, as efforts to bridge the optimality gap.

I like that as sort of the point of departure, then, to try to think about building a competition policy, one in which you can imagine market and non-market institutions, and it's important to remember that non-market institutions can be public as well as private, and there's a role for potentially private self-regulation. And the interesting question, and one that Arrow doesn't necessarily focus on our answer in 1963, how do you try to get these sets of market and non-market institutions working together. I sort of conceptually view the work of a competition policy as building the proper blend between market and non-market institutions.

When you do that, you have to always be policing private self-interest. And this is sort of the critique that Jim Blumstein was alluding to under worthy purposes. This is also a wonderful rationalization for anti-competitive conduct, and sort of the important

objective of antitrust enforcement then is to filter what will be welfare enhancing in the public interest from what will be in private self-interest.

Interestingly enough, and this is why it's very exciting that the FTC is holding these hearings, historically, there has been no effort to develop a rational competition policy. Historically, it's been path-dependent, it's been accidental, and there's been very few efforts to try to calibrate public and private efforts to resolve market failures.

As you're building a competition policy, one of the issues I'm going to try to focus on in my presentation is what should be the proper role of antitrust courts within this general framework.

Medical market failures. On one side, you sort of see just the traditional listing. You have information problems, moral hazard, adverse selection, agency issues and down the line. On the other column, you have what I would envision various ways in which private markets or organizations can respond to market failures. On the private side, sort of again thinking of some of the work that Clark Havighurst has done and some of the older work of Ronald Coase, oftentimes, private contracting can be a response to market failure. Clark Havighurst tries to argue that there's a series of legal

obstacles about effective contracting and tries to argue that contract failure actually might be a form of market failure.

So, you want to think not only about what are the list of market failures, but what's the range of ways that private businesses or markets can respond. Interesting contracting practice is one approach. If you go back to Coase's theory of the firm you have -- really vertical integration and the creation of managed care, a wonderfully novel way to get the two donkeys to be ridden by different riders. So, you have interesting levels of ways you can restructure firms and organizational innovation to respond to market failures and you also have the ability to introduce new forums or products and the ability to create new markets entirely.

So, you're sort of thinking, again, an underlying system of market failures, a variety of interesting potential innovative ways to respond to that.

How does that then influence the challenge of the DOJ and the FTC? And very consistent with what Bill was talking about, there's a two-fold mission when you're talking about a competition policy, and one is what I call inward-looking and one is sort of external or outward-looking. If you're going to build a competition policy -- and this I would have to have lengthier

discussions with Jim about what are the implications for antitrust doctrine -- I think you can tweak the traditional antitrust doctrine and massage it in interesting ways to deal more effectively with market failures, but I do think you have to have some level of massaging.

In particular, as a very interesting sort of legal and analytical question, how should antitrust courts deal with the problem of second best? That hasn't been well thought out and there isn't very good law trying to deal with that set of issues.

There's another underlying tension with antitrust law itself between the objectives of things that are going to be pro-competitive or sort of structural views of competition versus things that were looked at from a welfare economist as being welfare enhancing, and oftentimes, the two go together. What's pro-competitive is actually welfare enhancing, but there may be important differences between an antitrust doctrine focused on pro-competition, which is under the structural view of competition, and an antitrust policy grounded in social welfare or total welfare. And, indeed, you have to move more in the direction of total welfare if you're going to start dealing with problems of second best and more effectively dealing with problems of

market failure.

There's another interesting kind of conceptual difference you can think of between types of interventions, either public or private, that are market facilitating versus ones that are market displacing. Much easier to get market facilitating interventions within existing antitrust doctrine. You give better information. You simply make markets work more like they're supposed to in the textbooks. But that will foreclose a wide variety of types of interventions that might be welfare enhancing that would be more market displacing. So, you have another sort of interesting divide about how far you push a market failure defense.

Clark Havighurst has an interesting article in a collection of essays looking at Arrow's '63 article where he tries to limit a market failure defense to market facilitating, and some of the work that Bill Sage and I have done try to push the envelope further in antitrust doctrine to say antitrust doctrine should be encompassing to take certain forms of market displacing interventions as well.

A competition policy is also going to run headlong into the state action doctrine. What do you do with states that might have legislation that has adverse effects upon competition? I would argue, if you really

want to think from the ground level, you might want to introduce a federalized competitive impact statement for state regulations and want to get different ways to force the federal mandate and the infrastructure of the antitrust laws in ways that could actually help root out forms of state regulations that are not pro-competitive. You're going to have similar problems trying to mediate a political action at the federal level and will raise interesting questions on the Noerr-Pennington Doctrine.

Those are all things that you sort of have, your antitrust hat and antitrust doctrine. If you think of now external looking, it's great that Tom Scully gave the keynote address yesterday because you can't have a competition policy if you're not getting Medicare and Medicaid into the act.

One interesting conceptual issue is, are there ways that you can use monopsony power. Now, I'm thinking not private monopsony power that Jim Blumstein was discussing, but rather public monopsony power in lieu of traditional regulation. That sort of opens the door that actually the purchasing power might accomplish things that are traditionally done through regulation.

At a minimum, Medicare has to be aware of its conduct that is both market-shaping and market-facilitating. When Medicare chooses to reimburse a new

technology, it creates a new market. When it has a misalignment of the regulatory pricing system, as we saw illustrated numerous times yesterday, it creates competition gaming the regulatory system. So, the regulatory structure has to be conscious of those effects.

There's other things that Medicare can do that are market facilitating, improving information, designating centers of excellence, a wide variety of other things that private markets can actually piggyback off of the innovations and improvements of Medicare. More generally, at the same federal level, there has to be a greater sensitivity to the competitive implications of regulation, and I'll sort of raise the issue that Mark Pauly also sort of raised and dodged, technology and innovation has to be thought about in the context of a competition policy.

I would argue that we probably have too much innovation, too much technological change, and that you need more rationality and a competitive or competition policy thinking about dynamic efficiency technology and innovation over time.

The hard part is, what's the appropriate division of labor? What should the FTC do? What should CMS do? What should states do? If you're going to

devise a competition policy, you're going to have to start thinking about what tasks you assign to what actors. And you have to do that in light of a recognition of strong institutional constraints and different comparative advantages of making different types of issues. So, sort of generally thinking what functions can antitrust courts and antitrust enforcers realistically accomplish, what's better left, as Jim Blumstein was saying, to a legislative process to make exceptions.

The problem is, at least historically, and this can be solved if everybody's thinking in competitive terms, if it hasn't been an antitrust issue, it hasn't been thought of in competitive terms. So, if you're going to create a division of labor, you want to develop an infrastructure in issues that you declare not to be germane to the antitrust world, to the actors, than to think in competitive terms in areas that traditionally do not.

So, what can antitrust courts do well? And this is kind of a brief summary of some of the findings that we found when we did a comprehensive survey of the last 15 years of medical antitrust law. What antitrust courts do very well is create a space for private markets, and I think you can make a strong historical

argument that but for rigorous antitrust enforcement, you would not have private health care markets today.

The way it did that, however, was through fairly blunt and traditional core antitrust principles, getting rid of price fixing, policing naked restraints. And there's a continuing mission for that. I don't think that will ever go away. There will be a constant need to be policing naked restraints. But antitrust law has not been very effective going beyond these sort of core principles. At least that would be my contention.

There's a narrow range in which antitrust law can accommodate and deal with productive efficiencies and I think that it has done that in health care as well as other areas. But it has only limited potential, at least under a traditional application of doctrine, to deal with quality concerns.

The way that we've found antitrust laws predominantly accomplishing a quality task was use of heuristics of choice and of information as proxies for non-price concerns. And that's actually fairly strong and powerful and is done fairly successfully in antitrust courts. If things minimize or limit consumer choice, that's anti-competitive and, therefore, declared unlawful. If things normally reduce the amount of information, that's anti-competitive and unlawful. And

protecting choice and information can indeed protect a range of non-price attributes and quality competition as well, but there's a lot of quality and non-price concerns that don't fit within those heuristics.

The other way that antitrust courts have tried to deal with non-price competition or quality is through what I term the demand side models of non-price competition. If quality can enter into the demand function and either increase the price or increase the number of people consuming at a particular provider, then it fits the traditional antitrust mode in sort of thinking through the way competition works, and to the extent that quality can be incorporated in demand side models, it can be fairly well protected under traditional antitrust doctrine.

Again, it's not saying that that's not good. That is good in the domain that it actually takes place. It's just simply saying that these traditional concepts might not necessarily protect a range of non-price and quality concerns that don't fit those tight models.

What don't courts do well? And, again, this is sort of learnings for the last 15 years of medical antitrust litigation. They generally don't do well in addressing and acknowledging the problem of market failure. The important exception to that is the

California Dental case that Jim was talking about, and there, I think most people would say they didn't deal with it necessarily well. So, there's sort of a continuing challenge for antitrust courts to acknowledge market failures and develop a better infrastructure to try to deal with the problems of market failure.

Antitrust courts don't appreciate what I call supply side quality concerns. An interesting sort of economic, an interesting sort of thought experience is what is the production function in health care. I talked about production efficiencies or productive concerns on the earlier slide. Not at all clear exactly what the health care production function is, what is the supply curve? Things that deal with technology, with innovation, with the knowledge base of medicine, practice guidelines, medical errors, all squishy and incredibly more squishy when we when look at the Wennberg studies that show that there's no consensus even on what the answer is for a number of these issues.

Those supply side concerns are incredibly important for competition policy and have not yet necessarily been effectively worked into tools or processes that antitrust courts have grappled with effectively.

And the last thing I would sort of list on the

short list of things courts don't do well, courts do not address price quality trade-offs very effectively. They normally assume that if they're facilitating price competition that that's also protecting quality competition. In a number of instances, that's true. But there's a lot of instances where price and quality might be in conflict and there is no general sort of analytic framework to deal with price quality trade-offs, which is something that's sort of core. Modern health policy now is trying to make trade-offs between price and quality.

The objective then is to think about how you get better engineering now between private markets and antitrust law in public institutions or non-market institutions. I would suggest that we go back to Arrow's insights and we see that there's a wide range of things that might be functioning to fill these optimality gaps. The antitrust challenge then is to be able to do that filtering function between what is welfare enhancing and what is actually a sort of special interest capture or private manipulation.

In that realm, I would say that antitrust courts need to be more open to market displacing types of mechanisms, to forms of cooperation that might have an optimality gap-filling function, and at least to be willing to have open ears towards non-traditional forms

of arranging health care services.

The public policy challenge is to better calibrate the social institutions to fit within an interface to work well with private markets. Social institutions can do as much damage as they can do good and those people making public policy need to think more carefully about the interventions that they have and whether or not they're helping or harming competition.

One could imagine a wide range of plausible private actions and responses to market failures. This is fairly rote and tentative. You have information failures, which means you get better information, credentialing, accreditation, et cetera.

Risk selection is a more complicated problem, and actually one of the difficulties of health policy is trying to deal with the insurance function and the provision of medical services. Would you permit private actors to standardize insurance products? Interesting complicated question.

Would you allow them to orchestrate coordinated restrictions on choice in efforts to deal with problems of adverse selection? In some instances you would say, I'd be open to that argument. At some point, you might say, this is better fit for a regulatory or administrative process to set the constraints around

which private markets are going to ultimately function.

Public goods are sort of straightforward. You can have joint R&D. Practice guidelines might be cooperatively developed. The important thing that I think has been neglected is acknowledging the significance of organizational innovation. And, actually, I think that one of the most important things that could come out of this set of hearings is just simply acknowledging that one of the most important things that law needs to do is not chill or deter private forms of organizational innovation.

Creative contracting. This is going back to the earlier slide about private responses to the various forms of market failures, offerings of new products, new forms of contracting and various forms of integration to provide the financing and delivery of health care services.

There needs to be, again, a similar sort of function on the public policy screening. The minute you walk in and say that public markets can respond to these optimality gap-filling sort of Arrow functions, it's just a feeding trough for special interest. And you have to be very savvy about special interest manipulation. You need a stronger sort of set of tools to try to police special interest activity.

There's a particular -- in this thing, I'm showing my biases. I think that the problem is greater at the state level. I think it's interesting that a lot of provider functions have far greater political power at the state level that eclipses even their economic power within markets, and that is an area where you can get a lot of state regulation that actually might be anti-competitive. This, again, is going back to the thought that we need to be rethinking the state action doctrine and it may not be appropriate simply to defer, as a matter of antitrust or competition policy, to state determinations of regulation.

Public action can do harm. So, this is not an open invitation to say that all public action is good, that all public intervention necessarily facilitates the working markets; that's certainly not true. The sort of social engineering, the sort of legal engineering task is to try to filter those that are actually aiding in competition and deterring those that are not successful in aiding competition.

Now, that being said, everything I've said so far is basically within the tight economic framework, and I want to sort of add a caveat here. As Jim was suggesting, these are contested boundaries where economic values compete with non-economic values and other

concerns, and at some point, antitrust law in economics has to be sensitive to that, and that actually might be the point at which you hand off issues to the legislative realm. I agree with Jim Blumstein's instincts that you don't want antitrust courts to be operating in a framework that would expressly consider non-economic objectives. I think that is an invitation to going down the road that you had in Butterworth and some other opinions.

So, I think that there's a need to keep the antitrust focus, both within the enforcement agencies and within the courts, within a tight economic model. And when things are not fitting within a tight economic model and there are important, non-economic concerns or values at stake, I think that's the point where you then send an issue to the legislature. Again, as I said earlier, if you're worried about special interest capture, we're not always guaranteed that the product of legislation is going to be in the public interest. That, at least, is a conceptual framework to think about what's the appropriate division of labor between antitrust in a competition policy and how would you then incorporate important non-economic values that are relevant in making medical decisions.

Reiterating what I said a little bit earlier,

law can do a lot of damage on the ability of private markets to respond to market failures on their own. Something I just find fascinating is the structure of hospitals, just historically. No other industry has such a sharp demarcation between the ownership and control of sort of the physical capital in the human expertise or the human capital. From a Coasean perspective, completely irrational, it makes no sense. You don't have law firms divided up between the partners and then the people who own the buildings. When you go to an auto mechanic, either the garage employs the mechanics working on your car or the mechanics in a smaller setting might own the garage. But there's an integration of the human and the physical capital.

Not so in health care. And there's a lot of reasons for that. You can go back to the corporate practice doctrine. I would argue that the absence of the ability to innovate along this sort of theory of the firm or organizational dimensions has perpetuated a lot of the economic market failures. There's a lot of these failures that could have done more effectively through integration. And, indeed, the sort of antitrust story is a history of professionalism against forms of prepayment. Go back to the 1943 AMA case, you know, the 1956 Oregon Medical Society case, all wars against prepayment.

Prepayment then being a form of organizational innovation. So, professional boycotts, the corporate practice of medicine doctrine historically preventing forms of efficient organizational innovation.

In a modern structure, Medicare is actually perpetuating a lot of the limitations on the ability to innovate on organizational dimensions. Things that are necessary to police, fraud and abuse, in a fee-for-service realm impairs substantially what a hospital can do in terms of structuring its business arrangements. The Stark prohibitions on self-referrals are another area. I think if you're going to want to have private markets freed up to deal with market failures more effectively, you're going to have to think through top to bottom on the whole laundry list of legal impediments to organizational innovation.

Similarly -- I mean, and Clark Havighurst is the person who's written most prolifically on this -- there's all sorts of legal barriers to simply entering into contracts, and a lot of this is reflective of what Jim was talking about, the battle between the professional paradigm and a market paradigm. It is dang near impossible for me to enter into a contract to provide you a lower price quality trade-off than would be recognized by tort standards.

Similarly, if I'm going to now restrict your choice of providers, you have the Supreme Court ERISA case now out of Kentucky dealing with the provider laws. There's a lot of these non-Medicare, non-antitrust rules that limit the ability to private contract and the ability of firms to organize. And a competition policy that really is trying to maximize the ability of private markets to increase total welfare has to deal with those problems as well.

Concluding thoughts, and I sort of organized these, all things that start with I, introspection, interdependence, information, and intra-system rationality.

Introspection simply says a wake-up call both for antitrust professionals as well as for non-antitrust actors to think about the competitive dimensions. I think that antitrust actors have to be open-minded in ways they historically haven't about the optimality gap-filling roles of non-market institutions and be more accommodating to problems of market failure and second best. And, clearly, the people over at CMS and other government actors that are regulating at the federal and state level have to be far more sensitive to the competitive effects and implications of their regulations. So, some level of introspection on all

parties' parts is necessary for competition policy to be built.

Interdependence, and this is what makes health care both interesting and perennially complicated. There's multiple dimensions, they all inter-relate. It's a complicated web. And you have to acknowledge that from the beginning and to respect the fact that boundaries are going to be blurred oftentimes and distinctions may be hard to make.

That is then the call for information. A lot of these sort of echo -- I like to see -- what Bill was talking about as the objectives of these hearings. We need more empirical understanding of what the effects of particular business relationships are on important outcomes, both price competitive and quality outcomes.

One of the most shocking things about the survey of antitrust litigation that we did, not even a handful of cases or sections of cases out of 500 that we examined dealt with learning or information that could be gained from the health services research literature. There's these huge walls between antitrust lawyers, their clients and not trying to incorporate and learn empirical dimensions into the litigation strategies or to try and aid courts as a matter of education or even lawyer's themselves as a matter of competitive consequences.

Some of that requires generating new information and there's a whole series of important empirical questions that we need to just get better answers to that we don't have the answers. Some of that is actually learning from what we know already, and we haven't even begun that process.

And the final I that I would throw out is what I call intra-system rationality. We have to make the pieces that we have fit together. And I think the Arrow framework in thinking about the role, the complementary role of particular forms of non-market institutions and markets can help us make it fit together better. But that's got to be the goal.

And so far, if you look historically, everybody's been in their little domains without a lot of discussions of cross boundaries, and one of the most exciting things to me about these set of hearings, particularly one looking at competition policy broadly, and not just antitrust policy, is letting these conversations take place to hopefully get more rational pieces of the puzzle being fit together in the aid of not just simply competition, but of making health care more effective, more affordable and higher quality for the American people.

(Applause.)

MR. HYMAN: Thank you, Peter. We're going to take about a seven to eight-minute break and we'll start up again at 11:00 with a panel discussion. Thank you.

(Whereupon, a brief recess was taken.)

MR. HYMAN: Okay, we're now going to continue with a panel discussion and I'm going to briefly introduce everyone on the panel and then we'll get started. Over on my far right is Chip Kahn who now has his slide up and you can see he's the President of the Federation of American Hospitals, which are for-profit hospitals. He's going to start off with a PowerPoint presentation and then we'll just sort of work across. Even though Chip's sitting next to me here, he's standing there so he gets first introduction.

Next is Helen Darling who is the President of the Washington Business Group on Health. Then sitting next to her is Jacquie Darrah who is, I believe, the head of Health Policy at the American Medical --

MS. DARRAH: Health Law.

MR. HYMAN: Health Law, excuse me, Director of Health Law at the American Medical Association. Then Mark Botti who is the head of Litigation I at the Department of Justice who you've heard mentioned periodically throughout the first day in his absence. Litigation I is the part of the Department of Justice

Antitrust Division that, among other things, handles health care. Chip's seat is here, but he's not here, he's over there.

Then Stephanie Kanwit who is General Counsel of the American Association of Health Plans. And finally is Arnie Milstein who, although it says on the agenda is with the American Benefits Council, he's actually the Medical Director of the Pacific Business Group on Health. He also wins the prize for what is easily the coolest title of anyone on this panel because in addition to being the Medical Director of the Pacific Business Group on Health, he is also the National Health Care Thought Leader for the Mercer Human Resource Consulting. When I found that out, I, of course, went to Bill and said, I want an upgrade in my title.

Each panelist will speak for seven to 10 minutes and we're going to strictly keep to the time restrictions so that we can have as much time as possible for discussion among the panelists. Mark's and my job is to keep the ball rolling. Thank you.

Chip?

MR. KAHN: Thank you, David. I will be as brief as possible. I am Chip Kahn and I'm here this morning representing the Federation of American Hospitals. We represent Americans investor-owned

hospitals. We are, by definition, strong advocates of market competition and believe that antitrust law, when applied appropriately, considering all the unique characterizations of health care and hospital markets, can contribute to ensuring access for Americans to high quality, affordable health care.

Initially, let me say that one of the reasons we are here, at least from my view, is because we have an ever-increasing growth in health care cost and there's a belief that that threatens the availability of affordable quality health care and health coverage. Unfortunately, many of the players in delivering and financing are pointing fingers of blame at one another seeking exoneration from this point, and from my point of view, this finger-pointing is a waste of time and also avoids all of us facing very tough public policy questions raised by the complexity of health care delivery in this country. There are no easy answers.

What I'm going to do this morning is cover three areas. First, I want to set a context for health care and hospital spending growth over the last decade and into the future. Second, I want to point out a few of the distinctive characteristics of hospital markets that result in this unique complexity I'm talking about, which I think is critical to take into account when

analysis and enforcement is done in the area of antitrust. And, finally, I want to outline a few recommendations that the Federation has for FTC and DOJ as you review specific hospital markets.

First, I'd like to point out, and these numbers look at cumulative growth over a decade. This work was done by Price Waterhouse from public numbers, National Health Expenditure numbers that are generally available. And what this shows is that over the last decade, in terms of cumulative growth, hospital care has been growing at a slower pace than other sectors in the health care system. I use this chart not so much to point out that hospitals are that different or should win any prizes, but to make a point that if you looked at the middle '90s, you would see that hospitals arguably underpriced their products to meet the demands of managed care contracts, and then a little bit later in the '90s, we're confronted with BBA-97 and significant Medicare reductions.

And then, in recent days, some will argue there is a blip, an upswing in hospital spending, and I would argue that is a combination of things and partly catch-up for the dip in the '90s for the reasons that I outlined. I think if you look at the number growth cumulatively, it gives you a sense for that factor.

Second, if we look at this period from '97 to '01, which is the period that we have the latest data, where we have this blip, in a sense, this $83.6 billion growth blip in hospitals -- it's higher growth than hospitals had experienced earlier -- we can attribute that to two things. One, more services, that includes both population growth as well as more intense services being provided, all those services being ordered primarily by physicians when patients were in need, and the other side of the cost spending ledger is hospital costs and the primary driver there, almost a third comes from compensation for wages and benefits. So, work force is the big banana in hospital spending.

This chart reflects recent projections by the CMS actuaries and shows that blip I described, the actuaries see as evening out, and at least in terms of the decade from the actuaries standpoint, they see hospital growth, and this is gross spending growth across the country for all hospitals, that hospital care will increase at about 6 percent a year. Now, whether this is the right percentage or the wrong percentage is obviously an issue we can talk about. But at least from the actuaries', at CMS, standpoint, we see hospitals basically at a historic pattern in terms of the increases we're likely to see into the future.

Now, let me describe some of the distinctions of the hospital market that I think are important for our discussion today.

First, hospital care is generally inelastic. You don't find that many two-for-one sales on drug-eluting stents and other kinds of services provided in hospitals.

Second, the actual cost of hospital care is borne on and from many ledgers. Even hospitals themselves bear a part of that cost because they are mandated, in some cases, to actually provide services and there is no payer other than sort of coming up with the money inside the revenues from the hospital to pay for those services.

The idea of so many different types of payers and costs coming from so many different places makes the hospital an extremely complex institution to run, and I was interested in the last presentation. Not only is it complex, but it is, in a sense -- and probably if you compare it to other places, other hospital systems in the world, it's sort of unique, because in most other places, the doctors do work. You have inpatient -- at least on the inpatient side you have doctors working for the hospital.

So, here we have those people who order the

services not generally working for the hospital and all these different ways in which costs are raised for hospital services.

And, finally -- and Tom Scully noted this yesterday, government is the 800-pound gorilla for hospitals. This is important to point out because it makes hospitals, particularly, and actually health care because generally, Medicare, Medicaid and other public programs are the 800-pound gorilla for all providers. It puts providers in a unique situation because, as Tom said yesterday, he basically is a price setter regardless of the years, and I worked on Capitol Hill in the years of some of the development of fee-for-service payment reform. There was always an attempt to try to be market-oriented. But at the end of the day, you have prices that are arbitrarily set that really don't relate very closely to any kind of market scheme that we could define.

Beyond the issue of prices, you also have hospitals being probably the most regulated institutions, at least private institutions, in our society and that regulation varies from a life and safety code regulation to a regulation that mandates that if someone shows up at an emergency room in an unstable condition, they have to be treated regardless of their ability to pay and they

are not obligated to pay for those services. In a sense, this kind of mandate affects hospital behavior and it ought to be accounted for when analysis is done for purposes of antitrust, looking at consolidations and other kinds of reorganizations of hospital or hospital systems.

Finally, let me go to a few recommendations. First, hospital markets are distinct. You've seen one hospital market, you've seen one hospital market. Now, having said that, in terms of that category of antitrust that relates to sham arrangements, naked price fixing or market allocation agreements. I mean, clearly there's no question that you got to get in there and root out a wrongdoing. I think when we get to other levels of judgment, of whether a consolidation is appropriate or inappropriate in terms of antitrust law, things get much more complicated.

Second, and this sort of reinforces the point I just brought up, I think traditional antitrust analysis using statistics may obscure the realities of hospital markets, the realities of this relationship of the different payers, the relationships of the mandates, and so, I think all that has to be taken into account, and the earlier speakers referenced that.

Third, all hospitals are not created equal. If

there is a consolidation, one hospital may bring, in terms of numbers, something to a consolidation but depending on their relationships with their medical staffs, their relationship in a market, any two hospitals that may have the same numbers may not reflect the same issues if you're forming some kind of merger between those institutions, and that has to be accounted for.

Fourth, there are competitive effects of non-general hospital providers that need to be taken into account. Now, Paul Ginsburg referred to these yesterday. I use the word "non-general hospital" because here I mean ambulatory surgery centers, ancillary kinds of services, but also physician-owned specialty hospitals also sort of fall into this.

The fact is that hospitals -- the general hospital to be able to survive, to remain viable in a market, has to be a full service entity. There is cross-subsidization within that entity and anything that's lost in competition with these other kinds of providers cannot necessarily be made up on the inpatient side in areas where hospitals provide unique services by simply upping prices. So, that's something that's got to be taken into account.

Also, I should point out that hospitals live in an environment in some areas where payers not only

predominate in a market but basically are the market. States like Alabama, places in Pennsylvania, in Michigan, that warrants scrutiny where private payers have so much weight.

And, finally, there's just this notion of government policy having unintended consequences that has to be accounted for. The Stark Law was mentioned earlier. One of the unintended consequences of the Stark Law is this issue of physician-owned specialty hospitals. There is an exemption in Stark Law for -- a whole hospital exemption which had in mind, basically, allowing doctors to own stock in hospital companies.

What that has been used for, though, are these niche players who have created whole hospitals, whole orthopedic hospitals, whole cardiology hospitals, and taken services or taken doctors, in a sense, into financial arrangements which have great allure, which can't be replicated by general hospitals because of the Stark Law, and those, in a sense, create a situation for general hospitals which, in a sense, attack viability. Those kinds of issues have to be taken into account when you're doing analysis of consolidation mergers and markets because those are realities for financial viability and economic viability that hospitals have to live with.

Let me end on that note and just say I hope this was useful and I look forward to the discussion.

MR. HYMAN: Thank you. And you can speak either from your seat or go up to the podium, depending on your personal preferences.

MS. DARLING: I'll go up just because I'm short and nobody could see me.

MR. HYMAN: I'm not sure the podium addresses that problem.

(Laughter.)

MS. DARLING: Well, at least I get to stand up. Thank you for the opportunity.

The Washington Business Group on Health is the national voice of large employers committed to innovative and forward-thinking solutions to health care issues. We have about 175 members, and we represent about 40 million workers, retirees and dependents. Employers would like to see a health care marketplace -- clearly, everybody else would as we've heard all morning -- that competes on the basis of quality, service, innovation and price. All of those are important, especially so in the health industry, which is notoriously slow moving in a number of areas.

Unfortunately, the health care market falls far short of that. I hate to tell Bill, but hospitals don't

follow you outside your admission and keep track of what happens to you. So, that's bad news, I know. They do get your address usually, if they can, in case there's a billing problem. But they don't follow and look at outcomes data and things like that. But it's a nice concept and we should work on it.

One of the major problems, as you know, in the health care industry is that information is imperfect and asymmetric. Transparency is a critical ingredient in everything that we're going to be talking about and that we talked about this morning. Unfortunately, we don't have that in the health industry. Consumers need information. They need it to be accessible, which it is not, and they need it in order to compare quality, innovation, service and cost. And some of the recent studies that you've seen reported and some of the recent incidents are very good examples of that.

Most people, at least, who are in the know could get information about volume of procedures utilization, some indication of quality, just how many somebody does if they know what they're looking for in about three states in the union, including New York. But if you want that information any other place, you won't be able to get your hands on it and you'd have to know a lot to know that you can even do that in New York.

Probably a grand total of maybe 100 people know that, and it's all the same people who know all these other things, too.

Consumers do need information in order to compare treatment options. I mean, we sort of talk about cost and all these things, but the fact of the matter is an awful lot of care that's recommended may not even be the care you need or want. So, regardless of even quality of price, even the issue of what should you be getting and when you should get it, is information that you should be able to get from the health care industry and from the institutions that we're talking about today.

We would like to ensure that every hospital and every institution in the United States is required, at a minimum, to post the publicly reportable information today, in some instances for more than 30 years, on their own web site, just for a matter of convenience. And we're not even debating about what other information we would like to have, just what they already have to give to health departments, to the Federal Government through Medicare, state and federal, for Medicaid and that kind of thing. Right now, they don't even have to do that, which seems bizarre.

Employers and consumers -- and I would note, we had a lot of framing this morning. I would add one very

important factor. Hard to see in this town and in academia, but we're in a recession in this economy. We only have three parts of our sectors that are growing. Two of them are bad news and one is mixed. The one is corrections. We have more than a million people in jails in America and those costs go up endlessly. We also have -- most jobs last year that were created were the people who inspect you when you go through airports. We had a big job jump-up in those jobs.

And the third is the health care industry, and you saw some of the data on that. The rest of the economy is in serious trouble. So, one of the reasons we are all here, I hope and care about, is we are trying to have a more efficient industry because we can't afford the industry that we have been given by the health care industry.

You've heard, I'm sure, about employers and consumers double-digit increases. We've had an increase of 50 percent in the last five years, and for 2003, it's either 14 or 15 percent, depending on whose numbers you agree with, and there's no end in sight. We consider good news when we're saying, like with prescription drugs, it used to be 18 to 23 percent, it's now only 17 percent increase, and that was considered good news. So, this is really a bad situation we're in right now.

The cost increases have broad implications for the entire economy and what we can do in terms of education and all the other things that are important, so we will have a work force in the future. So, it's incumbent on all of us to try to make the system more efficient and effective for what we're paying for, not just debating about whether it's a reasonable thing for somebody to get X amount of dollars or not. We're talking about the whole pie that's important to worry about.

Now, employers still actually bear the majority of health care costs. It's estimated that employees pay about 19 percent of the total cost of health care for an individual coverage and about 24 percent for family coverage. So, employers really do pay the vast majority still of health care.

To deal with that, employers are making a lot of changes in what they're doing, and you'll just begin to feel the full effects, because most of those really started in January of 2002 and will have a bigger impact for January 2003. What you'll see is starting in 2004 and 2005, you'll see the impact of these changes. In some ways, they will be good and other things won't be so good. But everybody will learn more about the cost of health care whether they want to or not, because, among

other things, employers will be changing cost sharing. They're going to put in spousal surcharges, heftier out-of-network charges. Everything is going to go up and employers will do everything they can to make the consumer more price sensitive and we will see some big changes in the demands for information because of that.

You've had Chip and others talk about -- and there's some material out there -- about the growth in hospital spending. It's not so bad, folks. Well, it is still pretty bad and you could argue that some people need it and some people want it and the economy may want it as a whole, but again, we cannot afford the total package.

Provider consolidation, especially hospital consolidation is aggravating these cost increases. In a number of geographic areas -- I would love to be able to be here for the Boston discussion tomorrow -- we have seen contract showdowns, we have seen demands for higher charges. We've also seen an unwillingness to pursue quality inpatient safety initiatives in some markets because, in effect, they don't have to take the pressure, so they're not doing it.

Preliminary findings of a recent analysis by CALPERS (phonetic) found the cost of admission at a Tenet hospital in California, adjusting for case mix, is 32

percent more expensive than the statewide average cost for all hospitals. The Joel Hay study, done for Blue Cross-Blue Shield Association, attributed 18 percent of rising inpatient costs to hospital market restructuring and concluded that every 4 percent increase in hospital market share due to consolidation leads to a 2 percent increase in inpatient expenditures. I'm sure the health economists of the country can enjoy some more employment for a couple more years debating the merits of these studies and the people who are responding to them.

But, frankly, worse yet, the impact is that as a practical matter, purchasers and others who are trying to buy into these markets are finding that they have far less leverage than they had in the past and, again, keep the focus on the total cost. It is astonishing what's happening and it's estimated that costs will double again by 2011. So, we're talking about over a $3 trillion economy. Somewhere, we have to find more efficiency and effectiveness.

We've also seen systems that came together, but, in fact, made no changes in anything that would have improved efficiency, whether they came together just to negotiate or they came together because they were in a fantasy world or what, the reality is that, in fact, it's not having an effect in terms of benefits for the

consumers, quality or efficiency.

Employers support fair market rules that promote access to affordable medicine as well as promote the development of tomorrow's innovative therapies, but we also are concerned about what's happening in the prescription drug arena. I know that's not the subject of this particular presentation or anything that's going on, but we do think that that's a serious problem and we hope the FTC will continue to keep a very strong eye on them.

Employers are very concerned about efforts to ease or waive health care antitrust regulations in general and for any specific segment of the health care industry. We believe that this will reduce access and competition and lead to higher costs and, again, make it impossible for purchasers to insist on quality inpatient safety improvements.

In an increasingly consumer-driven world, which is where we are, there must be a clear benefit to the consumer. We strongly applaud recent efforts by the FTC to step up antitrust enforcement efforts in health care and your increased staffing in this area. And, obviously, we applaud these hearings and any publicity you can give to these problems.

In addition, employers believe that post-merger

follow-up and continuing oversight -- we were really glad to hear what was said this morning about that -- are essential to determine whether hospital mergers have actually benefitted consumers and improved quality and efficiency or simply allowed to charge more and resist efforts to improve quality and patient safety.

We also were very pleased to hear the comment about judicial education. As a group of employers and purchasers looked at some of the recent decisions and been appalled by the reasoning, not being attorneys, just good old plain common sense, like is having one business person on a board actually going to represent the consumer. I mean, this was even before all the scandals about board rooms. So, the idea that that could make a difference really has never made sense.

So, we welcome anything that can be done to make those kinds of changes. Thank you.

MS. DARRAH: My test for the podium is always to just see if I can see over it. So, this is good. I'm short, also.

Good morning. As David mentioned, my name is Jacquie Darrah. I'm the Director of Health Law at the American Medical Association and it's a pleasure to be here today on behalf of the AMA and to address the Federal Trade Commission and the Department of Justice.

The issues raised today by the Commission and the Department, although quite broad, have very specific implications for this nation's patients. The AMA has recently expressed to your agencies a heightened concern that the dramatic consolidation in the market for health insurance has led to decreased competition among health insurers and increased problems for patients and physicians. Therefore, we commend the Commission and the Department for holding these hearings.

To put it bluntly, we believe that federal antitrust agencies have placed physicians under far greater scrutiny than is warranted by our comparative economic strength in today's health care system. By contrast, we are aware of only one federal enforcement action against a health insurer. The absence of enforcement activity on the payer side is puzzling because there are plenty of reasons to be concerned about the level of competition in payer markets.

In the late 1990s, managed care organizations consolidated at record pace. Today, we are seeing double digit increases in premiums and in health plan profits. At the same time, consumers have expressed deep dissatisfaction with managed care and physicians have found themselves vastly overpowered in their dealings with payers. In any other industry, a merger wave

followed by an abrupt rise in prices would cry out for an investigation. Why should health insurance be any different?

I will now address market imperfections in health care. There are several characteristics of the health care market which we believe are imperfections or distortions that create unique problems for physicians and patients. One is the system of third party insurance in the U.S. and the Medicare system of payment for physician services. Our written statement goes into more detail about these market imperfections.

Today, we'd like to focus on the market problem that concerns us the most, the dramatic consolidation of health insurers in the United States. This consolidation not only exacerbates the problem created by other market imperfections, but it also raises serious questions about the level of competition in the health insurance marketplace.

We now turn to the issue of consolidation in payer markets. Today, the 10 largest health plans cover over half of all commercially insured Americans. The effects of this consolidation are mostly clearly seen in local and regional markets. In 2001, the AMA conducted the most comprehensive study ever done on competition in health insurance. Last December, the AMA published its

second study based on updated information.

What we found confirmed the results of our previous study and show the problem is even more widespread. Using the agency's merger guidelines, we looked at 70 large metropolitan statistical areas or MSAs. In those MSAs, we found the following: 100 percent of PPO product markets were highly concentrated; 90 percent of HMO markets are highly concentrated; 87 percent of combined HMO, PPO product markets were highly concentrated. In almost all of these highly concentrated markets, there was at least one insurer with a market share in excess of 30 percent, and in nearly half of these markets, a single insurer had a market share in excess of 50 percent.

The study confirms what patients, physicians and employers around the country already knew. In many parts of the country, not just Pennsylvania, as we highlighted yesterday, health insurance markets are dominated by a few companies that have significant power. We also looked beyond market concentration at other characteristics of the markets for health insurance. Entry into a market requires investing millions of dollars to comply with state regulations governing insurance companies. New health plans in the market must also invest time, labor and money to establish

relationships with physicians and health providers in the market.

These costs and regulatory hurdles facing a new entrant make it possible for existing dominant firms to increase premiums without the concern that it will lose its market share. Even worse, large health plans often use contractual devices such as most favored nations clauses or all products clauses to lock in physicians and keep out new rivals. The large companies are clearly in the driver's seat.

Now, let's shift gears and talk about what's happening with health insurance premiums. In recent years, after the dramatic consolidation of health insurers, health plan premiums and profits have skyrocketed. From 2001 to 2002, premiums increased by 12.7 percent. This is the sixth consecutive year of accelerating premium increases. Overall, health insurance premiums increased 42 percent from 1998 to 2002. This is more than double the overall increase in medical inflation and more than triple the increase in overall inflation during the same four-year time period, and premiums are expected to rise again by 15 percent this year.

It's important to note that medical costs have not been the primary driver of these increases. To the

extent these increases may be driven by the rising cost of health products or services, the data continue to show, and we've seen some of these data today, that physician costs have not been one of the major drivers.

Data also indicate that premiums have been rising at a faster rate than administrative costs and claims expenses. Recent reports on payer profits refute any notion that claims expenses are driving premium increases. Profit margins of the major national payers have been steadily rising despite a slowdown in the general economy.

In 2001, health insurers reported a 25 percent increase in profits. In 2002, third quarter earnings were up 47 percent on average for 11 major insurers and good fourth quarter results are also expected.

Let us now turn to the effects of reduced competition in the health insurance sector. When health premiums rise due to a lack of competition, some employers cease providing coverage or reduce the scope of benefits provided. The number of uninsured individuals remains at a crisis level. Lack of coverage for individuals places enormous pressures on other segments of the health system. It leads to increased expenditures for emergency treatment and increased pressure on government programs and the public health system.

Clearly, continued double digit premium increases don't help the situation for the uninsured or for those at risk of becoming uninsured. As the Justice Department recognized in the Aetna matter, a lack of competition among health insurers may also lead to anti-competitive effects on the health provider markets. A dominant insurer exercising monopsony power can drive physician payment rates well below the level needed to provide medically necessary care.

Over time, these fee reductions can lead to a decrease in time physicians spend with patients. Physician departures from the market reduce access to care for patients, and in some cases, medical groups are even forced into bankruptcy. This is exactly what we are seeing in some areas of the country. And from the consumer's perspective, the result has been chaos; higher out-of-pocket costs, longer waiting times, and reduced access to physicians.

In conclusion, the agencies should care about competition in the health insurance sector. There's no justification for a one-sided enforcement policy that puts the sole burden of compliance on physicians. We respectfully ask that the agencies reconsider their approach and take a serious look at competition on the payer side. The AMA hopes to continue a dialogue with

the Commission and the Department regarding these important issues, and thank you for the opportunity to participate in these proceedings.

MR. HYMAN: Thank you. Next, Stephanie.

MS. KANWIT: Thank you. Everyone's doing it from the podium, so I may as well, too, right? Keep us all awake this morning.

Thanks very much for inviting me to participate today. We really, really appreciate it and it's a nice turnout here.

I'm Stephanie Kanwit. I'm General Counsel and Senior Vice President of the American Association of Health Plans and, as many of you know, we represent about 170 million Americans, our health plans, our 1,000-member health plans who have health care coverage through our members. What's not so widely known is that that coverage doesn't just deal with commercial coverage, you know, the Aetnas, CIGNAs, Humanas and Pacific Care, but also the "public" coverage, the S-CHIPS, the Medicare, the Medicaid. Our plans administer many of those very, very important public programs where about half of our health care dollar goes. So, that's very, very critical.

I want to stress today briefly, aside from my written testimony, which is out there on the table, what I did in the hearing before the FTC and DOJ last

September, which was very worthwhile, the concept of competition and collaboration as the key ingredients in the health care system, that all of us at this table, all these representatives you're hearing from today and yesterday and tomorrow need to work together to get costs down, as Helen Darling so rightly said, and improve quality here.

I also look forward to the debate after we give our very short statements here because we have lots of things to say to some of the panel members. Jacquie Darrah's presentation was wonderful, but those of us in the health plan community would say, in a nutshell, hey, wait a minute here, we've got a highly competitive market out there with really, really savvy employers, as Helen knows, and with employees, two-thirds of whom have an enormous number of choices among health plans. So, in terms of concentration, we can discuss some of those issues.

I wanted to make two particular points here that are near and dear to my heart as a reformed antitrust litigator. One is this whole issue of consumer empowerment and the need for transparency, the same word Helen used. Very, very critical. Many of you have read the recent IOM, Institute of Medicine, report called, To Err is Human. If you haven't, I commend it to you. It's

an excellent report. And it called all of us to be "accountable to the public" -- I thought that was a great phrase -- and work to build trust through disclosure, even of the system's own problems. It's just critical.

This came home to me this week, of course, with the horrible tragedy of Jesica Santillan at Duke and what's happening right now in Congress with the medical malpractice reform bill, HR-5 that's up there, what's going to be happening. It is an issue we all need to deal with.

What I'm very proud of is that our health plans at AAHP have empowered consumers with information to make informed decisions about their health care coverage. For example, provisions of key information to consumers, often by electronic means, and I can't tell you how revolutionary that's been. We can get into details on that. Turn on your computer and find out almost anything you need to know. This flexibility is truly made possible by technology.

I was interested to find out last week that 84 percent of our health plans have web sites that allow members to choose or to change their PCPs, their primary care physicians online, just terrific. Many of them allow you to fill prescriptions online. The same technology is going to be useful for what we've all been

talking about this morning and we're all working toward, which is quality improvements. How do we get information online and in paper, but online is the key right now, to improve communication between medical clinicians and to patients? How do you collect and share medical information?

For example, how do our health plans, and we're working hard at this, get information to physicians on up-to-date treatment, cholesterol treatment, beta blockers. How do we get that information out there?

You heard Professor Hammer this morning talk a little bit about the need for joint R&D, perhaps, and practice guidelines. We're working on that, too. We're very, very concerned about our ability to get what's called evidence-based medicine out there. Is it safe, is it effective? How do we get the standards up and make sure people are getting the best possible medical care when they need it?

So, we all agree that dissemination of accurate, truthful up-to-date information is a goal. The question is how to do that. In a nutshell, I'm kind of mystified, again, as a former antitrust lawyer, at the rush of the Department of Justice and the Federal Trade Commission -- I hope we have a debate about this -- to give their imprimatur to information sharing by

horizontal competitors, namely physicians, and it's information about pricing, highly sensitive, and these are groups of doctors that want to disseminate information on what they're paid by health plans, all ostensibly on the public good.

And I would ask us to discuss three major points on that. Number one, is there, in fact, a disconnect between what these physician groups claim they are doing when they're collecting this information on what they're paid? In other words, they're claiming they're empowering consumers with information, and what they're actually doing in a real world where consumers, as you just heard from Helen Darling, aren't contracting for their health care benefits and aren't paying the bulk of the benefits. Consumers, on average, are paying less than a fifth of their health care benefits and 99 percent of them don't contract for health care benefits.

Secondly, questions in real time, does this fee information, what health plans pay providers for specific procedures, you know, a hysterectomy, whatever, appendectomy, does that really make doctors deliver better quality health care? That's really the bottom line. How does it impact consumers? And even more important, is that information useful to consumers?

I just have to share with you one of our -- I

found out this week, one of our biggest health plans did a survey and said to consumers, what do you want to know? What do you want to know? Because it's going online in a big way, it's costing the plan hundreds of millions of dollars to put everybody's medical records online. What did they want to know? They wanted to know how to refill their prescriptions. They want to be able to e-mail their doctors with questions. They want health information on their own particular chronic conditions, asthma, diabetes. My child has cystic fibrosis, what do I do?

Did they want to know how much their doctors were reimbursed for flu shots? No. And I just cite that because the FTC just last week came down with an advisory opinion on a Dayton group of doctors, and we can discuss it in great detail, where the doctors said, we need to tell everybody how much health plans are reimbursing us for flu shots. And I say, who cares?

So, the bottom line is that there's, in principle, free flow of information. I'm all for it, but we have to tread carefully, everybody, in this area, lest that dissemination of information facilitate collusion or stabilized physician rates.

My second point, and, again, this is covered in great detail in the paper, we are still seeing -- and

Helen went into this a little bit -- the impact of rising health care costs. We all know this. We're all paying more. Everybody's paying more and they're going up exponentially. One of the issues we are tracking carefully because we have to, our health plans are bombarding us with information on this, with complaints on this. Hospital consolidation is causing a rise in health care costs and affecting their practices and the health plans' ability to contract cost effective care out there in the market.

And many of you know that GAO just came out with a report citing provider consolidation as a leading factor contributing to the 11.1 percent growth in premiums in the FEHBP Plan, the Federal Employees Health Benefit Plan. Last year, the average was 5.5 percent. Now, it's 11 percent. Unbelievable.

What are we seeing out there? Two things. Many others, but these are the two that are the key. Our health plans are complaining to us bitterly about two things. One is hospitals' refusal to contract at negotiated rates. They're saying that the hospitals are saying, we won't contract with you, managed care. We're just not going to contract with you. We want full billed charges which, as many of you know, can be many times what the contracted rate would be.

Second is a practice called all or nothing contracting, which many of you may have heard about, where the hospital systems are requiring our health plans to contract with freestanding facilities, radiology facilities, ambulatory surgery facilities. You have to contract with them if you want our hospitals.

We're also seeing many issues out there where must have hospitals -- must have hospitals, you can't have a network in such and such an area unless you have the major teaching hospital, the major hospital in that particular area. So, there's tremendous pressure on cost out there.

Last -- and this is detailed in my paper -- last, but not least, I really enjoyed Chip Kahn's presentation. He did a nice summary of the context for hospital costs which are soaring and a nice defense of the private hospital market out there. I just want to point out one thing. We took a look at that line chart that he showed you up here on the screen about how our administrative costs were soaring and said, wait a minute here, wait a minute here, this doesn't look right, and we had somebody just take a look at that. That particular line that Price Waterhouse Cooper did on their study amalgamates, public administrative cost and private cost, or private cost as a change, are much, much lower there.

Also, when you talk about admin costs, and you hear a lot of people out there saying, oh, these private health plans, they're paying, you know, a lot of money in overhead and admin costs. I just want to caution everybody to make sure we're all talking in the same terminology. Our private admin costs include things that are state and federally mandated, like reserves and like premium taxes.

So, just to clarify this, I've got some papers out there and I look forward to the discussion. Thanks, everybody.

MR. HYMAN: Arnie?

DR. MILSTEIN: Thanks. To allow plenty of time for discussion, I'll abbreviate my comments, but they're available in writing on the table.

Large employers and consumer organizations agree with the Institute of Medicine's reports over the last four years that there's a very wide gap between the health care that Americans are getting and what health care could and should be. I think it's what Peter was, among other things, referring to as the optimality gap. We think it's very big. We think based on research being published by folks at Dartmouth and expert opinion pulled together by the Doran Institute (phonetic) last year. We think that that optimality gap with respect to American

spending on health care could be as large as 40 percent of the dollars that we're spending.

Most large employers also agree with the Institute of Medicine that closing what the IOM referred to as the chasm between health care delivery as it is and what it could be in America requires that purchasers and insurers correct some serious flaws in the market for doctor and hospital services by taking two actions that do not require any FTC intervention.

Number one, routinizing performance measurement and reporting of doctor and hospital performance. Secondly, rewarding doctor and hospital excellence via either performance-based payment or insurance plan designs which encourage consumer selection of better-performing doctors and hospitals.

To accelerate this, large American employers have launched two linked pro-competitive initiatives. One is called the Consumer and Purchaser Disclosure Project, which I'll refer to as the Disclosure Project, and the Leapfrog Group. The Disclosure Project is an informal partnership of large employers, large employer groups, such as Pacific Business Group on Health and the American Benefits Council, and consumer advocacy organizations, such as AARP, the AFL-CIO and the National Partnership for Women and Families.

The Disclosure Project's goal is that by January 1 of 2007 all Americans will be able to select hospitals, physicians, integrated delivery systems and treatment options based on public reporting of nationally standardized performance measures for clinical quality, for patient experience, for equity and for efficiency.

The Disclosure Project is currently using the National Quality Forum's multi-stakeholder process to come up with that common scoreboard. Its members are also committed to pursuing other options if that progress isn't swift enough.

The Leapfrog Group, which is the twin pro-competitive measure, is a private non-profit organization of more than 130 of America's largest employers, as well as unions, which provide over 56 billion in health benefits annually. The members of the Leapfrog Group commit to encouraging their employees to select, and/or their insurers to reward, better performing hospitals, doctors and treatment options.

The Leapfrog Group initially focused on identifying and rewarding hospitals that excelled in three important safety features. The Leapfrog Group is now expanding its focus beyond patient safety and aligning its market rewards with doctor and hospital excellence across all the performance domains adopted by

the disclosure project.

Our vision of intensified market competition faces multiple challenges. Among these challenges are doctors or hospitals commonly, but not exclusively, in the form of aggregated doctor and hospital organizations which may, and sometimes do, use relative market dominance in their service areas to impede competition based on disclosure and reward of their comparative performance.

Many employers are quite supportive of doctor or hospital aggregation when it is used to create sufficient scale to mobilize the capital or management talent necessary to attain performance excellence. However, we strongly encourage the FTC to consider how its efforts might assure adherence by both aggregated and individual market dominant providers to, what we will just call, pro-competitive rules of the road.

The following are eight such rules based on my personal trench level work with employers and insurers across all U.S. regions over the last 24 months.

Number one, assure performance-based tiering of providers. Aggregated provider organizations should not restrain insurers from classifying individual providers into performance tiers on which insurers can vary consumer out-of-pocket costs or inclusion in insurance

plan offerings. This is because performance may vary widely among individual providers within aggregated provider organizations. Obscuring these important performance differences within multi-provider performance averages and so-called all or none provider contracting demands that Stephanie referred to prevent market recognition and reward of individual provider excellence.

Secondly, assure service line based tiering. Market dominant providers, whether individual or aggregated, should not restrain insurers from varying consumer out-of-pocket cost or the content of insurance plan offerings based on an individual provider's performance within specific service lines. Scientific evidence is clear that many hospitals and physicians that excel in one service line, such as cardiac surgery, may perform poorly on obstetrics or other service lines. Performance cannot be optimized if market dominant providers insist on all or none insurer contracts that require that their poorly performing service lines receive the same level of market preference as do the service lines in which they excel.

Three, assure uniform provider ID numbers on every provider bill for insurers, consumers and purchasers, to enable detection of individual provider excellence. Aggregated provider organizations should

routinely provide, on every bill, the Medicare unique provider ID number or UPIN of the individual physician or hospital providing the service. Without such information, insurers, purchasers and consumer groups cannot assess individual provider performance for services in which individual performance matters, such as surgery.

Four, assure dis-aggregated price negotiations. Aggregated provider organizations should not restrain individual provider members from voluntarily, independently negotiating their prices with insurers, nor should they restrain individual providers from independently responding to performance recording requests from insurers when data needed for performance measurement extends beyond billing data.

Five, assure consumer access to dis-aggregated performance scores. When an aggregated provider organization exercises de facto control over an insurer by providing a majority of the insurer’s services, the provider organization should disclose to the public the same individual provider performance measures as do other providers who do not control an insurer. This will allow consumers who use provided controlled insurers to recognize and preferentially select higher performing individual providers in all health insurance plans.

Six, assure reasonableness of comparative prices where providers, whether individual or aggregated, dominate a service area, their unit prices as well as their efficiency with respect to the total health benefit costs incurred under their care should be held to a reasonableness test based on comparisons with other providers who do not dominate their markets.

Seven, assure customer definition of and access to performance ratings. Market dominant providers, both individual and aggregated, should not restrain insurers' freedom to define and disseminate provider performance measures. It should be up to a customer of a service or the customer's intermediaries to judge the value of a service not the producer.

Eight, assure consistency of performance measures. To minimize consumer confusion, insurers in the same market should not be restrained from collaborating and adopting common performance measures for doctors, hospitals and treatment options, including measures intended for performance-based compensation or providers. We understand and accept that insurers should be prohibited from collaborating with each other when negotiating compensation agreements with providers.

Let me close by saying that America's large employers do not seek to unwind all of the many hospital

mergers and physician aggregations permitted over the last 20 years. However, market dominant providers should not restrain the performance comparisons and the performance contingencies needed to enable the market's invisible hand. It's time to, we think, to emancipate all health care stakeholders from the American irony of offering world class biomedicine via a pre-industrial health care delivery system. Relying on regulation and professionalism to ensure excellence has proved insufficient. Employers, consumer organizations and insurers are ready to foster a more discerning market.

Consumer research published in 2001 by the Voluntary Hospital Association indicates that over 85 percent of Americans are prepared to select their physicians and hospitals based on credible performance comparisons. We think competition can heal our health care delivery system if we assure that such competition is robust. Thank you.

MR. BOTTI: Well, I think the way we'd like to start this is maybe give you a chance to comment on each other's remarks. Since our framing presenters have listened patiently for a little bit, maybe we can give each of them a chance to start us off.

Jim, what would you like to comment on?

DR. BLUMSTEIN: Let me make a few very brief

comments. First, on Peter's -- we don't want to do this all with the academics talking to each other, but on Peter's comment, I think there's a lot of consensus, a little dis-sensus. Where I get nervous is on his last point about balancing non-economic factors and market displacing mechanisms as part of the antitrust analysis. That makes me very cautious. I think if we're going to substitute either non-economic values or market displacing mechanisms, we should go through a legislative process and make the case. I think antitrust enforcement has maintained strength in the political arena.

The other thing I want to mention is a number of you have talked about these all or nothing provisions and so forth, and that's an example. That's one of the things I had in mind in discussing bundling. That's an example of bundling. I think that the antitrust law has not been sufficiently attentive to the negative effects of that kind of bundling. In fact, if it's required, one could even call it tying, which would be a harder form of bundling.

I think that where there are production efficiencies and where integration brings about efficiencies, we don't want to be blind to the benefits that come from that, also. I think we have to look at the positives. But I don't think we should ignore the

negatives that can be associated with that. And the negatives can be a lack of access to higher quality facilities or lack of innovation and technological advancement. And so, I do think that is a real risk where there is some market power, like a must-have hospital and so forth.

So, I would like to basically put those two points together. That's one of the things I had in mind when I was discussing bundling.

MR. BOTTI: Peter?

DR. HAMMER: Just a few brief comments. I think it's important that we don't turn the clock back. I think we've made a tremendous amount of progress in the last 20 years on antitrust enforcement and creating markets where they would not have otherwise existed, and I think the agencies have to be very strong about policing the traditional rules of antitrust price fixing and naked restraints. That will always be an important goal.

That should be applied to every actor in the industry. I'm not going to comment on the merits of whether or not the empirics show problems now with provider concentration, but conceptually, the payers are subject to the antitrust rules as strongly as anybody else. And antitrust policy and competition policy should

be aggressively pursuing all actors in the industry, without favoritism, with an even playing field.

Now, obviously, the issues of payer concentration are different in nature and require a different type of legal and economic analysis and that may well legitimately lead to less enforcement activity against one sector than others. They're just different beasts and one shouldn't necessarily expect the same amount of antitrust enforcement against every actor within an industry.

The thing I find most exciting about the presentations here are the innovative efforts to get more information and to have more active purchasers, both employers and consumers. If you really want to know sort of the low-hanging fruit on the tree, that's the first things to be grabbing, more information, more educated choice, compensation levels that are based upon the factors that the market wants to reward, regardless of whatever anybody does as a regulator or antitrust enforcer, active participation by employers and consumers could easily discipline this market and do far more good far more quickly and far more successfully than any amount of government intervention.

MR. HYMAN: Why don't we have individual panelists speak, sort of in the order they originally

spoke, if they wish to comment on subsequent presentations, and then we had a couple of questions to the extent that doesn't precipitate enough of a battle.

MR. KAHN: Well, let me just say, first, I think on a market-by-market basis, you can point to consolidations in certain markets being extremely significant. In terms of broad national policy, we're looking at less than 10 percent of the hospitals since '99 and maybe a blip above that if you bring in earlier years, even be included in consolidations.

So, I'm not saying if we look at Washington, D.C. or some other city that we might not find consolidations being a significant factor, but in terms of sort of pointing fingers at consolidations as this incredible cost driver, I don't think it's there because it isn't as prevalent across the country as we make it seem here.

Two, I think hospitals are caught in a bind. For years, there was all this hand-wringing over too many beds. We've got too many beds, we've got too many beds. So, hospitals reduced their sizes in response to constraints for managed care, in response to Medicare cutbacks, and now that there are less beds and, in a sense, more market power in negotiating with payers, and all of a sudden, there's a problem. Well, you can't have

it both ways.

And, finally, in terms of information, I think that you'll find hospitals very open to providing more information. The American Hospital Association, the Federation, the JCAHO and CMS are in the process now of developing a means of making more information -- or information public on measurable results from hospital services.

But I think there's also an issue here, too, of there is no free lunch, and a lot of the payers' attitudes about information is -- and particularly the government's -- is that there is some sort of free lunch. The fact is, to collect the kind of information you want in the way you want it, which we can probably do, somebody's got to pay the tab and nobody's stepping up to the plate to do that, except in thinking about more mandates on hospitals. So, I'd just leave it at those thoughts.

MS. DARLING: Boy, I just wish I didn't have to follow Chip because I had a lot of things to say and now I want to react to everything he just said. But one of them is that there is a free lunch in the data recommendation we have, which is right now, every hospital in America and surgi-centers and a set number of organizations already report a lot of information to the

state health department to the federal government. It's sitting there. It used to be reported to PSROs, now QIOs. I mean, these data are sitting there.

Would you agree that this would be something that your hospitals and all hospitals would simply say, we will put on our web site all of that information that we already have to provide, publicly available, there's no cost to that. I mean, they all have web sites for marketing purposes. They could sure just add a little real data.

Second, they have to do it anyway and all the battles about whether it's the right information or not have been fought. Now, you can argue about some of the newer stuff and it may take longer to get that, but we could do that right away and you would see, for example, that say in a state there may be 200 hospitals that do somewhere between two and five procedures of a particular type and two or three that do in the hundreds and you could at least check those kinds of things out very easily.

I just want to go to a couple other points. The FTC does have the ability, as I understand it -- this is an area, the whole area of consumer information and even information for other providers, in this case, for performance in a quality way and for patient safety, to

have that information available is something the FTC could, in its role, insist on and work with the other bodies and there's another IOM report that talks about getting these federal agencies together. Among them, they have a ton of data, too, which they could also make available. So, this is an area you don't need to have 20 years of studies to make progress in.

Second, your attention and pressure in this area is helping in the sense that it gets everybody out there saying, why aren't we doing some of these things. Let's agree that we shouldn't be pointing fingers. What we should be saying is, what do we know like the 48,000 to 98,000 deaths, so maybe it's only 10,000, but 10,000 is still a lot that we all would agree, without any further dispute, must be done to protect the consumers of America and to improve quality, patient safety. Could we do that and could the FTC help them make that more likely?

Some of you -- I don't know if you're old enough to remember or you read it in the history books, but the whole movement about cigarettes and tobacco in this country did not start at HEW. You know where it started? Actually, it was the FTC. If you don't know that, please do a search on it because it's one of the most important stories -- they did more for American

health care and life and death than some other agencies probably ever did, and it might be nice if the FTC thought about getting back to that more, nudge people forward, use what authority you have in order to open up the system for better consumer information. Consumers will react.

I mean, this recent story about the transplant. There's so many issues related to that, as you all know, I mean, ethical, everything. And, by the way, it's probably going to totally screw up tort reform. But the fact of the matter is, that's made everybody interested in safety, and perhaps for the wrong reasons in some instances. But it's gotten people's attention and people will be asking questions now that they never would have asked before.

The FTC has the ability to drive that process quite differently and I'm impressed that they're trying to do that and we would urge you to do more.

MS. DARRAH: First, I'll respond to the issue about the Washington letter from the FTC and I think Stephanie said it right. Who cares? I mean, the FTC has not been shy about going after doctors that are agreeing to collude, that are entering into illegal agreements. But this is information sharing and it's a totally different -- information sharing is good. We have safe

harbors, we have court cases. Information sharing is good. And so, who cares because this is -- what we really are talking about is information for consumers, performance standards, things like that and the AMA has always been for quality, for patient safety.

We have several initiatives that we can rattle on and on that we participate in, but I think that the point is is that when monopsony power and health plan monopsony power starts to decrease access to care. If access can be, in fact, a proxy for quality, then that's what we should be caring about. We're not suggesting that the FTC -- I think the comments from the person from Michigan Law School -- I'm sorry, I can't remember your name. But it's -- Mr. Hammer, thank you.

It's not that we're saying be super heavy-handed. What we're saying is, where you ended up, which is let's level the playing field when it comes to enforcement. Let's take our thumb off the scale and let's look at those data and let's look at the impact of those data and those impact on access and quality. Then just again to reiterate, especially again in light of what Helen said about the patient at Duke is that, you know, we have been in the area of standards and quality before everybody else was thinking about it. We helped create the National Patient Safety Foundation. We've

been on record as saying one preventable error is one error too many. So, we would also embrace discussions about quality and those types of initiatives.

MS. KANWIT: Thanks. I've addressed a little bit of Jackie's comments and a little bit of Chip's. I want to make two quick points to Arnie's comments which I hadn't heard before. I don't think anybody realizes how much information is already out there and the yeoman work, what the Leapfrog Group has done and the other groups have done in terms of quality.

If any of you are interested in this, we just did a study at AAHP talking about the quality information that's available in the single payer systems, the Canada system, the GB, the Great British system and the German system, which is often touted as a model of efficiency and it's minimal, it's really minimal. We are in the forefront here, and what I hope is that we can develop these quality measures and be a leading template, Arnie, for the rest of the world, as to how to get this quality data out there and how do you use it to get evidence-based medicine to people, you know, medicine when they need it, where they need it at the best possible price.

Just a quick answer as well to my friend's, Chip's, point about hospital consolidation. Again, you know, it doesn't really matter who's causing what here.

We have got to work together. We've got the fastest-rising medical costs in a decade. Our plans are telling us that their hospital costs are going up 20, 30, 40 and even 50 percent. The 50 percent figure, by the way, is from the New York Times. That's the kind of demands out there. You can't blame it on anything specific. You know, the PWC report that Chip referred to says, well, labor costs are going up. Sure, they are. But CMS data says labor costs are going up 6.1 percent. That doesn't justify the price increases.

We really all have to work together to get these costs down. I know employers are working very, very hard, as Helen points out, in a very competitive environment to make health care affordable to their employees, because what we're seeing out there is many of these employers, especially smaller, self-insured employers are saying, forget it, I am not going to get into this industry. And remember what we have, I often remind groups of students, we have a voluntary employer-based health care system. There's no employer in this country, not a GM, not a Delta Airlines, not anybody, who is mandated by law, state or federal, to fund a health care plan for its employees, and I think that's a really basic fact here and we do not want to drive the system into the brink.

MR. KAHN: Well --

MR. HYMAN: Can we just let Arnie speak, if he wishes to, and then, Chip, you can. . .

DR. MILSTEIN: Actually, I'll just ask maybe a question of Chip and -- I can read down there without my glasses -- and Jacquie --

MS. DARRAH: Jacquie.

DR. MILSTEIN: Jacquie. And that is, how do you feel about whether or not social welfare is served by all or none contracting conditions by aggregated provider hospital organizations?

Let's stay away for the moment from the issue of all or none on service line, but just with respect to our negotiating on behalf of 19 hospitals or 500 doctors and I won't do a contract with you unless everybody in my organization is included, irrespective of their quality and efficiency scores.

MR. KAHN: I can't comment on physicians, obviously, but in terms of hospital systems, I mean, if you're a cooperation and, you know, one of my companies and you have three or four hospitals in a market, I don't understand why they can't do a contract for those three or four hospitals. If you don't like it, you don't have to sign a contract with them.

It seems to me that's a fact of life and those

kind of discussions are going on right now, and if they decide that they can't do business that way, then they won't. But that's how they've decided to approach it and I guess the point for the FTC is, at some point, if the size of the market participation of that system is such, then that brings in questions. But that's a very rare case.

Second, you know, I'll go back to the numbers that I had. I just don't see two-for-one sales for stents and the fact is that most of the increase in spending right now is related to people going to the hospital because they're ill, because they need treatment. If you want to stop them, fine. And, actually managed care tried to. They tried to stop them at the door and we had a backlash.

So, all I can say is the hospitals, in some ways here, are receiving the orders of the physicians and the patients in terms of demand. Demand is the driving force right now. We can talk about the cost side and debate whether or not we are as efficient as we should be, but that still is not where the spending growth is coming from. It's coming from use. To blame us for that -- and I'll go back to the stents and say that the stents are a good example on the cost side because all of a sudden now, in a few months, we're going to have drug

eluting stents and that ought to be good because I had two angioplasties 10 years ago. And I wouldn't have had two if there had been a drug eluting stent, I probably would have just had one.

But the fact is that the cost of that stent at the get-go is going to increase hospital costs. They're going to come back and say, well, gee, you know, you're increasing costs. Well, sure, because now there's stents and it will soon become state-of-the-art. We don't have a choice.

MS. DARRAH: I think --

MR. KAHN: Now, I'm not saying that efficiencies can't be made, but I think you've got to take those realities into account.

MS. DARRAH: From the physician's perspective, I think that we'd like to see where that's happening. The data in our written testimony shows that most physicians that are self-employed are in small group practices, they're not aggregated. In fact, the statements, even though we've got clinical integration and financial integration, they're such high bars for even any type of integration that they can't hit it. MedSouth is a great example of that.

So, if that's happening, I'd like to see where it's happening, but I think the secondary answer there is

that physicians typically don't walk away from a plan issue in order to -- if it means that their patients aren't going to get access. The physician ethic is to make sure that their patients get the care that they need and access to care that they need. They've been champions of making sure that they're enrolled in the appropriate plans, have the right relationships with hospitals in order to provide that continuity of care and access to their patients.

MR. HYMAN: Arnie and then. . .

DR. MILSTEIN: I want to say that one of the perspectives from the buy side that's been very much informed by research over the last four or five years is the research published in most of the national papers a couple of weeks ago that's been developed over 20 years at Dartmouth, which suggests that most of the big dollar variation from region to region in how much it costs Americans to pay for health care is not driven by differences in consumer demand. It's driven by what Dartmouth would refer to as supply sensitive services, services that consumers don't actually have a preference one way or the other that much for, but they really seem to be correlated with the volume of specialists and the volume of hospitals in communities.

Dartmouth estimates that only about 7 to 8

percent of health care cost differences are rooted in what's called preference-sensitive services, where differences in how much you or I may have for kind of a hard-edged, you know, dietary approach to cardiac management versus bypass graft may vary. But I think what Dartmouth is essentially saying is that the amount of cost variation from region to region that's driven by so-called supply sensitive services as opposed to preference sensitive services, the ratio between those is about four to one. So, I think that saying the problem here is a voracious, insatiable American consumer appetite for all these expensive things is partially true, but there's a big opportunity for efficiency, even holding consumer preferences constant.

MR. KAHN: You know, there is a big opportunity and the Dartmouth work is great. However, in those articles, they also were careful to note that they didn't have a public policy formula. They didn't have a formula how to come to grips with these differentials. I mean, the differentials are there. Wennberg's been showing them for years. And in some ways, there's nothing new. Maybe it's a little bit more sensitive now. But there is no magic bullet. I mean, I wish there was, I'd be sitting here advocating it.

More information is important and can make some

differences. But it's not a magic bullet and I would argue it's not a bullet for cost or for quality necessarily.

MR. HYMAN: Helen?

MS. DARLING: Yeah, these numbers may have changed a little bit, but the last time I saw a study it showed that something like one in five or 20 percent of all hospital admissions result in a hospital related infection. One of the points that we have tried to make to large employers and purchasers is that if we could drive quality and patient safety and different behavior in the hospital, in a different way, that -- and that, in fact, let's say on an average four-day stay would become a five or six day stay because of the infection, if you could stop that, then you wouldn't be paying for these extra visits.

By the way, Chip, I've heard you argue this in the past yourself. And we could use then that money to do all the other things, the extra stents that everybody needs and wants and all that, and you could also -- you could pay for the 21st Century digital infrastructure that allows you to do these kinds of things.

So, I mean, I don't think it is true, and I'd be surprised if anybody else around the table does, that when we talk about health care cost in any part of it,

but especially in hospitals, we're really not talking about just these wonderful stents that everybody ought to have. We're talking about a multi-trillion dollar industry. And there's so many services that are either the wrong services or not the right services or something, and that the rework and consequences of that cost the system a lot.

If we could do some of the things we've talked about, for example, we now have, for nursing homes, thanks to Tom Scully and CMS's initiative in nursing homes, you can now find out a couple of really pretty depressing things about nursing home care in this country, and we, as employers have said, in our resource and referral, we contract -- large employers contract with usually elder care EAPs to give advice on nursing homes around the country, and it's usually an employee's mom or dad or something.

They now can put into the report, when they send out a list of nursing homes in America that have available beds for your loved one, they can now put the data that show the bed sore rate. Now, if you're sitting there making a choice about somebody, that's a pretty important thing to know. We also -- this has just happened in less than six months. We can also say to our resource and referral people, do you want anybody on your

list that has a bed sore rate that's above average. Average, by the way, is pretty grim, too. But maybe you would even want to say, I'm only going to put on my network list those that are 10 percent or less.

We ought to have that in the health care system, I mean, infection rates in hospitals and things like that, and people ought to know that if they choose this hospital, that that's a hospital that has a significantly higher infection rate. You have to control and make sure the data are right and everything. But that stuff's been reported since the health services research in the 1940s at the University of Michigan and places like that.

So, we could make a big progress without arguing about whether it's going to be about -- you know, somebody's not going to get the stent. That's not what any of us are talking about.

MR. HYMAN: Arnie?

DR. MILSTEIN: I'd like to re-endorse Chip's comments about there are no villains here. I don't think there are any villains. But I do think there are some solutions and what I would hope would be that we'd get -- that the solutions would get widespread support from multiple stakeholders. Though there's no silver bullet, I think there is an answer to Chip's question to me, and

that is, let's begin to create some metrics at the doctor and hospital level with respect to the longitudinal efficiency with which the total stream of resources associated with one doctor's longitudinal is responsible for a patient. Or in the case of what Dartmouth has also shown is that most people with serious illness orbit around the same hospital.

So, that's the way to -- I mean, what the Dartmouth research published a couple weeks ago showed is that those huge differences in the number of dollars being consumed and taken care of, in the case of the Dartmouth research, the Medicare population, was not associated with any increase in patient satisfaction or health levels.

So, let's begin to move toward, as quickly as possible, some metrics to begin to allow us to discern which providers are generating excellent levels of patient health maintenance and patient satisfaction, but denting the payroll deductions of those consumers a lot less.

MR. BOTTI: Let me get a question in here because I don't want to miss this topic. Either Helen or Arnie, you seem like perhaps the best people to respond to this. We've heard some numbers today about concentration among health plans and we've talked a lot

about the importance of information in order for consumers, customers to make informed choices. I'm wondering, do the concentration numbers in health plans concern you? Do you see these increased premiums as related to that concentration? Are you looking for differentiation among plans, more information on plans as opposed to providers?

Can we turn on these topics, for a moment, on the plans and get your reactions to it as customers?

MS. DARLING: Well, our large employers are self-funded, so they pay their own claims, basically, through a plan, usually, that they contract with. So, the only time -- they don't usually pay premiums. I mean, they might in some markets where they happen to choose to. But basically what they pay attention to is what the administrative fees are. So, for example, if you -- you could have a product with, say, Aetna and pay a premium or you could be self-funded and you'd pay their admin fees plus the claims.

In our experience, and my experience actually for 20 years is, for the most part, there's still a lot of competition on that front. You can always shift to -- you can hire -- and a lot of small companies do this -- a local TPA which runs like labor funds or something and they pay claims. There are a lot of ways you can get

your claims paid, if that's what you want to do. And you can buy reinsurance if you're a medium-sized employer. So, we don't see that as a big problem.

I'd say another point, I'm certainly not here to defend the health plans of America, but if you look at the data, it's a little bit disingenuous. The numbers say profits went up 48 percent because it was from actually two or three years of near bankruptcy. And, again, I'm not here to defend them, but if you look at the data, they lost a lot of money. Now, some of us might fuss at them and say, you didn't do a good job of managing and we could always find fault with some of the dollars in there. But the cycle that they're dealing with is why you have, at least -- in a couple years you had a big increase because literally the prior two or three years they probably lost, literally, millions and millions and hundreds of millions of dollars.

So, looking at the baseline is important. But we don't want to get anybody off the hook. We're happy to go after anything that's hurting efficiency and quality in this country, but we want to go at it with data that's based on a time frame that's more like a two to three to five-year with hospitals or doctors or anybody else. We don't want anybody off the hook that isn't driving to efficiency, effectiveness, quality and

patient safety.

MR. BOTTI: Arnie, I'm just wondering, are you folks also not interested in premiums or --

DR. MILSTEIN: I have to say that, you know, the employers I hang out with, I could characterize their behavior as getting insured at favorable points in the insurance cycle and getting into self-insurance at unfavorable points in the insurance cycle. So, we do have some interest in health insurers.

I mean, I think our point of view, by and large, is that differences in the value of the health benefits that we're buying are not very much affected by whether we're using Carrier A or Carrier B. There are some minor differences. But in terms of the big differences in the potential value of health benefits to our people, the leverage is not very much as to which plan you pick. It really has to do with the mix of doctors, hospitals and treatments that your health benefits are buying. That's where the big, big value difference is and value uplift opportunities lie.

So, for us, I think going forward, our primary test of whether an insurer has become too consolidated is to what degree are they using the consolidation to resist our interest in using their power to begin to create performance metrics that differentiate among doctors,

among hospitals and treatment options with respect to their performance, and then any resistance that they might offer in terms of their structuring insurance products to begin to reward excellence on the part of doctors, hospitals and treatment options.

I mean, as long as carrier consolidation does not get in the way of intense value differentiation and value seeking at the hospital, doctor and treatment option level, we're okay with carrier consolidation.

MS. DARLING: If I could just make one point, in fact, we are asking all the health plans or anybody, whether to network or PPO network, to help us drive this quality and accountability agenda and, you know, we believe because there is competition, if somebody tries to not do that when we want to have that, then we're going to -- we think they're going to lose our market share and we think it's going to be a fair amount of market share. So, we think there's enough there to drive it and we think it's really important to do that.

MS. KANWIT: David and Mark, can I just make one quick point? The enormous variation, to piggyback on Arnie and Helen's point, of health care products out there. I mean, an Aetna may offer thousands, literally thousands of different products to thousands of different employers because the employer gets to design, by and

large, its own benefit product. And I think as Arnie made the point, it can be a Ford product or a catalog product, depending on what the employer wants to pay and how much money it wants to ask its insureds to pay in terms of copays or deductibles, et cetera. So, you include cosmetic surgery if you really want to pay for it.

So, the concentration point is a little mitigated by that.

MR. HYMAN: I think my principal job here is to keep the trains running on time, and so, we're going to stop now and reconvene at 2:00 when we'll have two more framing presentations and another panel with different individuals participating. Thank you.

(Whereupon, at 12:30 p.m., a luncheon recess was taken.)

AFTERNOON SESSION

(2:00 P.M.)

MR. HYMAN: Okay, if everyone can take their seats, I think we're ready to start.

Preliminary announcement, just reiterating, we canceled tomorrow afternoon, the Little Rock session, but we are planning to go forward with tomorrow morning, Boston. If the federal government completely closes down, that's the only circumstances I can conceive of under which we will not do the Boston session, although predictions are always falsifiable.

Second, the framework for this afternoon is going to be the same as the framework for this morning. We will have two framing presentations by Judy Feder and Tim Greaney. Judy is Professor and Dean of Policy Studies at Georgetown University and Tim is Professor of Law at St. Louis University. If it looks like I've stacked the agenda with my friends from academics, your assessment is accurate. So, Tim is going to start and Judy will follow.

And then we'll have a panel of representatives of the provider, payer and employer communities, each of which will present seven to ten minutes, followed by an extended period of discussion and we will wrap promptly at 5:00 so you can avoid the snow.

Tim?

DR. GREANEY: Thank you, David, for organizing this great set of hearings, and thanks to the DOJ and FTC staff for putting it together. I think it's going to be quite a contribution to understanding and maybe to the literature in this area.

Fifteen years ago, I published an article in the Yale Journal of Regulation entitled, Competitive Reform in Health Care: The Vulnerable Revolution. The article cautioned against the assumption that competition would develop without friction or would necessarily flourish in the American health care system. It identified a number of obstacles, legal, institutional and political, that might impair effective competition. For example, I cited state regulation, the slowness of public programs, like Medicare, to adopt competitive principles, the absence of good information and guidelines to help third party payers become better buyers and professional norms.

My point here is not to persuade you that you have a latter day Nostradamus before you, but to observe some of the persistent issues that stand between consumers and the benefits of a competitive marketplace.

I'm going to divide my remarks into two sets of problems that competition policy encounters today.

First, I want to explore some of the issues that are outside the box. Outside the box of antitrust law, per se. That is, issues of health policy and market performance, some of the things I think Peter Hammer may have touched on, that shape the underlying conditions necessary for effective competition.

From the Commission and the Antitrust Division standpoint, many of these issues might be beyond their immediate control, but perhaps, however, they can intervene indirectly by broadening their competition advocacy mission, as the Antitrust Division back when I was there with the telecommunications industry in the '70s and '80s.

Well, first, let me sketch out some thoughts that underlie my thinking of why the state of health care competition is less than optimal. First, there's ample circumstantial evidence, I think, that despite the furious activity in the marketplace, competition is not living up to its promise. For example, the strong dissatisfaction among the public and legislatures with the performance of managed care suggests a market in which the signals sent by consumers are not effectively communicated to buyers and their agents.

Second, the never-ending incidence of false claims, up-coding, fraud, suggest a marketplace in which

even large sophisticated buyers have enormous difficultly evaluating exactly what it is they're buying.

Third, the fact that some 20 years into the competitive revolution in health care "evidence-based medicine" is considered a novel and promising approach to improving health care delivery. That, I think, speaks to the continuing failure of the marketplace to provide adequate information and mechanisms to overcome market failure.

Fourth, economic studies have indicated that consolidation of providers, both horizontal and vertical, has had the opposite effect that conventional economic theory predicts. It has, in fact, enhanced more market power more than efficiently rationalized delivery, suggesting the likelihood that the efficiency, market power trade-off has been something of a one-way street.

Fifth, quality of health care debate sparked by the Institute of Medicine reports and other sources challenges antitrust's traditional assumption that the market will dictate appropriate trade-offs between cost and quality.

I would add, also, that the persistent reports from the field, including those of the Center for Studying Health System Change, to the effect that increased concentration has resulted in higher prices,

has at least some probative value on the question of the current state of competition. There are, to be sure, certainly other factors that contribute, including the increased use of expensive technology and new techniques that may or may not indicate lessened managed care rivalry. Nevertheless, there is a robust empirical record out there that suggests a relationship between provider concentration and prices. So, I do take that literature seriously.

So, with managed care on the decline to the extent that even the long-time competition advocates, like Professor Clark Havighurst, are wondering out loud whether “the health care revolution -- the competition revolution in health care is finished,” one could question where antitrust finds its raison d'etre. Can a convincing case be made for vigorous antitrust enforcement when the market lacks the driving force that most competition advocates claimed was essential to making competition work?

Well, let me go outside the box and talk a little about the infrastructure issues. I’ll just survey a couple of issues that popped into my mind. I’m sure there are dozens out there. The most obvious place to start, I think, is where the money is, reform in the Medicare system offers the largest opportunity to

stimulate formation of sophisticated managed care entities, generation of information and protocols, supplying other pieces of the missing infrastructure. It's worth noting that the studies that attribute the failure of Medicare plus choice, Medicare's attempt to bring managed care into the system, those studies point to the absence of competitive provider markets and networks. I'm thinking of the Kaiser Family Foundation study in California.

So, I think the success of Medicare market-based reforms and stimulation of market-improving mechanisms go hand in hand and are certainly something that the competition advocacy program I'm advocating should pay attention to.

Second, questions have been raised about the adequacy of the information infrastructure for purchasing managed care by managed care entities. David Eddy's work in this area suggests that the quality and cost effectiveness assessments of technology and procedures are needed to assist purchasers and it's sorely lacking today.

The market's inability to produce them is attributable to what economists like to call the public goods nature of these products. Even large managed care organizations cannot benefit by unilaterally developing

this information as it could be used by others, or worse yet, they are not able to encourage changes in practice styles across large numbers of independent physicians.

By the same token, employers sophisticated or not, large and small, lack the information infrastructure to effectively evaluate and bargain with third party payers.

Third, competition policy often overlooks the supply side of the market. Physician work force policy ranging from graduate medical education to availability of foreign trade practitioners and other issues controlling the supply side have come under scrutiny recently. Likewise, issues regarding scope of practice and nurse practitioners and others who could provide an important competitive spur deserve attention. As suggested by the Pew Health Profession Commission, there's a need to take a close look at the possibility of setting national scope of practice standards, removing barriers to professional mobility as well. It's certainly possible that adjustments on the supply side can help as well.

Finally, it's impossible to discuss the current state of the market without observing the impact of state laws on managed care and the cost they impose on the system. One estimate supplied by Price Waterhouse

Coopers attributes 15 percent of total cost increases in 2002 to mandates.

More problematic, however, may be that these laws may impair, in some instances, the ability of payers to effectively select and monitor providers.

As we all know, health care is an enormously complex and highly regulated environment. The success of competition policy is only as good as the infrastructure supporting it. It seems entirely appropriate to this taxpayer for the antitrust and consumer protection agencies, charged with promoting quality and competition, to go outside the box to improve the system.

Okay, let me move inside the box and talk about antitrust law and doctrine and the courts. My thesis here on the state of the case law and what's happened in recent years can be summed up simply. The courts have dropped the ball. The problem is not simply that the government has lost a series of cases. Indeed, it deserved to lose some of them given the unappealing factual settings in which some of them were brought. Poor case selection often results in bad precedents. But most troubling is the analytic approach we see in some of these court decisions. The article I'm currently writing on traces some of these mis-steps to a readiness to apply The Chicago School Antitrust Template to health care

cases.

The tendency is to ignore the nuances of health care markets when applying doctrines, creating presumptions, weighing evidence.

The sense of unreality comes jumping out when one reads Judge Posner describe supply side substitution in health plans, saying that HMOs and PPOs are supply side substitutes because their main input, physician services, can be readily obtained by physicians simply switching from one to another. Similarly jarring is the over-simplification found in Judge Easterbrook's Ball State opinion concluding, without a supporting record, that entry into managed care is just a matter of money.

Let me just mention a couple of the precedents that I find particularly surprising and troublesome. Most prominently, the hospital merger cases err seriously in determining market definition and their treatment of market definition. The court's naive interpretation of Elzinga-Hogarty into health care is the subject of a number of criticisms committing what one excellent economic analysis calls the silent majority fallacy, drawing inferences about market behavior from one group of customers based on the behavior of their neighbors. With hospitals offering heterogeneous services on the supply side and patients having highly diverse

preferences, these cases have created some thoroughly wrong-headed precedents and subdoctrines.

These cases, I think, have already had a ripple effect, the hospital merger cases have had a ripple effect by placing a high burden on plaintiffs in rule of reason cases where market definition is required.

Other remarkable precedents have added to the plaintiff's burden in these cases. Two circuits have explicitly adopted an evidentiary rule of thumb that discounts the credibility of the testimony of third party payers on facts that are really central to their business; e.g., whether the hospital system will -- whether their patients will respond to incentives to travel greater distances or whether certain hospitals are regarded by them, the buyers, as effective substitutes. It's simply inexplicable to me to say the testimony of the buyers, as a matter of law, when it's unimpeached, not impeached by a showing of bias or other defects, should be presumptively discredited as these courts do.

I find the simplifying assumptions of plain vanilla antitrust analysis guilty of other sins, ignoring reputation, learning curves, intangible barriers to entry, for example. But let me add that the erroneous application of plain vanilla assumptions does not always point to less prosecution. Sometimes, it might point in

the direction of erroneous prosecution as well, over-prosecution.

You can make the argument that the Department of Justice's monopsony charge in the Aetna-Prudential merger, where it claimed the merged entity could exercise market power over physicians by virtue of its size and certain characteristics and practices of the market. It's at least debatable whether physicians' service market beats the classic monopsony conditions the DOJ claimed. Real world factors like price discrimination, excess supply in the physician market, preexisting surplus in the physician market may have made the prospect of Aetna exercising monopsony power unrealistic.

The essential point I would make for antitrust agencies today is that these unfortunate precedents do not get corrected when they neglect to bring cases. A further point made in a recent article I wrote in health affairs was that I think this recent history may embolden lawlessness among some, admittedly fringe groups that may see the absence of enforcement as a green light and the absence of criminal enforcement as well.

It certainly gives one pause when 70 percent of a state's doctors can go out on strike, collectively denying consumers their services, and it fails to evoke any interest in antitrust enforcement agencies, the same

agencies, those of us old enough to remember, that successfully prosecuted an antitrust boycott case against lawyers for indigent clients engaging in almost identical conduct.

I'm running a little late, so I'll just give a synopsis of the last part of my paper. I just try to review what's happened on the legislative front, a little history of what happened when people decided to raise the claim, as they have in at least four or five different instances, that antitrust needed to be scaled back. There have been a number of such movements and the claim that the industry requires relief from antitrust is really as old as the first cases in antitrust.

Interesting, the rationale for these appeals for immunity or special treatment have shifted. But as I surveyed the history, none of them proved accurate. In the early '70s, we heard that health care markets were different and antitrust law was interfering with professional sovereignty and impinging on state regulation.

In the '80s, we heard that an overly rigid per se rule was insensitive to nuances and was preventing joint ventures from forming and impairing quality monitoring. In the '90s, as legislation was moving forward to reform the health care system, we heard that

relief was necessary so providers could better and more efficiently coordinate and combine through joint ventures and mergers to face the brave new world of managed care contracting.

Finally, in the late ‘90s, we’ve heard the appeal of leveling the playing field, that managed care has become so popular we need dueling monopolies, what I’ve called in other contexts the sumo wrestler theory of competition. You get two big guys with big bellies bumping in the middle of the stage and the friction will generate consumer welfare.

What I find remarkable about these calls for immunity or repeal is how shallow the economic evidence was supporting them whether viewed at the time or retrospectively. And the same, I think, could be called for some of today’s calls for legalizing collective bargaining under the Campbell Bill or state laws or whatever.

Well, if I haven’t succeeded in raising enough controversy as yet, I’ll give a few ideas for the panel to chew on. One question is, how do antitrust enforcers or legislatures find evidence of monopsony power? What are the practical indicia, to borrow from -- I guess it’s Brown Shoe -- that fact-finders or courts should rely on? What are the lessons we draw out of MedSouth? Where do

we go from there in terms of quality-enhancing performance as a justification for collective conduct? Are there spillovers into the hospital industry specifically that might legitimize virtual networks? Are there similar carry-overs we could see in the insurance industry where insurers could claim that we might have a justification based on quality to have uniform protocols and so forth?

And we have some insurance industry representatives here. I certainly would like to know more about how the insurance industry works and what exactly it is that repeal of the McCarran-Ferguson Act would or would not do to the way they conduct business today.

I have a lot more questions. I can give you all my final exams for the last five years, but I will spare you of that and look forward to the panel discussion.

(Applause.)

DR. FEDER: Good afternoon, everybody. I must say that when I was invited to speak at this hearing, I was not at all sure why that invitation was forthcoming. My experience is in efforts to promote the expansion of health insurance coverage, ideally, while containing health care costs. That causes me enough trouble without

becoming deeply involved in the issues that you're addressing at this conference. But with a little help from David and from Tim, I realized that to the extent that markets and competition are advocated as strategies to achieve the goals of insurance coverage expansion and of containment of cost, my experience may be quite relevant to your concerns.

So, today, as I was advised, for stage setting purposes, what I thought I would do is explore what we've observed in the last decade with respect to efforts on expanding insurance coverage, three periods and three kinds of evidence.

First, expectations for the marketplace in the effort to achieve universal coverage, represented by the period of the Clinton health reforms. Then, briefly, because Tim has addressed much of it, but I'll look at the experience with the insurance marketplace, the managed care revolution after the demise of those health reform efforts, and then turn to interest in the market and current efforts to expand health insurance coverage, such as they are.

What I realized in putting my remarks together, happily for me, is that I think I do have something of a story in these remarks. There is some coherence. And that is that there are real concerns about whether, in

the absence of government regulation of some kind or government intervention, whether private market competition in health insurance can pool risk rather than segment the healthy from the sick, and in some circumstances, the better off from the less well-off. So, there are real concerns.

But competition is advocated by people who are looking to the market as an alternative to government intervention and regulation, and that poses a real conundrum because if competition is being advocated in order to avoid or to minimize the government role, it makes it politically extremely difficult to create market circumstances or create a public policy framework for operation of the market that will, indeed, be effective in pooling risks and perhaps containing costs in ways that some of us would like to see. I guess I would say, in terms of efficiency and value for the dollar rather than simply benefit reduction.

So, that's my story in a nutshell. Let me lay it out for you looking at these three periods. The first period is the Clinton health reform effort, which I think many in the room -- I teach Master's students in public policy, many of which are relatively young and they don't even remember this, but I think many in the room will remember this, although it is receding into ancient

history.

Although perhaps not perceived or understood this way for good reasons, I will tell you, will argue that the Clinton Health Security Act was, indeed, based on the idea of market competition. It was not competition in the market as we knew it or as it existed, but it was based on the idea of creating a new kind of market or competition among insurers as the real essential basis for the way in which quality care would be efficiently delivered and available to all Americans.

The subsidies were structured in order to expand and ensure insurance coverage for all Americans. The subsides were designed in a way intended to promote competition among insurers. You will remember that consumers were essentially guaranteed a subsidy equal to roughly 80 percent of the average price of insurance plans in their communities. Consumers who found insurance for less got to pocket the difference. Consumers who chose insurance for more paid the difference and the idea common to advocates of managed competition was that that would lead to efficient delivery or that insurers would compete for these vouchers. They'd compete based on efficiency and we would have efficient delivery of quality of care.

But it was also recognized that in order to

have competition that focused on the efficient delivery of quality of care that the system needed new rules for insurers, and I am amused at myself when I give this spiel because it just trips off my tongue. You know, I did it a number of times and we're going to change the rules and here's what the rules -- where we're going to have new rules.

We were going to have standardized benefits so that competition would not affect those -- a division in the marketplace among those who needed services and those who do not. We were going to require insurers to take all comers, the idea, to have guaranteed open enrollment. We were going to require insurers to charge all individuals the same rates, and I used to have to say the rates they choose to define, not government-determined rates, but essentially we were going to require community rating. And because community rating can exacerbate the avoidance of high risks, we were going to develop a system to be determined, a risk adjustment to distribute -- to ensure that insurers who, because they were so good at treating sick people, actually got more sick people than other plans. So, we were going to adjust the revenues after the fact.

There is no question that this was managed competition with emphasis on the management and,

actually, I left out that there were also consumer protections and I did not get a chance to look at the old bill and see what exactly we put in on consumer protections, but a quick conversation with a friend and you'd be amazed at how much of this we actually remember.

We think it was unlikely that we had private rights of action in the bill, that we relied on civil monetary penalties thinking that perhaps there were some political battles that we should not take on, which is interesting. But there was definitely an appeals mechanism for consumers and our structure that allowed accountability was inherent in this creation of the alliances within which competition took place, essentially, organized places to shop, to apply the rules and to appeal the use of those rules, the application of those rules when and if necessary.

Now, I will, as an aside, acknowledge, because some people in the room might be twitching, that there was some concern that this competition might not be effective in controlling costs, and as I used to say, the President believed that it would control costs. It was the only time I used that language because I didn't. But the President believed this would control costs, but he had to -- because he had to get scored by the Congressional Budget Office, he had to be confident that

it would control costs.

So, just in case it didn't work, it was -- as those of you who followed it will remember -- this competitive system was backed up by very stringent and enforceable limits on rates paid to insurers and they were enforced through take-backs essentially on rates paid to providers. So, there was a powerful regulatory system underlying this market system in the Clinton proposal.

So, in some sense, we did have the best of both worlds, made everybody completely unhappy. If you didn't like competition, you didn't like that. If you didn't like regulation, you didn't like that. I think that to say that the bill did not garner much support would be an understatement. I think it is useful to consider, and I will throw out that insurers' opposition to the new rules played a part in insurance industry's powerful and quite effective opposition to the overall reform. But the truth of the matter is that there was so much to object to and so much opposition that we didn't even have to get to discussions about rating and enrollment and so on.

So, needless to say, but I will say it anyway, the Health Security Act went down in flames.

The next phase of competition as we observed, and which Tim was describing, is that it went forward in

a different form and it is useful -- I have had people say to me, they don't say it much anymore, but about five years ago it was not uncommon -- even a little longer ago than that. It's been a long time. That people would say, isn't it interesting that they didn't enact the bill and it happened anyway. Not quite true. The coverage part didn't happen, but that's an aside. It just needs to be mentioned. And, indeed, I think there's reason to question, as Tim has pointed out and I think many would agree, whether indeed what was anticipated and envisioned in the Clinton version of managed competition, in a word, competition around the efficient delivery of quality of care whether that has remotely taken place.

I think there is pretty much general agreement that despite the transformation which, indeed, there was of insurance into more constrained types of plans, that almost nobody thinks that it led to a competition around the efficient delivery of quality of care.

Where competition, I think, did have an effect was by employers charging more, charging their employees for more. If they wanted to stay in fee-for-service plans, they pretty much eliminated fee-for-service plans. That really was an anticipated result denied by us because we required the continuation of fee-for-service plans. It was a concern expressed with respect to the

Clinton Health Security Act and it wasn't all a matter of choice, particularly for smaller and low wage employers, if I remember correctly. It was not a question of choice, those were just the plans that they were offered.

But managed care, I don't think anybody thinks that the slowdown in cost growth that occurred with this change, the managed care revolution, was a function of competition around efficient delivery. The insurance plans stimulated, pressed by their purchasers, the employers, negotiated quite heavily or aggressively with providers leading to many of the concerns and issues that you are otherwise addressing, and that that really, I would call, much more like private regulation than competition, they began to negotiate still not -- well, in some areas some argue, more effectively than Medicare or public programs. But that was not the vision that was there before us. It was regarded more as managing costs than managing care and the quality side of this, the efficient delivery did not seem to follow.

In fact, there was a greater concern that what was -- instead of management of care, there were barriers to access, relatively arbitrary barriers to access that were being relied upon by managed care plans.

Now, the unacceptability of that regulation to employees accompanied by -- and we have to remember the

bigger picture, the bigger market in which all this takes place -- accompanied by a booming economy that now restored the ability of employees to complain about their health insurance benefits and get employers to respond. I would argue it was the reverse of that, the recession, that enabled employers to push managed care in the first place. So, now, these empowered in a hot market, empowered workers complained about these arrangements and they began, to some extent, to change. Indeed, I'm not sure that they have changed in terms of responsiveness to consumers' concerns about arbitrary constraints on access. I think those concerns are still there.

But it did turn out in this marketplace in which employers were not willing to be so hard on their employees, it did turn out that the best way to attract enrollees was to loosen the regulatory constraints, I would call them, of the plans and give everybody broad access to providers, reducing them the market power of these plans with respect to providers. It was okay with the employers because they wanted to keep everybody happy, but it was not doing a whole hell of a lot anymore to control costs, let alone control costs by providing care efficiently.

As Tim has said, that led proponents of managed competition to express tremendous disappointed in the

performance of managed care and managed competition. I've already alluded to the concern, the complaint that managed care plans were managing costs, not managing care. I have heard another complaint which really was that it was a failure of the marketplace to create an effective market for health insurance.

So, the lessons of that period, I think, or the two periods is that -- the lesson is that the regulations that the Clinton administration sought in terms of creating a market are politically very difficult to achieve. Not only were they not achievable in the Clinton Health Security Act, but they have not been very achievable at the state level as well in terms of establishing rules for the marketplace.

In terms of what I think of as an accountability mechanism, the patient bill of rights concept has also at the national level been difficult to establish and without regulations and perhaps other changes, as Tim alluded to in the overall health care system, it seems questionable as to whether the marketplace can achieve the expectations of those who advocated it as leading to a more effective and efficient health care system.

Now, let me come to the current period and say that although the coverage debate is, I would say, to a

considerable extent, dormant, the market strategy is alive and well. Tim talked about the advocacy of a market approach to Medicare. It is represented not simply by Medicare plus choice, but the administration's newest proposals for Medicare reform would essentially provide Medicare beneficiaries a prescription drug benefit only if they leave Medicare and enroll in private insurance plans. They describe what they're advocating as based on the Federal Employees Health Benefits Plan. We can talk about the competition in that plan. Interesting, but that's the way they describe it. Although there are no details on that plan.

They are not looking to a lot of regulation in areas -- benefits, for example, and nature of plan, it's pretty much -- I mean, there are -- that's not quite right. There is a specification of benefits so there is some standardization, but also variation. I was going to say 1,000 flowers bloom, it's not 1,000 flowers. But there is an interest in an array of different types of insurance plans, including a very high deductible plan.

So, there is not a concern relative to the desire to get beneficiaries out of a government insurance plan. I think there is relatively little concern with issues that both the Clinton Administration, that being the division or segmentation of the marketplace that

would not pool risk, but would separate the healthy from the sick.

For the under 65 and uninsured population, the market is also en vogue in forms that range from less to some regulation. The most hands-off approach is represented by proposals like the Bush administration has made to give low income individuals vouchers, refundable tax credits, to shop in the non-group insurance market. The problems with selection in that market are totally ignored in that proposal and, in part, some would argue that with lots of people shopping or some do argue that with lots of people shopping those, problems would be less than they are today. Although, I would argue that's not likely to be the case.

It is also regardless of what people think about selection issues, there is also an argument that some coverage is better -- for some people is better than no coverage for any of these people. So, that's an argument behind this approach, and it really is, I think, valued for its hands-offness, a way to provide, to expand insurance coverage and keep the government out.

The slightly more hands-on approach does involve some government, but not on a part with what was proposed in the Health Security Act, although it's got similarities. This approach, if pursued through

refundable tax credits or others kinds of subsidies, would give subsidies to low income individuals and rather than have them shop in the non-group market, would accept that there are issues of risk selection there and, therefore, would intervene to create a place to buy. The language -- you know, HPIC went out before the Clinton -- or in the midst of the Clinton administration. Nobody would advocate an alliance. So, what they are referred to as is little FEHBP plans.

Because, as an aside, warming to the memories, the best line we ever had, which we only used occasionally, was that everybody should have what members of Congress have in terms of health insurance protection. So, that's very popular, even though I think everybody in this room knows that nobody is talking about putting the uninsured into the Federal Employees Health Benefit Program. What they're talking about is building alliances, HPIC, whatever, but places to shop subject to certain rules for health insurance.

I heard such a proposal the other day and was hard put not to -- when asked actually whether there was any information available, anyone in the room had any information available or had seen any analysis on how such arrangements, little FEHBPs at the state level would work, I had to bite my tongue not to say I have the

tollgates in my office, I'd be happy to provide them to you. Because we spent a lot of time in the Clinton administration thinking about, as did everybody outside the Clinton administration, thinking about how such pools might work. So, there is a good body of literature on which to draw for that.

But the interesting thing about these proposals is that they essentially, I would argue, in part, because of the political difficulties of establishing rating and enrollment and risk adjustment rules for all insurers, they kind of agreed to leave the insurance industry significantly alone, create a pool where people -- it may be the only place in which they can use their vouchers, so that would, I think, not be regarded favorably by insurers looking for new customers. But what it says is that what that approach recognizes is that the healthy, the better risks will probably stay outside the pool. The pool will be selected against. It will simply cost more to get people adequate subsidies and adequate protections in those arrangements.

And so, I do think that politicians look and can consider, if they are looking to create new arrangements and expand insurance coverage, which political battles they want to fight, the one for the rules on the insurance industry or the ones to get the

money, if you don't do those rules, to keep the subsidies adequate, but for the poorer risks.

Now, as I said, there's not much push here on expansion of insurance coverage. You know, it's hard to hear on the agenda. But to the extent that there is interest, it is clear that the market mechanisms are a prominent vehicle that people land on as a way to expand insurance protection. Now, I have to say I find it really interesting that this is the case because based on the evidence and performance of the market as it is, as opposed to the market as some would like it to be, I don't see any evidence that this approach makes any kind of sense.

If you look at Medicare and talk about reliance on or privatizing Medicare, turning it into a system of competing insurers, it doesn't seem to me to have a leg to stand on, even on the simple issue of health care costs since nobody has more market power than the Medicare program, and essentially, if you look at the history of Medicare costs against private insurance costs, they track pretty closely because health insurance -- they're all buying in the same marketplace, but Medicare does somewhat better historically than does the FEHBP program or private insurance.

So, to argue that -- there's no evidence for

this view. There's certainly no evidence to say that it leads to -- that competition has brought us anything in efficiency or quality. So, there just isn't anything here.

Further, to work effectively, it is, I think, generally recognized that we do need government intervention of some kind, whether it's consumer protections or creating the spreading of risk or assuring the spreading of risk, that some kind of government intervention is needed to, if we do or when we do, rely on competing private insurance plans in order to deliver care.

But when I question the evidence on why it is that people are advocating competition and privatization and private insurance, I know the answer to that question. It really, in my view, is advocated to a considerable extent by those who question the role of government in providing these kinds of social benefits, and on the Medicare side, it is indeed the replacement of an extremely successful social insurance program, albeit with some difficulties with the private insurance arrangement.

That, to me, is ideologically driven, not evidence driven. And as I said, it is not at all surprising, given that's where the push is coming from,

that interest in regulatory or other kinds of structures that could make such a market effective are hardly to be seen in the conversation.

Thanks.

(Applause.)

MR. HYMAN: Okay, we'll take a 10-minute break. So, see you shortly.

(Whereupon, a brief recess was taken.)

MR. BRENNAN: My name is Jeff Brennan and I'm an Assistant Director in the Bureau of Competition. I'm in the Health Care Division. I appreciate everyone being here today. We'll get started with the afternoon panel. Let me first introduce my colleague, Mark Botti, Section Chief in the Department of Justice.

I thought what we'd do first is I'll introduce the panelists who have not been formally introduced yet and then we'll go back to the first person and begin with the remarks.

Our esteemed panel this afternoon includes Henry R. Desmarais, who is the Senior Vice President of Policy and Information with the Health Insurance Association of America.

We have Timothy F. Doran, M.D., who's with the American Academy of Pediatrics. He's also the Chair of the Department of Pediatrics at the Greater Baltimore

Medical Center.

We have Frank Opelka, M.D. from the American College of Surgeons. He's the Chief, Colon and Rectal Surgery, Beth-Israel Deaconess Medical Center.

To my immediate left is Peter M. Sfikas representing the American Dental Association. He is the Chief Counsel and Associate Executive Director.

Twice to my left is Winifred Carson-Smith, who's the Nurse Practice Counsel for the American Nurses Association.

And our final panelist today is Christine A. Varney, representing the American Hospital Association. She is a partner in Hogan & Hartson and a former FTC Commissioner. We welcome her back.

With that, I turn it over to Dr. Desmarais for his remarks.

DR. DESMARAIS: Thank you very much. The Health Insurance Association of America appreciates the opportunity to participate in these hearings. I think it's important to point out that our member companies provide not only medical expense insurance, but the full array of health insurance products, including disability insurance, dental insurance, long-term care insurance, stop loss and supplemental coverage.

What I'd like to do with my seven minutes is,

at least, introduce the topic of the health insurance marketplace and say a few words about that, and also talk about two issues of particular concern to us that I think are relevant to today's sessions.

Insurers and health plans are often described as having untold amounts of market power and also said to be exempt from antitrust scrutiny, while providers are often described as having little countervailing power to negotiate fairly with insurers. We think this is a deeply flawed assessment.

In actuality, the health insurance market is both highly competitive and highly regulated. According to a recent study, the number of managed care organizations competing in each of the top 40 MSAs in the country averaged 14. So, there were 14 competitors in each of those markets on average, with some as high as 41 different competing organizations in one market.

In addition, each of those organizations was found to offer, on the average, a choice of more than three different types of products in each area, obviously creating a very diverse marketplace.

I'd also point out that this is not a static market. Our member companies are busy creating other options, including what is now being described as consumer-driven products. In addition, new technology,

in particular, the Internet, is providing new ways for consumers to do comparative shopping for their health insurance products.

I should also add, as we talk about the insurance marketplace, that there's not just one marketplace. First, there's individual insurance products, and that's a marketplace unto itself. There's small group insurance marketplace, which has, again, different kinds of issues. You also have to remember there's a great number of people in this country, probably including many of the people in this room, who receive coverage through self-insured health plans through large employers. So, there's a great deal of diversity out there.

In addition, in each case, we're often talking about PPOs, HMOs, point of service. So, again, there's not just one flavor in the marketplace.

To understand this current marketplace, I also think it's important to recognize that insurers are subject to intense governmental scrutiny of their business practices. State insurance departments review and approve policy forms. They perform market conduct examinations, they investigate consumer complaints. They also regulate the form and substance of information disclosures to consumers. They regulate insurers'

investment practices. They also regulate the discontinuance and replacement of insurance policies and even claims payment practices.

Further, McCarran-Ferguson notwithstanding, all insurers must be subject to antitrust laws, not only state antitrust laws and rate regulation, and a lot of other requirements that are enforced by state's attorneys general and insurance regulators, but even then, insurers are not free from all aspects of federal antitrust laws and, in particular, they continue to be subject to federal prohibitions against anti-competitive practices, such as price fixing, bid rigging, market allocation or boycotting.

On the other side of the equation, I believe it's fair to say that physicians and providers currently have significant market power and plenty of opportunities to legally negotiate with health plans through group practices, IPAs, the use of the messenger model or by creating qualified risk sharing or clinically integrated joint arrangements.

In addition, employers have expressed a desire for less restricted managed care plan designs and access to large provider networks. All of this puts physicians and hospitals and other providers in a position of power in negotiations with health insurance plans because these

plans need to contract with large numbers of physicians or with specific physicians and hospitals in order to satisfy customer demands.

Finally, Paul Ginsburg from the Center for Studying Health System Change recently testified that one of the factors contributing to the increase in the cost of health insurance is increased consolidation of hospitals and the subsequent increase in their bargaining clout with insurers.

In the remaining couple of minutes allotted to me, I'd like to now turn to two areas, two issues. The first one has to do with information exchange activities that are being sponsored by various physician organizations. What I'm talking about is exchanges that include the collection and dissemination of actual reimbursements for specific procedures paid to physicians by named insurers. Both the Department of Justice and the Federal Trade Commission have recently reviewed proposals for such information exchanges and concluded that they fall within one of the safety zones in the statements of antitrust enforcement policy.

However, we find it hard to comprehend how such information can be utilized in a truly pro-competitive manner. In fact, one of the sponsoring organizations that recently received approval for such information

exchange has described its activities as a “public relations campaign to educate the general public about the policies and procedures, including depressed reimbursement by third party payers in Dayton.”

We think that the recent decisions depart from previous federal actions. For example, a 1985 FTC advisory opinion states, “A danger in the dissemination of average price information to physicians who currently charge varying prices and may provide services of varying levels of quality can be that the state average may, through tacit or express agreement, serve as a focal point for artificial price conformity.”

Suffice it to say that HIAA is concerned that the new, more permissive attitude could dramatically increase the number of such informational exchanges. The result could be price inflation, price fixing as physicians compare rates from one city to the next, looking for the highest rates paid by any named insurer.

We recommend that both the Department and the FTC reevaluate their recent decisions. At the very least, we believe that they should evaluate the potential anti-competitive effects of allowing physician organizations to disclose payer specific reimbursement data. As many of you know, in terms of collecting data from the physicians, they don’t release physician-

specific information and it has to be aggregated. On the other hand, the current information exchange proposals will disclose specific insurer payments and not be aggregated in the same way.

The last issue I'd like to touch on is one that I addressed when I appeared at a workshop sponsored by the FTC last fall, and I'm referring to the MedSouth decision, which last February there was an FTC advisory opinion that broke new ground by advising MedSouth, a Denver area IPA, that its proposed clinically integrated joint arrangement would be sufficient to allow participating physicians to collectively bargain for fees.

During last fall's workshop, I discussed in great detail HIAA's concerns and I won't repeat all of that, but we remain uncertain at this point about how the Commission plans to monitor MedSouth's operations in order to ensure that it will function as proposed and not violate antitrust law.

In that regard, I think there are three challenges the Commission will face: Determining what kind of clinical efficiencies have actually taken place; understanding whether the reasons for any price increases in that format and whether those price increases are driven by some kind of an increase in quality or value or

simply due to anti-competitive practices; and lastly, determining whether that network remains truly non-exclusive.

Morever, by issuing the MedSouth opinion, the FTC staff has basically provided a road map to any other physician organization to basically replicate the same approach and arguably then allow them to collectively negotiate on the basis of fees.

We are really concerned about this. We're not sure the FTC has the resources it would need to monitor what is going on, and we really don't think that simply relying on complaints from the field will be adequate to protect the public.

In closing, let me say that, again, we appreciate the opportunity to participate in this workshop and we look forward to continuing to work with both the FTC and the Department of Justice, as well as the other stakeholders to ensure that we have a competitive marketplace. Thank you very much.

(Applause.)

MR. BRENNAN: Thank you. Dr. Doran?

DR. DORAN: Good afternoon, everybody. Thank you. The American Academy of Pediatrics is pleased to be able to present its testimony today. I am Tim Doran, as mentioned, a practicing pediatrician and Chairman of the

Department of Pediatrics at the Greater Baltimore Medical Center in Baltimore.

The American Academy of Pediatrics is an organization of 57,000 primary care pediatricians, pediatric medical subspecialists, pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults. Today, I speak to you both as a representative of the AAP, but also as a solo pediatrician.

In my comments today, I will first describe the health care marketplace for children and then describe market distortions that impact access to care and the ability for pediatricians to provide quality care to children.

There are three health insurance markets for children: The commercial market; the public market; and the uninsured. In 2001, 57 million children and young adults through age 21 were insured in the commercial or private market. The public market, primarily Medicaid and the State Children's Health Insurance Program, SCHIP, covered another 18.8 million children, playing a vital role as a health care safety net. Medicaid is, in fact, the largest single insurer of children and while over 50 percent of Medicaid enrollees are children, they account for only 22.9 percent of Medicaid spending.

Finally, 12.5 million children and young adults are estimated to be uninsured and must seek their health care through public health clinics, emergency rooms and other providers of charity or low cost care.

Pediatricians play a crucial role in providing health care to children. Pediatricians provide nearly 70 percent of children's visits to primary care physicians. Theoretically, pediatricians may have the flexibility to set fees they charge, and I'm glad to know I have all this market power that I didn't know about, but as a practical matter, this often has little or no correspondence to the payment they actually receive. Because of their small size, the vast majority of physician groups do not have the leverage, certainly from my perspective, to negotiate with health plans, and I have been in a large consortium with a few pediatricians and other physicians, multi-specialty physicians before my current job now as a private pediatrician.

They're expected to sign contracts as-is. Pediatricians may not always be allowed to see fee schedules before signing contracts. Equally troubling, health plans' coding and bundling practices are usually not made available. In some cases, contract language eliminates a physician's right to appeal such decisions. In others, health plans reserve the right to change the

fee schedule.

My personal experience is that one insurer provided excellent reimbursement initially then dramatically lowered reimbursement rates after my practice accepted large numbers of their members. A classic bait and switch.

Mr. Greaney's comments I appreciated about the sumo wrestlers, but I almost feel like it's the sumo wrestler against the 110-pound weakling, again, from our perspective.

Another factor that undermines a pediatrician's ability to negotiate is the very limited information available on the provision of health care for children. Access to information drives allocation of resources, promotes innovation and invention and brings parity to those at the negotiating table. You've heard these themes.

While health plans are free to make decisions about coverage and reimbursement, the Medicare Resource Based Relative Value Scale, RBRVS, Fee Schedule, in fact, serves as the national standard. Yet, children are often inadvertently left out of this system since it is primarily Medicare driven. Medicare payment policies mandated by CMS have a significant impact on Medicaid and its reimbursement policies. A new forum has to be

developed to discuss key Medicaid payment and operational issues and to advise CMS and Congress on physician coding and payment policies related to state Medicaid programs, especially for children.

A quick example of the misfit in fee schedule is the immunization administration fees. I spend literally hours of time explaining to anxious mothers the lack of scientific evidence, for instance, linking MMR and autism. I'm sure you've heard of this. Yet, my administration fee for childhood vaccines is exactly the same as an adult who walks in and receives a flu shot from the nurse in the office. So, there are clear inequities in that kind of a situation.

At a time when many pediatricians are unable to negotiate appropriate reimbursement, they're also experiencing factors that increase the cost of providing care, rising medical malpractice premiums, rising costs associated with regulatory compliance. In recent years, physicians have also come under greater scrutiny for fraud and abuse and are anxious about that, yet physicians who are audited for fraud are audited for fraud in an environment where there are no clear guidelines.

The up-coding issue that was mentioned before is an issue for me every day. I see children and it's

unclear. They could be coded in two different ways and I have that fear in the back of my mind, am I up-coding or is this the appropriate code. There is not really -- there are lots of gray areas in the coding situation.

Pediatricians also have a limited ability to leave a market because they're committed to their patients. I'm sure as many of you who have children in this room know, they're very close ties with your pediatricians and the ability to just leave those patients to go elsewhere is difficult for most pediatricians.

Medicaid reimbursement rates are, on average, about 64 percent of Medicare rates nationally for the same codes. Yet, more than half of pediatricians accept all Medicaid patients who contract their practices.

All of these factors make it difficult to provide high quality care to children. There are a number of things that the AAP recommends to begin to rebalance the relationship between health plans, pediatricians and our children.

First, the continued consolidation of the health insurance market poses a risk in our minds. We urge the FTC and the DOJ to bring greater scrutiny to the health insurance industry and its contracting practices.

Second, the Academy calls for legislation that

would allow physicians to negotiate, as mentioned earlier, on a level playing field with health plans. We ask for the FTC and DOJ to provide clearer guidance on what is currently allowed and to take a leadership role in helping to initiate such discussions between health plans and physician groups.

Third, the Academy supports medical liability insurance reform. The professional liability coverage marketplace is undergoing significant stress and strain. Without reform, the increased costs of professional liability insurance will result in increased costs of health care.

Fourth, the Academy supports the creation of a national Medicaid database to ensure pediatricians have parity in transaction costs and choice of contractual arrangements.

Fifth, the Academy also supports the creation of a national Medicaid payment authority or advisory commission to address the many physician payment issues related to the Medicaid program.

Sixth, the Academy is deeply committed to protecting the 18.8 million children who receive health care through Medicaid and SCHIP. Efforts to strengthen these programs through enhanced funding and simplified and continuous enrollment policies will remedy much of

the problem of un-insurance and under-insurance in children.

Thank you for the opportunity to speak today. The American Academy of Pediatrics stands ready to assist you as you're examining these issues in more detail as you go forward. Thank you.

(Applause.)

MR. BRENNAN: Dr. Opelka?

DR. OPELKA: Good afternoon. I appreciate the opportunity to address you today. I am a physician and it is my mission to deliver, what I believe, is the highest quality of health care to every patient. As a surgeon, I'm dedicated to the ethical practice of surgery. The single most important aspect of my practice is my interaction with my patients. I'm Frank Opelka, as you've been told, Vice Chief of Surgery at the Beth-Israel Deaconess Medical Center in Boston, Massachusetts.

I speak to you today from my own experience as a physician and on behalf of the American College of Surgeons, an organization founded to raise the standards of surgical practice and to improve care for the surgical patients. With more than 64,000 members, the College is the largest organization of surgeons in the world.

Our commitment to our patients is unwavering. We believe that the commitment reaches far beyond the

operating room. As a surgeon, I must always place the needs of my patient before my own. If nothing more, I am first and foremost an advocate for the health and the welfare of my patients.

The College commends the Federal Trade Commission and the Department of Justice for undertaking these hearings. Health care is an evolving market, a complex market. If consumers are to realize the maximum potential for the delivery and financing of health care services, we must all look to the competitiveness of our actions.

To that end, let me begin by stressing the importance of competition in the health care system. Competition is the driving force that can lead to innovation, quality improvement and improved access to health care. It will forever play an important role in ensuring free markets.

My comment today will focus on a number of issues important to surgeons and the effects of current antitrust laws and enforcement policies on physicians and, importantly, on patients. Of greatest concern is the unyielding power of health insurance, including health plans.

In many parts of the country, a small number of companies with significant market power dominate the

health insurance market without sufficient leverage. Insurers offer surgeons take-it-or-leave-it medical services agreements. Insurance companies set policies and prices for surgical care with little or no direct relationship to the actual cost for providing that service. In an increasing number of markets, physicians find themselves with little left on the table to negotiate. Yes, insurance plans are widely credited with stabilizing the growth rate of health care expenditures, but at what cost?

The primary objective of insurance is not the provision of health care of the highest quality, but the pursuit of profits. As a physician, I am forced to accept lower fees with no relationship to that cost of service. I've waded through stacks of paperwork and managed countless administrative burdens. Frankly, as an individual physician, I feel powerless. I, alone, lack the bargaining power to compel change for the good of the care delivered to my patients.

Cost shifting was once the remedy to ensure a stable practice, but this no longer a solution for surgeons. Rising practice expenses, as a result of the medical liability premiums and the regulatory burdens, are too great. We must provide services in a fiscally viable manner. With underpayment, sometimes this results

in a decrease in the number and the type of services we can provide. This results in insurers essentially rationing care.

For our discussion today, I pose the following questions. First, as discussed previously, we have seen unprecedented consolidation in the health insurance industry over the past decade. According to the SEC filings, the 10 largest health insurers account for almost 50 percent of commercial enrollees. That provides coverage to more than 88.8 million Americans. Have these mergers yielded sufficient market efficiencies?

Second, physicians have been left with little, if any, ability to negotiate with insurers. The resulting decrease in fees have made it difficult in many areas to find recruits for new physicians. Simultaneously, older doctors are choosing to retire early in lieu of accepting shrinking fees with rising costs, all of this while the patient demand is increasing. Now, certain markets have fewer specialists, like surgeons, to serve these increased patient demands. Is this a market imperfection?

Third, unlike all other actors in the health care marketplace, insurance companies may agree amongst themselves to raise prices and to restrict coverage. In fact, they may engage in a host of anti-competitive

activities. In times of economic prosperity, competition works to keep them from vying for greater market share. But in economic downturn, they may collectively raise prices without fear of prosecution due to the protections embodied within the McCarran-Ferguson Act, which harkens back to an era when insurers had less power.

Next, physicians remain skeptical of managed care payment policies. Questioning all product clauses, undisclosed fee schedules, unilateral amendments by payers and delayed payments. The insurer has no incentive to meet its contractual obligations with prompt payment in a timely manner.

Insurer pre-certification for surgical services does not ensure payment for services rendered. Often, the company may deny a claim, even after the procedure was pre-certified. Are these practices abusive?

As a result of the health insurers' increased market power, physicians continue to see greater encroachment into the doctor/patient relationship. Most notably, the restrictive definitions of medical necessity. Aren't doctors, not health plans, best suited to determine the quality of care on an individual basis?

Surgery appreciates innovative new care opportunities for our patients. Insurers, however, are not quick to cover these new services, acting as a

gatekeeper to improved quality. Even after insurers cover these innovations, there is no reasonable consideration to cost structure or reimbursement frequently prohibiting the urgent implementation. And isn't it the patient who suffers most from the slow acceptance of innovations? Does a market imperfection exist where patients cannot obtain the best care available at any cost?

Even as physicians attempt to stabilize their footing in the marketplace by forming physician organizations, insufficient guidance exists during a period of increased enforcement actions. There remains substantial confusion about what constitutes sufficient clinical integration for a fee-for-service network to quality for rule of reason analysis.

The greater subjectivity implicit in the analysis of quality and clinical integration rendered definition of this alternative safety zone as unnecessarily vague. After MedSouth, what constitutes sufficient integration?

With the emergence of physician-owned specialty hospitals, some general hospitals have been denying privileges to those who participate in these ventures, particularly in geographic areas where there has been significant consolidation of hospital ownership. Does

the refusal to deal with physicians participating in these ventures raise antitrust concerns?

Let me conclude by telling you that the College of Surgeons was pleased to read the advisory opinion issued early this month to PriMed Physicians. As I noted earlier, advocacy is an important part of my responsibility as a physician. The College believes the surgeon's role includes informing patients, other physicians, employers, and payers about the operation of the health care market.

Most importantly, we believe that this can be accomplished without injury to competition. We are glad that the FTC agrees.

I thank you for the opportunity to participate in the roundtable concerning health care competition and law policy. I look forward to participating.

(Applause.)

MR. BRENNAN: Thank you. Mr. Sfikas?

MR. SFIKAS: The American Dental Association would also like to thank the Federal Trade Commission and the Justice Department for this invitation. You know, when I leave Chicago in February, I seldom go to a place that has worse weather than Chicago. That's not the case today. So, I may be leaving a little early so that I can catch an airplane and go back to Chicago.

I'm going to talk about three things. I'm going to talk about applying the competition law to the dental profession, some concerns that we have about quality and also concerns that we have regarding the insurance market. There are difficulties that competition law presents, particularly in the professional context, such as, for example, applying the antitrust laws to professional ethics codes. The pro-competition role of professional ethics codes is especially true for professional advertising.

Consumers frequently lack information to adequately evaluate professional services and there is little standardization of these services. The layperson cannot readily evaluate the competence of a dentist, doctor or other health care professional's advertising. Advertising by professionals poses special risks of deception. Thus, professional deception is a proper subject of an ethical code. Indeed, the Supreme Court, in one of its landmark cases, Bates vs. State Bar of Arizona, noted that professional associations have a special role to play in ensuring that professional advertising flows both freely and cleanly.

In the same case, the Supreme Court stated that advertising claims as to quality of services are not susceptible of measurement or verification. Accordingly,

such claims may be likely to be misleading and, therefore, warrant restrictions.

A dental association's ethical codes, which preclude false and deceptive advertising, are pro-competitive because they prevent deceptive advertising. In the competitive context, eliminating non-truthful advertising reduces transaction costs. In the dental profession, ethics codes are enforced by the local and/or state dental associations with the right of appeal to the American Dental Association.

However, the prolonged involvement of the Federal Trade Commission in filing complaints against health care associations involving advertising has completely discouraged the state and local dental associations from policing false and misleading advertising in the dental profession. The fear is that if the FTC were to file a complaint, the state dental association or local association might have to litigate this case before the ALJ, in front of the full commission and one of the Courts of Appeals and ultimately in the United States Supreme Court. Although one of the state dental associations was successful in pursuing that route, the other dental associations still stand back and determine that if they were to have to face that same sort of litigation with the federal government, the costs

would be overwhelming.

So, at the present time, most false and misleading advertising dealing with dentists is going completely unregulated. The states do not have the resources with which to police false and misleading advertising, so that we would request that the FTC either make it abundantly clear that false and misleading advertising can be prosecuted by the state dental associations, or alternatively take a case itself, one involving false and deceptive advertising, involving a dentist and prosecute that case.

On the subject of quality, the dental profession has grave concerns with reference to the FTC determining antitrust cases which require quality judgments. The dental profession has no problem in applying the antitrust laws to the business side of the profession, but when it comes to quality, the dental profession believes that it is the dentists who understand quality and not the Federal Trade Commission.

Finally, the dental association is also troubled by the concentration in the insurance industry. The profession believes that -- we've heard this already and I'll repeat it, that there is not a level playing field with the insurance companies when it comes to enforcing the antitrust laws. There are certain markets

in the United States where it appears that certain insurers have monopsony power. To avoid the professionals from undertaking self help, which is something we in the profession would discourage, would not like, and I'm sure that the FTC and the Justice Department would not tolerate that either.

In any event, we would encourage the Federal Trade Commission and the Justice Department to scrutinize the insurance market because of the concerns that we have over monopsony power in certain markets in the United States. Again, thank you very much for this invitation.

(Applause.)

MR. BRENNAN: Thank you. Next is Ms. Carson-Smith.

MS. CARSON-SMITH: Good afternoon. I'm Winifred Carson-Smith and I am Nurse Practice Counsel for the American Nurses Association, and I am here representing them and I want to, first of all, thank you for the opportunity to testify today.

ANA represents the interests of the nation's 2.7 million registered nurses throughout 54 constituent member state and territorial associations and over 150,000 members. ANA also has 13 nursing organizational affiliates, collectively representing another several hundred thousand additional nurses. On behalf of these

nurses and specifically advanced practice registered nurses, APRNs, I am presenting this testimony.

I would like for you to keep in mind that the people I represent, the nurses I represent, the individuals I represent are scared to come forward and testify. In many instances, the individual nurse practitioner faces certain challenges in the marketplace that compel him or her not to come forward and testify because they fear having employment and those are the people that my association authorized me to represent today.

Evolving over 35 years ago, the category of practitioners that I am discussing includes nurse practitioners, nurse midwives, nurse anesthetists and clinical nurse specialists who have been prepared at the Master's level to provide various levels of primary and specialized care. In lieu of making references to all these sub-categories every time I speak of them, I will refer to them with the terms APRN or nurse practitioner, NP.

Those who envisioned this role 35 years ago envisioned the evolution of a clinician who would work independently or in collaboration with physicians and other providers. Early definitions characterized NP roles as providing primary care in a variety of settings.

Early on, many NPs were denied hospital nursing privileges and the evolution of the nursing role was not consistently welcomed within nursing. Since that development, NPs have sought recognition both inside and outside of nursing. However, the definition and scope of NP practice has evolved with more independent clinical decision making.

Think now of a new paradigm, one where nurses or nurse practitioners could enter an equitable market in all aspects, a market where they could actually compete. What would health care be like? What would the costing and valuation of health care be like? We constantly question that and we have considerations, and that is why we push for change.

Does this market exist? No, it does not. We want to change that market and we need doing so. Nurse practitioners or APRNs are looked upon very highly and very favorably by docs when they're employees, but when they attempt to be independent practitioners, that's when the rubber hits the road and the competition truly begins, and it begins in such a fashion that we're working in an inequitable marketplace.

With statutory and licensure recognition of nurse practitioner practice, many in nursing believe that the new profession would gain acceptance and the ability

to practice as primary care providers. Today, all states recognize nurse practitioners through legislation or regulation and all but 50 states have authorized nurse practitioners to prescribe. Thirteen states allow nurse practitioners to prescribe controlled substances without physician involvement. An additional 32 states allow nurse practitioners to prescribe controlled substances with physician involvement. At least 12 states recognize nurses as primary care providers for their public programs and another 12 states have anti-discrimination laws to protect nurse practitioner practice and mandate non-discrimination in privileging and credentialing.

With all these protections then, why is it such a problem for an advanced practice nurse to practice independently or alternatively bill independently?

Concern about the perceptions of physicians, the nursing community, when creating the nurse practitioner role debated potential structures for advanced practice legislation and decided to advocate for a structure that would statutorily mandate collaborative practice. As most health care providers know, collaborative practice is expected and anticipated because when you provide health care, you provide it as a team member. However, the nurse practitioners took the usual step to get their role acknowledged, of mandating

it within statute.

Unfortunately, docs jumped on this and turned it around. In lieu of us having a role where we actually collaborate, there was a use of this term to create mandated supervision, practice agreements or other impediments to practice. In short, it was used as an effort to control the collaborative process and to mandate employment of nurse practitioners.

The catch-22 between mandated legislative collaboration and physician support has created an infrastructure which makes independent practice for APRNs extremely cumbersome and economically unfeasible.

Nurses can and initially could -- nurse practitioners could practice independently without physician supervision in economically under-served areas. However, in urban areas, they must be supervised or in collaborative relationships, and we believe that that is a market imperfection.

Other laws have been structured to counteract the provision of nursing licensure laws. A classic example of changes in law designed to undermine the ability of nurses to practice independently have been provisions added into medical licensure laws to limit the number of arrangements between nurses and physicians. For example, a physician cannot collaborate with any more

than four nurses under certain laws, and if he or she chooses to collaborate with more, than that physician is disciplined.

Also, provisions have been added to medical practice acts to discipline physicians for failure to properly supervise APRNs and provisions have been added to medical and nursing practice acts to create advisory boards or committees to oversee advanced practice regulation.

I, personally, in my 12 years of working with the American Nurses Associations, have seen five instances where the multi-disciplinary boards have been used to limit or impede prescriptive authority or to limit or impede the rules that are developed related to collaboration.

Some laws have been enacted to promote alternative arrangements to increase the market strength of physicians. Physician collective bargaining bills fall into that category. The ANA has worked with states to oppose this legislation in part because allowing physicians to collective bargain typically minimizes the ability of nurse practitioners and advance practice nurses to obtain arrangements to practice independently.

Also, with physician collective bargaining, APRNs are usually blocked out of the collective

bargaining group and have no protections against the activities of the larger physician-dominated unit. This legislation ultimately undermines competition between nurse practitioners and physicians. Any willing providers laws have been passed to equalize the market, then challenged or interpreted to give disproportionate power to existing market forces.

Originally designed to ensure that any licensed health care provider authorized to provide the service would be allowed to contract with managed care providers, the any willing providers laws have been interpreted, restructured and interpreted over again to, one, cover only physician practice; two, allow the managed care company to choose the provider, as to do otherwise would grant inappropriate interference into business decision making; or three, negate the provisions as the state laws have been held to violate ERISA.

A case is currently before the Supreme Court to address concerns created by these types of laws. That case is Kentucky Association of Health Plans, and because I don't want to run over my time, I'm not going to go into the details of it.

Additionally, the environment around health care reimbursement has created serious impediments to NP/APRN practice. Insurance companies and the government

use payment codes based on a medical model of care and designed by non-governmental organizations who continue to own and control the coding process. Such ownership and control of the existing reimbursement codes by non-governmental entities, combined with the widespread health care infrastructure that supports such use of the codes, creates an unfair disadvantage for non-physician practitioners.

The payment and coding process is the backbone of any health care organization or entity. One is paid based solely on the codes. Originally, the coding was designed to address physician practice only and was later expanded to cover non-physician practice. Fiscal intermediaries that contract with the government, review and process claims and often have problems determining appropriate application of reimbursement codes for NPs and APRNs. Thus, the fiscal intermediary determines if the skill sets of the nurse practitioners allow him or her to take the proper steps related to the diagnostic codes used. If the fiscal intermediary does not believe the nurse is competent to work at the skill level required by the code, that coding is denied. The nurse must code at a lesser code for a lower reimbursement.

Coding challenges are cumbersome, complex and time-consuming and decisions tend to favor the fiscal

intermediary. In the past, the fiscal intermediary could create an additional set of codes specific to reimbursement responsibilities, which was applicable only to the care process through that fiscal intermediary. In doing so, inconsistencies occurred in the interpretation of the primary and the extrapolated code. Nurse practitioners with businesses have to gingerly address the mine field of coding without comprehensive direction or guidance from coding manuals or the government.

Although nursing codes and coding exist, one often gets conflicting advice from the experts. This is an important concern in the existing health care environment where all health care practitioners and providers fear inappropriate coding, government audit and potential assessments or fines.

Further, with the enforcement of the HIPAA regulations and the standardization of reimbursement and other electronic transactions, the additional intermediary specific codes that were designed to address perceived deficits or inconsistencies in the reimbursement codes have been eliminated. Thus, the reimbursement infrastructure for nurse practitioners have little uniformity. Only those who are willing to tread on unknown territory, knowing that they might not get any reimbursement strike out at independent practice or bill

independently. There are some uncertainties and support for uniformity and reimbursement policies in physician practice. There isn't any certainly within nurse practitioner/APRN practice.

Additionally, the process for development and evaluation of codes begs for change. Nurses and other non-physician providers sit on advisory committees and make recommendations to a full committee of physicians. However, the advisory committee does not have full participation in the coding process. They have one vote for all of the non-physician providers.

In short, the process limits the ability of non-physician providers to have full participation in the coding process. Again, we believe that this is a market imperfection. Likewise, we believe there are imperfections in the medication certification process. The primary Medicare certification organization, the Joint Commission, treats nurse practitioners and other non-physician providers as licensed independent practitioners.

Although nurse practitioners are allowed to practice and prescribe independently in many states, this group of practitioners is lumped with other practitioners who are required by law and certification to practice in a supervised structure. The JCAHO standards mandate

physician review of care and treatment plans of licensed independent providers and further require physician supervision of complex care. This standard obviates the nurse practitioner patient relationship by forcing the nurse practitioner to introduce another practitioner into the relationship, regardless of the need for additional review or the patient's desires. It also increases the cost of care.

The patient is required to pay for his or her practitioners and the additional services of a physician. Moreover, the nurse practitioner has to explain why this third party is mandated to intervene in the hospital setting, when such interventions may not be required clinically. In short, the requirement creates a market balance toward protecting the status quo, and once again, we believe that is a market imperfection.

I could go on and on and on, but my testimony has been written. It will be available hopefully tomorrow. I provided you with attachments, and I'm sure that some questions will arise as a result of this testimony. I thank you once again for the opportunity to testify.

(Applause.)

MR. BRENNAN: Thank you. Ms. Varney?

MS. VARNEY: Thank you. As you've heard, my

name is Christine Varney and I'm here today representing the American Hospital Association and its nearly 5,000 members. We're pleased to participate in the hearings.

Let me take a moment on my own first and apologize to pediatricians worldwide. I am one of the mothers who comes in with the French study translated into English in alternative management of asthma, or the Canadian study on prophylactic administration of antibiotics before it's been published in the U.S. So, I know what you're talking about and we all apologize.

(Laughter.)

MS. VARNEY: But that's part of why health care today is quite different than it was five or 10 years ago. I think we have, with the advent of the Internet, as someone mentioned, and a new class of consumers who are much more aggressive. Maybe not always so good for the doctors who are trying to manage efficiently.

But the antitrust agencies need to understand the complexity and the recent trends in both the payment for and the delivery of health care services. Health care is not provided or paid for in a vacuum. We need to look at the financial, regulatory and community pressures in the system. At the same time, we must be aware that consumers, or in our world, patients, who have health insurance are struggling with rising health insurance

premiums. To understand rising health care costs, we must examine not only the delivery of service, but how those services are paid for, or as importantly, not paid for.

Spending on hospital services reflects the price that is paid and the quantity or volume of services that are delivered. If we look at the price side, the price paid by the majority of patients is fixed by the government, and in many cases, the price paid is less than the cost of the service delivered. For other patients, the hospital may never be reimbursed for services provided.

According to a Price Waterhouse Coopers report released last week and submitted with our written comments, the rise in health care spending is due primarily to the provision of more health care services.

Since 1997, the largest source of hospital spending growth has been increased volume. Simply put, more services are being demanded by more patients. This increase can be understood by looking at four principal factors. The first is the aging of the American population. As Americans grow older, they use more hospital services.

Second, lack of access to primary care and inadequate management of chronic diseases, such as asthma

and diabetes, continue to lead to expensive emergency room treatment. Every parent in this room has been in an emergency room with their kids, and you know what I'm talking about.

Third, patients are moving to less restrictive managed care plans and insurers are relaxing utilization controls so that now patients finally have access to more services.

Fourth, and finally, patients are being treated earlier with more aggressive and new, very expensive technologies, technologies that save lives. While the demand for and the provision of hospital services are rising dramatically, payment is not keeping pace. Together, Medicare and Medicaid account for more than half of all hospital volume. Payment rates for those programs are fixed. In aggregate, these payments are below the cost of providing hospital care.

At the same time, more people are demanding more hospital services. The costs of providing these services are rising while payment fails to keep pace. What this means is that the aggregate total margins for hospitals continue to fall. Contributing to falling margins is the skyrocketing growth of labor costs. In the face of a severe nursing shortage and shortages of pharmacists and technicians, hospital labor costs have

risen dramatically. In order to attract and retain qualified workers, hospitals increased hourly pay far more than other employers. Today, wages and benefits accounts for nearly 57 percent of all hospital costs.

As input costs go up, it is not surprising that price will also rise. Other cost pressures include a staggering growth in the profusion of professional liability premiums, a phenomena that seems to be spreading. The PWC report found that premiums increased by 30 to more than 100 percent in 2002 alone. Although not a new development, a persistent financial pressure unique to hospitals is non-compensated care. Hospitals must provide emergency care regardless of the patient's ability to pay. In America today, there are 40 million uninsured.

Judy, that was the number when we started the health care reform and it went down and it's back to what it was.

DR. FEDER: I knew it was bigger than when we started.

MS. VARNEY: In 2001, uncompensated care amounted to $21.5 billion. We believe the cost of uncompensated care will continue to rise, putting more pressure on hospitals.

As is apparent, the key drivers for growth in

spending on hospital care are unrelated to antitrust enforcement in the hospital sector. Rather, spending growth is due to increased volume, increased costs and the unique characteristics of hospitals. Although spending on hospital care account for 32 percent of total health expenditures in 2001, hospital spending is rising more slowly than spending on pharmaceuticals, payer overhead and profit, professional services and nursing homes. The PWC report contains more in-depth data and analysis on important hospital spending issues and I commend it to you.

Hospital consolidation, we've heard a lot about hospital consolidation yesterday and today and it's been blamed, by several, for driving up the cost of hospital care, and consequently, health care premiums. In response to these allegations outlined in the Blue Cross-Blue Shield Association report, we released a report today that clearly demonstrates such claims are unsubstantiated. The new report, authored by the respected health care economist, Margaret Guerin-Calvert from Competition Policy Associates, concludes that hospital merger activity does not explain the increases in spending for hospital services.

The report demonstrates that hospital consolidations cannot possibly account for the increased

spending on hospital care, but rather, such increases are explained by many factors. Not surprisingly, first among those factors are increased patient volume and increased costs of providing care.

The Blue Cross-Blue Shield Association report conclusions cannot be substantiated by the facts. For example, the number of hospital mergers has fallen steadily since 1998. In the last few years, less than 6 percent of hospital facilities were involved in such transactions. During the same time frame, total aggregate margins for hospitals declined. This trend supports the findings that increased expenses and not revenues have driven up hospital spending. Increased spending on hospital care does not warrant a conclusion that greater antitrust enforcement is required in the hospital sector or that past mergers and changes in the market structure have generated price increases. In fact, in many cases, hospital mergers have yielded significant efficiencies and savings that have helped to control costs.

As a commissioner, I took the position that antitrust agencies should expand efficiency analysis in hospital mergers and that in the absence of severe competitive threats, efficiencies should be presumed to flow to the benefit of consumers. I never advocated that

we should not review hospital mergers, contrary to some popular belief. Although after losing seven or nine cases, you begin to wonder.

Recent years have been marked by both dramatic increases in input costs and increased pressure on most hospitals to spend on plant maintenance and improvement. Trends in managed care, government reimbursement and uncompensated care have also been significant factors affecting hospitals. As a result, many hospitals are grappling with very poor to moderate financial performance. These trends and related data provide useful background and valuable context for evaluating the hospital sector, including assessing the rationale for and the potential gains from mergers and consolidations. These trends do not, however, indicate that either past hospital mergers or consolidation hospital markets have caused price increases.

If the antitrust agencies are serious about determining whether competition policies or antitrust enforcement have a constructive role to play in understanding the cost of health insurance premiums, they must have a broader horizon than simply hospital consolidation. The FTC announced last fall that it would undertake significant economic research directed at hospitals. There appears to be no similar initiative at

either agency directed at HMOs, pharmaceuticals, medical device firms, or indeed any other sector of the health care economy, despite increasing levels of concentration.

A retrospective analysis of hospital mergers is meaningless if not undertaken in the context of all the changing market factors. We were heartened to hear Hew Pate yesterday outline his concern regarding the payer's role in rising health care costs. If the federal antitrust agencies truly seek to contribute in a positive way to understanding rising health care costs, we believe equal time and resources need to be dedicated to all sectors of health care, not just hospitals.

Hospitals are extremely complex organizations, operating in a highly regulated environment, where supply and demand are not always easily understood. The types of bricks and mortars industries with which the agencies are well-acquainted, such as grocery stores and car dealers, simply do not provide an apt comparison for analyzing hospital mergers.

These hearings are the opportunity for the federal antitrust agencies to broaden and improve government's understanding of how hospitals operate in today's health care environment. Specifically, these hearings provide a forum to fully examine all the factors that contribute to spending on hospital care. Thank you

very much.

(Applause.)

MR. BOTTI: Let me thank all of our panelists for their prepared remarks. What Jeff and I thought we would do today, if we may, is somewhat manage the competition and the marketplace of ideas we have going on here today. What we'd like to do is take a topic and one of us ask a few questions to a few of you and move through it that way rather than just have a free-for-all.

One thing that's coming up again and again this morning, this afternoon, in other conversations, is the question of whether payers are exercising some form of monopsony power due to increased concentration or some other factors. What I'd like to do is maybe start off with Dr. Opelka, if I can, because I think you expressed some concern over this concentration and how it's affecting surgeons, and ask you to expand on your experience.

Is it your view that we're seeing a reduction in the number of surgeons, the quality of surgical care due to the exercise of monopsony power? If I can, just to sharpen the question a little bit, should we not let payers negotiate for better rates? Is that always monopsony power?

DR. OPELKA: Okay. Are we seeing a reduction

in the number of surgeons to meet the demand? You might see more surgeons come out of the barn, but if you look at the patients' demand, the patients' demand is increasing. So, the way you might best measure whether we're meeting the demand is what's happening in the wait time, the time to get an appointment in the surgeon's office. It's not just a simple game of numbers. That's one.

And you may see that the wait times, in my practice, have gone from four weeks, which I find rather acceptable, to I'm now approaching three months. And to get someone in that office who's got an urgent issue means somebody's got a back door phone call and I've got to make arrangements to squeeze someone in between an operation or around lunch or some other example, just because the demand of the patients is increasing and the amount that they need, the time they need, the sophistication of the market that's coming in demands a lot more from a surgeon. It's becoming increasingly more difficult to meet that.

Secondly, you can look at what we termed the match, the number of people applying for residencies and how many of those places are filled. Even though there is demand for these services, the fact is that the medical students who see the rewards of the profession

diminishing and the work that's required and demanded of them increasing, they're moving away from surgery. They're floating off to something else saying, it just isn't worth this. The burden that's been put on me by the payers, the burden that's been put on me by the government to meet regulatory issues, they look and see the life of a surgeon who's sitting there at a 12-hour day and he's still got a long list of callbacks to try and manage, that's an issue.

In terms of the quality of the surgeon that's out there, I think that's only improved, and it's improved for a lot of reasons. The educational tools, the teaching of surgeons has improved, the technology has improved, the medications have improved. A lot of the integration and care and the IT technology has improved. So, those are all good things.

The down-side is that we work closely -- surgeons can't live without a hospital. We work closely with that hospital, and if we don't have coverage, nursing coverage, if we don't have the ability to get into an operating room, if the latest technology has come out there or the latest device has come out there or the latest pharmaceutical has come out there, but it is so prohibitively expensive that we can't carve it out with the insurance company to get this thing taken care of,

that patient can't be offered that service. We can't get into that market.

So, the hospital has to pick and choose which loss leaders they can tolerate to actually accommodate their business. We're in the business of taking care of patients and we're going to do whatever we can to survive to take care of those patients. If I took all the loss leaders on in that hospital and I drove that hospital into the ground, I lose, the hospital loses, and worst of all, I've got no place for those patients.

When we bring that to an insurer's attention, you're met with very courteous, appropriate, we're more than willing to discuss this, and sometime within the next five years, doggone it, we'll get to the bottom of this. That's way too late. That's unacceptable, and that's the situation that the surgeons feel today.

MR. BOTTI: Thank you. Dr. Desmarais, let me ask you if you would pick up on this topic, because obviously the focus of a lot of these discussions is on health plans and their bargaining, aggressive or not, to control medical costs. How do you view our task in distinguishing between monopsony power or what might be legitimate bargaining?

DR. DESMARAIS: Well, first, let me start by saying that it wasn't all that long ago that I was

employed by the American College of Surgeons and got to work with Dr. Opelka quite closely, and I have a great deal of respect for him. But obviously my current employer is the Health Insurance Association of America, so let me try to look at that.

First, the whole premise about monopsony implies that we're not paying enough. And yet when our member companies are meeting with their customers -- the employers and the individuals who buy their own policies -- very few of them are saying the costs are too low. And, in fact, as we know, the Census Bureau tells us that there is a falloff in the amount of private insurance coverage today, and in particular in the small employer community.

So I guess, you know, if we talk about monopsony, the implication is the end result here is we're going to have to pay more than we're paying now. And if that's the case, then all other things being equal -- and perhaps they aren't. But all other things being equal, we're going to see rising -- continued rising costs. And so that's not a free lunch. In other words, there is a lot of implications here for society.

I also think in terms of monopsony it is very difficult -- I mean, if you go back historically, if you talk about, you know, Blue Cross and Blue Shield plans

and the percentage of the private market they have had historically, I'm not sure what we're looking at today is all that different. And quite frankly, when people talk about mergers and acquisitions in the insurance industry, they tend to want to mix everything up as if it is all the same. If one of my member companies, Well Point, wants to acquire Care First here in the Maryland suburbs, that's controversial, yes, I know. But that mere acquisition doesn't consolidate the market power of that company in Maryland necessarily.

So I think there are a lot of things going on in the marketplace. We also should remember when we talk about profitability, well, a lot of people are in self insured plans. Profit is not relevant. So when the GE is having the problems it is having, it is not as a result of the profitability of the industry. So there is a lot going on here, and I think it -- and a lot of the things that we have talked about have nothing to do with the private sector directly, because we're talking about Medicare and Medicaid.

And quite frankly, our member companies are concerned about cost shifting, in that the public payers are not paying the cost of the care for their recipients and beneficiaries, and as a result it just tends to add more pressure on the remainder of the marketplace to try

to "make up the difference," which quite frankly, they're less and less willing to do as certainly compared to where we were, say, 10 or 15 or 20 years ago. I think every buyer, every employer, wants to only pay the cost of caring for their own workforce and dependents and not anybody else.

So I think there are a lot of problems. Let me stop there, because I could go on and on.

MR. BOTTI: Okay, thank you. I'll ask one more question. And, Ms. Varney, I want to follow up with you on this topic, because a lot of the discussion has focused on, I think, physicians and health plans and the question of whether monopsony power is being exercised against physicians. And yet, I guess to me, if health plans have this type of monopsony power, why would we be hearing about increased costs of hospital care? Even if justified by their input, increased demand for hospital services? Why aren't they exercising the monopsony power against hospitals, I guess is what I'm asking.

MS. VARNEY: Well, I think that what you heard about it -- I mean, you know, I'm really glad that you had our two framers, because I think you have to remember the overall context that we're working in here, where we've gotten an extremely complex situation that has political drivers. It has ideological drivers. It has

market drivers and failure of market drivers. So, you know, if you put that on top, hospitals are obviously a key part of the equation, and they are subject to a lot of the same pressures that insurers, doctors and nurses are subject to.

We've got an increasingly aging population that is demanding more and more services. The services are more and more expensive and more and more effective at extending life. And we haven't balanced yet how we -- the mechanism that we use to allocate those services are insurers, whether or not they're private insurers or government insurers. And what we're struggling with right now, is the system breaking. There is too much cost that has been pushed into the system and it hasn't been allocated. And the private insurers, in my view, anyway, are saying, wait a second. We can't continue to support the breakdown in the system. We can't continue to support what Medicare and Medicaid does not fund.

At the same time, there was a violent reaction to the insurers being the gatekeepers. So we don't want to be the gatekeepers anymore, either. So what we're going to do, is we're going to open the gates slightly. That's going to lead to more demand. Hospitals and doctors are going to continue to try and meet the demand. That's their mission. That is what they do. So when the

hospitals are subject to all of the same market pressures that you're seeing everyone else experience, what we're trying to articulate to you is, look, we know spending on hospital care has gone up. We can identify the discrete areas that are driving the hospital's care spending going up, but it's a misnomer to try and think that consolidation that occurred in '90s in the hospital sector is driving up hospital spending today.

You also have to go back and look in the '90s. There was a tremendous overcapacity in the system. You look at all of the hospital cases in the litigation that you reviewed. I mean, you're looking at areas that had four, fix, six, seven hospitals, all of whom were running at 20, 30, 40 and in the best cases, 60 percent capacity. So we took the excess capacity out of the system, which was a good thing, but what does that do? It drives up the demand on the existing capacity when you have all of the other factors that are driving the demand.

So I guess, you know, it's a long way of answering your question. Yes, we are experiencing the factors that have been identified here in the room. What our concern is, is that as the antitrust agencies examine these issues, first of all, think about what it is that competition or lack of competition contributes to and what doesn't. And I think that was part of what you

heard Judy saying, part of what you heard Tim saying, and certainly your speakers this morning I think drove that home very clearly.

When you peel that back and you look at, okay, what competition -- what can and can't competition policy do, yeah, there are some areas in the hospital arena where I think competition policy could help us focus and be a little bit sharper and perhaps provide services a little bit more efficiently. But at the same time, I think it's a mistake to think that consolidation in hospitals is what's driving the increased costs. We see monopsony power, and we're responding to it the best we can.

MR. BOTTI: Okay, thank you. Before, Jeff, I let you take us to another topic, do any of the other panelists want to pick up on this one? Jeff?

MR. BRENNAN: Thanks. I thought I would maybe switch gears a little bit, but not a whole lot. I heard a few remarks this afternoon about physician collective bargaining. And there were advocates and opponents, I think, on the panel about that, and I would like to turn to that for a second. Dr. Doran, you were -- you mentioned that in your view -- I think you said that physicians should have the right to bargain collectively even with competitors in the market in which the

physicians compete.

And as a -- in light of that view, how should an antitrust agency assessing that conduct interpret the conduct in light of the mission of an antitrust agency to prevent consumers from paying higher prices for goods or services?

DR. DORAN: Right. Yeah, I think that's a very fair question, and the issue of whether it's collusive or not is obviously central to your mission. It is just experientially, as a pediatrician and as a provider, and having even been in, as I said, a large multi-specialty group, the power that you bring to the table as opposed to what I've heard today is pretty minimal. The influence and the ability to really -- even in a coalition of larger groups of physicians, has not -- was not really effective.

But to bargain alone, as a private pediatrician or as a private physician or surgeon, you really have no power at all. And you don't have the data, and you don't have the information, and you don't have the ability to look at -- physicians are scared to even talk to each other. I mean, they don't know the framework. They don't know the borders of what is allowable or not allowable in terms of changing the format of what has gone on historically.

And the marketplace has changed dramatically. I mean, it used to be you would set a fee and, you know, patients would submit that to their own insurer and that was sort of it. But that's -- those days are long gone, and we really all work -- you know, we don't work in a -- like lawyers who set their own fees and clients come in. If they go to the best lawyer at Hogan & Hartson, it's not going to be the same fee as when they go to a lawyer on the other side of town who is not the same quality as somebody at Hogan. That's not the case in medicine. That's not the case for physicians at all.

So there are all these distortions we feel that occur because there are payers and then there are insurers and then there are physicians. So what's driving this whole process is complicated, and it's not straightforward, and it's not market-driven in a way we usually think of it, and I think that physicians are at a real disadvantage in those situations.

So that's why I raise that here. And obviously on the other side of that, you can't have huge numbers of physicians colluding to raise prices inordinately. So I understand both sides of that issue. But right now it's -- instead of, I guess, a sumo wrestler, I see the hundred-pound gorilla there and it's not a pretty sight when I sit down with a big large insurer as a private

pediatrician.

MR. BRENNAN: If I could just ask a follow-up question, and ask Mr. Sfikas to respond to the same question. Following up on, I think, your final point, Dr. Doran, is there any limit that you see on the number of physicians in a given market that you think should have an exemption from the antitrust law? And by number, I mean a concentration or percentage of physicians in a market. Do you think 100 percent should be able to --

DR. DORAN: Well, no. Obviously, 100 percent would be unacceptable. But, I mean, I would have to look to staff for that in terms of what percent. I know there are percentages in other fields and other businesses. And I don't know -- I don't have a number for you here today.

MR. BRENNAN: Okay. Mr. Sfikas?

MR. SFIKAS: True collective bargaining is not applicable to dentists, because in dentistry there is a very small percentage of the dentists who practice as employees. To have true collective bargaining, the physicians -- what, about 50 percent of the physicians now are true employees? You could have collective bargaining with physicians. But in dentistry, it would simply be looked upon as being collusive if the entrepreneurs, the owners of the businesses, tried to

collectively bargain. So under the labor laws, it simply would not be tolerated.

MR. BRENNAN: Ms. Carson-Smith, I know in your remarks you had a view opposing physician bargaining.

MS. CARSON-SMITH: Yes.

MR. BRENNAN: And I would like you, if you would, to respond to that, and then maybe we can wrap up this topic with Professor Greaney. It would be helpful to hear his views.

MS. CARSON-SMITH: None of the bills that have been either passed or are being considered include nurses in that entity that can collectively bargain. The physicians have the option of selecting them, or any other non-physician provider, to actually negotiate. And that has been one of our primary concerns. Another is the provisions related to market saturation. In the AMA model -- and I'm sorry I didn't look at it before I left the office, because I've been looking back and forth at these issues over the past year.

The actual market saturation that is allowed of collective bargaining entities -- physician collective bargaining entities -- is oppressive to us. Our concern is that if 60 percent of the market has collectively bargained, then that other 40 percent of the physicians who are out there are naturally going to be clamoring to

get into a collective bargaining unit or they will have lower rates. And what if -- you know, the if out there -- someone says we don't want any nurses on the panel, because in many instances, nurses are either not empaneled or they have been empaneled and they are being removed from panels so they cannot compete as individual practitioners.

So it would be good for the nurse who is the employee. It would be bad for the nurse who is trying to practice independently.

MR. BRENNAN: Okay, thank you. Professor Greaney, just if you could respond to the same issue. And going back to your sumo wrestler analogy, from the consumer's point of view, having the two sumo wrestlers up there fighting it out, does that lead to benefits for consumers? Or if it's a sumo wrestler and a half a sumo wrestler, does that help consumers?

DR. GREANEY: The image is too unpleasant to think about. Let me try to switch analogies here. I have written about this. I think this is one of the truly awful ideas to come down the pike in some time. There has been a lot of writing about it in literature estimating what the potential spike in costs could be of the ripple effect of collective bargaining into other areas. Truly enormous costs could be generated by it.

And you know what we might be losing sight of is the fact that stable or even declining wages might be a sign of a well-functioning market. And some of the things we hear complaints about, when we put them side by side with the fact that the cost drivers -- a cost driver is labor cost, because labor is such a big part of the cost equation, we're not seeing physician shortages. We are seeing nursing shortages, but we're not seeing physician shortages.

And just to go back to the monopsony discussion, it is hard to very clearly show monopsony, precisely because sometimes an exit from the market and fewer physicians means you're moving, you know, along the supply curve as price declines. So I really don't see -- you don't really -- you're hard pressed to find an economic justification for this.

And just as an aside, let me mention. Just last week yet another study came out the Wennberg Group about the delivery of care in the United States, showing vast variations in care without variations in outcome. And there is a real question about whether we have the mechanisms to squeeze out the unnecessary care. Not every new machine is a good development. Monty Python calls it the machine that goes ping. It doesn't necessary mean we've made an improvement in terms of cost

benefit.

And the question is, if we have no collective bargaining, if we have a debilitated managed care industry, who is going to exercise the pressure to get rid of the machine that goes ping and make sure only the machines that really add effective benefits are going to be the ones that are added.

MR. BRENNAN: Yes?

DR. FEDER: I have a question. I would like to add to the perspective, to broaden the perspective beyond the two sumo wrestlers, or that provider sumo and the insurer sumo, and bring in the perspective of consumers and what they are asked to pay. And ask about the implications of -- or ask about the way in which out-of-plan service is handled or out-of-network service is handled. Because speaking -- not based on a reading of the literature, but anecdotally it seems to me an area that consumers have great difficulty -- just as providers have difficulty in knowing what charge structures are, consumers have great difficulty in judging what it means when they select an insurance plan to go out-of-network in that plan and what they will actually have to pay.

It seems to me it's an area in which insurers may have discretion as to how they set what they will pay on the beneficiary's behalf, perhaps independent of the

charges. So it seems to me it's something of a safety valve in which providers who have -- who can attract consumers may be able to -- can charge what the market will bear, and some can do quite well. And it's in a way in which obviously the insurers can keep their premiums down as well, but it is the consumer to whom it is stuck.

So I wonder if people could comment on that phenomenon as part of this picture.

DR. DESMARAIS: Well, stuck, I don't know. Stuck? I mean, obviously part of the reason for allowing out-of-network is to give people more choices than they might otherwise have because they've not always liked being forced to deal in-network only.

DR. FEDER: Yeah, Henry, but if they don't know -- if they don't know in advance what they're paying.

DR. DESMARAIS: Well, let me get to that. If we don't have a contractual relationship with an out-of-network provider, what can we tell the beneficiary about what they're going to be charged? We can tell them what their cost sharing is, and quite frequently, as you know, it is higher cost sharing than if you had stayed within that work part of the financial incentive to remain within the network. But it may not be possible to tell the beneficiary the total cost of going out-of-network, in part because there is no control on what they might be

charged by that out-of-network provider.

So I'm not sure -- I agree with you that plans should take every step to disclose as carefully as they can. This is not easy because of the different levels of understanding. I mean, the total amount of information you get. I mean, I used to be part of the FEHBP, and we used to get such a volume of information that you really didn't digest it all. Fortunately, there were people who, you know, tried to make sense of it all for us. But nevertheless, I think there is only so far you can go, and really the trade-off here is, they do have that option, at least. They have more choices than they would otherwise have.

DR. FEDER: I guess I just -- I would argue that it bears examination, because I think that the steps -- I'm not at all clear that as many steps have been taken as it is possible to take in terms of providing that information. And it is a part of this picture. Ignoring it means that you're missing much of the ball game.

MR. BOTTI: Let me pick up a somewhat different point, although it certainly deals with consumers' choices and the impact on them. Professor Greaney, I think, raised the question of what implications does the care person have for health plans? And to get at that

question, I would just, if I can, pick Professor Feder's brain for one moment. In your remarks, you talked about community rating as an idea at the time of the Clinton health plan.

Could you give us any insights as to whether community rating exists in any markets today? Is this something that is prevalent? Do Insurance Commissioners do any of that?

DR. FEDER: My sense, and it is somewhat limited, is that we're talking now about the non-group market, and in the non-group market there is not much community rating at all. There are a handful of states, or perhaps even smaller than a handful, I think, of states, who have done community rating and a range of other regulations in the non-group market. But it is only a tiny handful.

More common, I think, are some bounds on -- perhaps on rating or on rates of increase. But I think that that is a direction in which -- from which people have run as opposed to toward which they are moving.

MR. BOTTI: Thank you. Sure, Doctor.

DR. DORAN: Just to comment on that. I'm not sure -- severity rating is something that we implemented in Maryland when the Medicaid waiver went through. I'm not sure where we are now with the severity rating. But

the experience to the providers in Maryland, was this was a situation that Medicaid, when it went to managed care, the state was going to provide insurers different amounts of money based on the severity of illness of the child in Medicaid. But what we found is that money never got down to the provider.

DR. FEDER: Right. But that's -- I think what you're --

DR. DORAN: Not community rating, but severity rating.

DR. FEDER: No. But that's -- I think you want to distinguish. With the term community rating, we're really thinking about the premium that an individual pays as opposed as to your severity rating. I think you're thinking of in rates paid to providers, which is more commonly referred to as a --

DR. DORAN: Well, to the insurers from the state.

DR. FEDER: Oh, to -- aha. Okay, that's right. A risk adjustment to the insurer.

DR. DORAN: It was from the state to the insurer.

DR. FEDER: But that -- but I think your bigger point is that that didn't take place.

MR. BOTTI: Let me keep on this just for a

minute, because I'm curious, Dr. Desmarais. You may be in the best position on this panel to give us some insights as to whether McCarran-Ferguson is an important community for -- or an exemption for health plans, or is it irrelevant to health plan activities? Do you have any sense of what role it plays?

DR. DESMARAIS: Well, let me touch on it at least for a start. First, we're talking about an act that affects much more than just health insurance.

DR. FEDER: Exactly.

DR. DESMARAIS: And I do not represent property and casualty insurers or a host of other insurers who clearly are affected. I think that the implications of the Act do vary based on the type of insurance products we're talking about.

Secondly, I'm happy to say McCarran-Ferguson was before my time. And I'm finding it harder and harder to say those sorts of things these days. No. McCarran-Ferguson, first of all, I think the most important thing to remember is that Act is really what has set up our whole regulatory structure for insurance at the state level, and we've now had decades of experience with state regulation of insurance products. An insurer typically, in order to increase their rates, has to present that to the insurance department in their state. It's not as if

they have, again, unlimited powers as to what they're going to do.

So I think the one danger as we talk about making a change to that Act, or repealing it, is what implications does that have for the entire insurance regulatory structure in this country which is state-based. So I think that's one very large implication of McCarran-Ferguson. As I said in my own presentation, the premise there of that so-called exemption was that instead of the federal government regulating this area, it would be regulated by the states. And states do have antitrust laws and are quite vigorous at looking at them.

Secondly, McCarran-Ferguson does not really provide an overarching exemption to federal antitrust laws, and in fact as was said, I think, by one of the other speakers at one point, you know, the whole Prudential/Aetna merger that was challenged, I think, is a clear indication that the whole insurance sector is not free from federal oversight. And I know there have been a number of testimonies presented about that very fact, that there is still federal oversight in this area.

To get more specific to your question, it's my understanding, for example, that one of the things McCarran-Ferguson permits is the use of state -- of rating bureaus by the property and casualty insurance

sector, where they're able to essentially collect claims experience and information about reserving practices, and that is viewed as allowing collection of information in one place that might not be efficiently replicated by every individual property and casualty company. And these rating bureaus are state-regulated. So again, that is perhaps one example -- a specific example -- of where you might get into trouble with respect to a repeal of McCarran-Ferguson.

MR. BOTTI: Okay. Can I just ask you one quick follow up just to focus it for a minute. Are there any collective practices by health plans, vis-a-vis insurance regulators, that are protected by McCarran-Ferguson, similar to --

DR. DESMARAIS: I am not an attorney, so I'm not aware. Again, it is really a question of deferring to state regulation rather than federal regulation for a large body of what's going on. I would add, you know, when we start every meeting in our place, the one thing that starts every single meeting is the chair's instructions, which are, in part, intended to protect from violations of antitrust law. And the operative clause is no agreement with regard to pricing of products or the design of products shall be discussed during any meeting of any committee of the Association, except

within a legislative or regulatory context as allowed by law.

So again, we don't see ourselves as being exempt from antitrust control.

MR. BOTTI: Thank you.

MR. BRENNAN: I think Ms. Carson-Smith wanted to follow up.

MS. CARSON-SMITH: Yes, I would like to follow up. My Association has not taken a position on repeal of McCarran-Ferguson, but we do have some concerns that we think need to be flushed out. And one of them is, when is the activity truly anti-competitive, or alternatively unrelated to the business of insurance, or when is it related to business of insurance. For example, one particular insurer that we know systematically does not allow nurses on panels. We have been told by the New York State Attorney General that we can't go beyond the boundaries of McCarran-Ferguson to get at whether or not that action is antitrust related.

In another instance which we find very troublesome, nurses who are required to collaborate are then asked by state regulation to buy insurance from the same entity as the physician. So you have someone who has a low insurance rate, a very low insurance rate -- some are very low malpractice insurance rates -- going in

with someone with a very high malpractice insurance rate, and it's almost like you're forcing them in that market to bring down the risk within that particular market for that malpractice provider. Whereas, if they could buy it from the nursing insurer who provides that malpractice base that covers all nursing insurance, then, you know, that insurance for that nurse would be considerably lower.

There are instances of where nurses are required -- nurse practitioners are required to buy minimum coverages of malpractice insurance in a state, and the physicians in that state are not required to buy minimum coverages. The presumption is that the market will take care of itself for the physicians, but not for the nurse. But in reality, what you're creating is a market for making that nurse an attractive plaintiff.

So those kinds of issues beg us to ask the question of is there a need for further refinement of the anti -- well, the antitrust prohibitions related to McCarran-Ferguson.

MR. BRENNAN: Thank you. We're bouncing around on issues here, but let me bounce one more time. I would like to ask Christine Varney. I would like to follow up on your remarks. First of all, as a former FTC Commissioner, I'm particularly interested in your

observation.

Do you think it's an incorrect premise for an antitrust agency to be concerned that a contributing factor to rising hospital costs is market power?

MS. VARNEY: No, I don't think it's incorrect.

MR. BRENNAN: Okay. So if it is a correct premise, or a correct basis on which an antitrust agency -- or a correct reason to be concerned --

MS. VARNEY: It's within the purview of the agencies.

MR. BRENNAN: Okay.

MS. VARNEY: Every inquiry is going to obviously be fact specific.

MR. BRENNAN: Okay. And would those fact -- would those fact specific circumstances necessarily then require the agency to look at local market conditions, and if so, where would you draw the line between analyzing those local market conditions, pre-merger and post-merger on the one hand versus the national trends that you identified in your remarks.

MS. VARNEY: Right. A couple of things. As you may recall, I was fairly outspoken about these issues while I was here. And in part that was due to the fact that we lost, what was it, seven or nine cases between the two of us as we kept going up on mergers. Yeah, it

may have been bad law, and I heard a lot of talk this morning about what we need to do is educate judges. Well, I know one or two judges who think they need to educate us, because we kept bringing the cases.

A couple of things. I think that some of the best work that we did in the '90s on mergers was on the big mega mergers, the Columbia HCA. The large regional consolidations, where you were looking at multiple hospitals coming together and what was the effect of that on competition. I think we did a good job on that.

I think we did a less good job on small local markets in understanding what were the product markets, what were the geographic markets and what were the relevant factors in trying to assess competition. In particular, as you know, I had a very hard time understanding why we set an efficiency bar so high when we were importing, in my view, the markers for antitrust analysis that I think you said, Tim, didn't make a lot of sense when you were looking at the hospital market. I mean, to think you could take the HHIs and throw them into the hospital basket and come out with a result that was going to make sense, to me was ludicrous at the time.

So my concerns have always been, look, when you're looking at the health care marketplace, it's not cars. It's not grocery stores. You've got a role for

the federal antitrust agencies to play in hospital consolidation, particularly at the large regional level that crosses many jurisdictions, that we in the federal agencies may be more equipped to take a broad look at than in small regional markets. I have always believed that in small regional markets, number one, a state attorney general, if there is going to be an antitrust review, ought to be very involved in. Number two, there are tremendous efficiencies in the '90s, I believe, that came out of hospital mergers.

To go back now and try and assess what was the result of those mergers -- you know, I was joking to some of my colleagues the other day. You want to know if prices went up? Pay me the money. I'll tell you. Prices went up. There is no question, prices have gone up. But how are you going to isolate in a retrospective what the price increases were due to? You know, we've got a lot of data -- most of it has been referenced and mentioned by many of the panel -- that will continue to point you to three basic baskets of price increases.

There is increased volume. Whether or not we think that's a good thing, there is increased volume. There is increased costs. Okay. We've talked about the labor, the technology and the pharmaceuticals. There is clearly increased costs. And then the third basket that

I refer to is the unique characteristics of hospitals. The under compensated, the un-compensated care and the obligations of the hospitals to deliver care.

It's not clear to me that we have the tools to tease out what price increases are due where. What synergies and efficiencies can you isolate in the mid-'90s and carry forward to 2003 when technology today is completely different than it was back then. I mean, I have a short personal anecdote. My dad, who is 74 now, three years ago had emergency quadruple bypass surgery off the pump. Something unheard of. It was only done at two or three hospitals. You probably know far better than I. He was in intensive care for one night. He was in the hospital for three days. He was out and he was hiking in Norway with my kids a month later.

That surgery was astronomically expensive. It was not reimbursed fully by the variety of insurance products that he relies on. And the efficiencies that we may have seen from hospitals combining in the '90s, how are you going to pull out those efficiencies when you have to factor in the more expensive technologies and the higher demand for services that you've got today?

So a long way of saying, yes, there is a role for antitrust review of hospital mergers. That role has to encompass increased efficiencies, has to recognize

we're not talking about cars and groceries, and has to understand that we're operating in a complex, highly regulated environment where some care is paid for, and some care is not paid for, and some care is under-compensated, yet there is an obligation to provide care to all.

MR. BRENNAN: Professor Greaney?

DR. GREANEY: Well, here is how I read what we learned from the '90s and what the economics teach us. First of all, health care, God bless it, is well studied. Economists have done a lot of studies here. And it is one industry where antitrust really seems to matter, i.e., there is a strong relation between concentration and price, and the gaggles of economists have shown that. And it is an intensely local industry. So I think it is important to preserve market structures, and I think there is good healthy empirical support for it, would that there were for a lot of other antitrust, but we happen to have it here.

Secondly, on the efficiency side, I think the picture is much grayer. This cat is a lot grayer than Commissioner Varney indicated. I think there are a number of studies that question whether efficiencies -- promised efficiencies -- were realized. A big problem of combined hospitals is “herding cats.” No offense to

doctors, but that's the phrase used, because they don't get the cooperation of the doctors. They can't consolidate the way they planned to. So that's -- the benefits are very speculative, and I think the picture is a lot clearer on the risk side.

Finally, let me mention something that I think is an opportunity for the Commission to take the lead on and an important issue that is coming up now, which are the carve-out, specialty hospitals and the fights with doctors doing that. It is a very -- it's a tricky and thorny issue. In some cases, you have clear anti-competitive problems, where the hospital is trying to stop a rival surgical center from coming up. In other cases not so clear, because the physicians have such control over the patient. You may just be substituting one set of market power for another.

But a very interesting problem, and in fact one that the OIG at HHS is getting involved in now with the comments on whether staff privileges constitute remuneration. But that's an important issue, I think, that competition advocacy and perhaps policy statements can be out front on. Critical as I've been from time to time, let me just say, I think what the Commission has done in some areas, like pharmaceuticals, or, you know, if you need an advertisement for why the FTC earns its

money, there it is, because not only did they bring timely important up front cases. They alerted legislatures. They raised an issue to prominence. And, you know, I think that's a role they can regain here.

MS. VARNEY: Let me just respond to one thing. It's former Commissioner Varney, but Christine is preferable. I think that the efficiency cat may be gray, but the concentration and price increase is equally gray. I mean, there was concentration in the '90s, or merger activity in the '90s across virtually all markets. So how we isolate price increases due to market structure changes and the other factors we've talked about is not at all clear to me out of the economic literature.

Specialty hospitals are interesting, and I think it is an area where we do need some dialogue. The problem -- one of the problems that faces hospitals -- and I'm sure, you know, you've encountered this, and it's not what you're talking about. The obligation of hospitals to provide care for the uninsured can lead to some cherry picking. And that is something that, you know, a rational economic actor is going to look at to maximize the efficiency of their specialty hospital. And there is a challenge here, and I think we've all got to overcome it. You know, how do we deal with this issue. And it's something that we're interested in looking at

and working on.

MR. BOTTI: Maybe we can pick up a slightly different topic. There has been a lot of talk about information flow, and some people seem to say that it is damaging competition, or potentially damaging to competition. Some people seem to say that it is really important to have effective markets. And I want to talk about the business review letters that Dr. Desmarais raised, because I think those letters do acknowledge the concerns that you expressed, that fee surveys could give rise to problematic behavior. But they also raise a question that I think Drs. Opelka and Doran raised, which you didn't address and I would like to get to the facts of this.

And that is, physicians perceive themselves not to have appropriate information in order to make contracting decisions with managed care plans. And the proposition in these fee surveys is that they will correct this failure of information. And I'm wondering. I mean, do the health plans concede that, that the information physicians might appropriately want is not available to them, or do you think it is already available to them, in which case why are these surveys a problem?

Maybe you could expand on this. Thank you.

DR. DESMARAIS: Well, I think the surveys are a problem because, you know, there seems to be an intent to use them to simply raise prices and raise fees. And so, I think it's not sure to us exactly what the value to the consumers is going to be. I mean, it's not quality information we're talking about here. And when I hear a former Commissioner of the FTC tell me, well, it's so complicated, you'll never be able to figure out, you know, what's due to what, it makes us worried about the implications of, you know, can you do a rule of reason analysis in health care, or is it so complicated that it is impossible. And so, when you have MedSouth or information exchange, you really won't know what's going on or what is valuable or not valuable.

I do think it's probably -- it varies from payer to payer what kind of information is available. You know, we're talking about a contract. I haven't encountered a lot of sympathy out there if I sign a contract and I don't know what its terms are, or I'm not satisfied I know what its terms and conditions are. So I don't know what to do with that, but I suspect there are variations in business practices out there from insurer to insurer. I'm not sure I can do personally anything about that, given the antitrust laws, but at any rate.

MR. BOTTI: Maybe Drs. Opelka or Doran would

like to pick up on the notion of do physicians have appropriate information to make individual choices in terms of which managed care plans they might contract with or not.

DR. DORAN: Well, one of the issues -- and I certainly don't hold myself an expert in this area. But I believe that the Medicare Program provides a national database of utilization services for adults. And there is really no comparable -- speaking as a pediatrician, there is no comparable database for children. So in that respect, pediatricians are at a particular disadvantage. I don't know if that -- was that --

MR. BOTTI: That's helpful.

DR. DORAN: Okay.

DR. OPELKA: From a surgeon's perspective, these are -- these tend to be very complicated medical service agreements. They are not straightforward. There are 9,000 plus codes that the surgeons are dealing with in trying to put this together. So if you are a large group and you're going to an insurer, and you're trying to sort out how these codes are dealt with, you're just given a set of general broad guidelines -- this is how we do this -- and you don't really get down to the point where you understand the actual fee for the service rendered.

When you do come to understand it, usually in the course of that year, you are put on notice that there has been a change and the rules are now new or different. So just when you thought you had your arms around it, the game is changed. And in the middle of that, they throw in a whole new set of rules on payment policy and what we're now going to cover and what we're not going to cover. Right in the middle of where you really finally thought you had, boy, we're looking forward to the next contract cycle. When you bring these forward at the end of that contract and move into the next contract, they are typically recognized as great points of discussion and it ends there.

And the average surgeon doesn't have time for that, and they've got to get back to doing what they are supposed to do. We are spending an enormous amount of time trying to figure out what we should not have to figure out. What should be much more understood by all parties involved and get us focused on the patient. And it's sad to say that we're not, because we're chasing down very slim margins, rising costs and difficult malpractice issues. And it ends up where -- when it is finally understood, you start to have to ask yourself, what particular lines of service can I afford to continue to deliver, and that, to me, is where it really gets

criminal.

MR. BOTTI: Thank you.

DR. GREANEY: Just on that point, I want to thank the Commission for coming out with this letter, because when I go back to St. Louis, I have to revise my health law casebook. And this is -- I think this was written by a law professor. It is just full of great issues.

But one of the ironies here is that what the physicians decided to do is exactly what I think Joel Klein and Bob Pitofsky told them to do during the debate over the Campbell Bill, which was to say you don't need collective bargaining. Go out there and lobby. Get the information out. Throw it out there and let the market and everybody decide. And they're doing exactly that.

I can certainly understand why it is troublesome, and the context in which it is troublesome, I suppose, is because as the letter points out, it seems bizarre to set it up so the two -- the duopolists can more effectively collude. Get the information right out in front of them. It is a fascinating problem, but one I think if you have to err on one side, I guess you err on the side of information. But certainly there are situations where markets work better with secret bids and less information. But I guess -- I think in this case

you reached the right decision, but it is full of twists and turns, I think, analytically.

MR. BOTTI: Should we wrap up?

MR. BRENNAN: Yeah.

MR. BOTTI: Well, unless any of our panelists want a last word -- going once, twice, three times. No. Why don't we wrap up for the day. Thank you all.

(Whereupon, at 5:00 p.m., the workshop was concluded.)

C E R T I F I C A T I O N O F R E P O R T E R

MATTER NUMBER: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW

DATE: FEBRUARY 27, 2003

I HEREBY CERTIFY that the transcript contained herein is a full and accurate transcript of the notes taken by me at the hearing on the above cause before the FEDERAL TRADE COMMISSION to the best of my knowledge and belief.

DATED: MARCH 10, 2003

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SONIA GONZALEZ

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

I HEREBY CERTIFY that I proofread the transcript for accuracy in spelling, hyphenation, punctuation and format.

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