HEALTH CARE AND COMPETITION LAW AND POLICY HEARING

Wednesday, May 7, 2003

9:15 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

Health Insurance/Providers -

Countervailing Market Power Page 3

Speakers

Dr. Gaynor Page 6

Mr. Langenfeld Page 19

Ms. Noether Page 36

Mr. Crane Page 49

Mr. Leibenluft Page 58

Mr. Tobey Page 68

Most Favored Nation Clauses Page 109

Speakers

Mr. Kopit Page 116

Mr. Baker Page 138

Mr. Overstreet Page 145

Mr. Snow Page 154

Mr. McNair Page 163

P R O C E E D I N G S

- - - - -

MR. BERLIN: Good morning and welcome back to the joint Department of Justice/FTC hearings on Health Care and Competition Law and Policy. Today we pick up again with our second set of sessions directed at health insurance issues. I'll just repeat, for those of you who have been here and I know there's a good number of you to a lot of these, I'll repeat some logistics again.

These morning sessions, including today, will start at about 9:15 and last until 12:15. We'll take a lunch break, come back at 2:00; and the afternoon sessions will run until 5:00.

I'd also like to note that interested parties may submit written comments regarding any of these topics and the procedures and deadlines for doing so are on, I believe, both agency's websites.

Turning to this morning's session, first I'd like introduce my co-moderator, Sarah Mathias. Again, I think if you've been here before, you probably know us. And our topic today is Countervailing Market Power.

In the last sessions -- in the last two sessions two weeks ago -- we began looking at monopsony power issues with market definition, competitive effects; now we sort of continue that progression and look at the possible doctrinal legislative or perhaps structural ways that providers might address monopsony power when exercised by a health plan.

Each panelist on this, somewhat larger than usual panel, will have 10 minutes to do their presentation and, then, as we've been doing, we'll move to the moderator/roundtable discussion with a 10-minute break in between.

Sarah and I will pose questions during the roundtable, as we've been

doing, and we'll also invite, and certainly give every opportunity to the panelists to, you know, question each other and respond to each other's comments.

To make sure that we have enough time for the roundtable today, and hopefully to help the panelists, Julia will give each of the panelist a two-minute warning, but I think she's going to use a card rather than a whistle. I mean, we may have to go to a whistle, though, if we go too far beyond that.

And, I guess, before we start, I'd like to thank all our panelists for taking the time and effort to come here, and some traveled a fair distance, and I would note that everyone's full biographies are in the hand-outs that are available out on the table. But, before we start, I'll give a quick introduction, in the order of presentation, which will be running from your left to right.

First we have Marty Gaynor, on the end, and he's a Professor of Economics and Public Policy at Carnegie Mellon University. Dr. Gaynor's research is focused on the economics of health care markets and health care organizations.

Seated next to him is James Langenfeld. Dr. Langenfeld is the Manager of LECG's Health Care Practice Group and is a Professor of Law at Loyola University in Chicago. Formerly, he was Director of Antitrust in the FTC's Bureau of Economics, in a prior life.

Stephen Foreman, seated to my right, is the Director of the Pennsylvania Medical Society Health Services Research Institute. He provides consulting services, as well, for the American Medical Association for issues relating to health insurance markets, including, specifically, potential impact of physician-collective negotiating legislation on national health expenditures and the structure of health insurance markets across the United States.

Down on the other side of the table, we have Monica Noether who

heads Charles River Associates' Competition Practice in Boston. She specializes in antitrust analysis and in the economics of the health care industry and its numerous regulatory and policy issues.

Seated next to her is Donald Crane. Mr. Crane is President and CEO of the California Association of Physician Organizations. I'll leave it to him to describe his organization in more detail, but I'll note also that he is a health care and corporate attorney.

And on down the table is Bob Leibenluft, he's a partner here in Washington in the Office of Hogan and Hartson or in Hogan and Hartson's D.C. Office, where his practice is devoted to health and antitrust matters. Bob, too, was a former FTC -- or is an alum -- he was formerly head of the Health Care Division. I couldn't find any DOJ alums for the panel -- where are they?

And, finally, on the end we have Mark Tobey, who is Chief of the Antitrust Section in the Consumer Protection Division of the Office of the Attorney General in Texas. Two of his recent health care matters were Aetna's acquisition of Prudential's Health Benefit Plans and, more recently, implementation of Texas' new statute allowing negotiations by competing physicians with health benefit plans.

And, with that, Marty, if you'll get us started.

DR. GAYNOR: Thanks, Bill. We're at the mercy of technology. Coming from a high-tech University -- Carnegie Mellon University -- we're use to the malfunctioning of technology. Our main job is to build things that will -- build a bridge that will fall down; build machines that will break; and we turn out thousands of graduates a year to do that kind of thing.

(Group laughter.)

DR. GAYNOR: So, we're well familiar with this. Having predated

high technology, though, I think I can -- well, we only have to wait one more second -- well, there we go. The computer has decided to cooperate.

Thanks very much. It's an honor to be here with the other members of this distinguished panel and testify on this very important issue.

So, let me just briefly outline what I'm going to talk about. I'm going to talk a bit about countervailing power, what is it? Why might it matter in health care markets? Give you just a little bit of background on the concept, talk a bit about what economics has to tell us about this issue, address a few practical matters and, then, get to a conclusion, all in the space of 10 minutes or less. We'll see whether Bill comes up here and yanks me off if I exceed that time limit.

So, let me first talk a little bit about countervailing power, although the term has been used quite a bit, I think it's often used in a rather vague way. So, let me be specific about what I mean by this term. What I mean is the establishment or the existence of market power on one side of a market where market power already exists on the other side.

So, in health care instances, suppose that there is a health insurer with market power. If, on the other side of the market, there are some hospitals that have market power or are allowed to establish market power, or doctors who would do the same thing, that would be countervailing power.

Similarly, if there was a market with a hospital with market power or doctors with market power, and on the other side of the market, a health insurer that had market power or was allowed to establish that, that's what I mean by countervailing power.

Some general examples that are often referred to when talking about this outside of health care are labor unions. One of the notions of why we might want

labor unions to appeal to countervailing power, although I should be clear that the argument for this -- for labor unions -- are usually not an efficiency effect -- not that it benefits social welfare, but it benefits workers, and that's usually the argument given for that.

Another argument industry which has often been discussed has to do with retailing. The notion that allowing large retailers to get large or give them countervailing power against their suppliers and that they could then pass the benefits from this countervailing power on to consumers.

Now, whether that's true or not or as supported by any here, is a separate question, but countervailing power has often been discussed in that way. Retailing is much more common in Europe than in the United States. But you see this come up time and time again in Europe, but it has come up in the U.S.

So, why might it matter in health care markets? I already said something about this. Suppose there's market power on one side of the market; the insurer has monopsony power or take this to mean that either a single firm or group of firms; or there may be provider monopoly power.

Well, we know that monopoly power is going to cause harm, regardless of whether there is monopoly on the seller side or monopsony on the buyer side. The one thing to note that is very critical here is that the exercise of market power on one side of the market is a necessary condition for this to matter.

In other words, there's no point in talking about countervailing power if there is not market power on one side of the market and that power is not being exercised; meaning that it causes harm to social welfare.

So, the question then is, well, can countervailing power improve matters? And this has been a very hot issue for a number of years. It's a very big hot

button issue. In particular, most of the discussion in recent years has centered around whether there is monopsony power, possessed by insurers on one side of the market, and, if so, whether countervailing power by providers might improve matters. So, there have been requests for legislation exempting physicians from some of the antitrust laws and I'll just gloss over that at that level, understanding there are a lot of details to that.

In some hospital merger cases, hospitals have offered this sort of notion as a defense, but by the same token it applies to insurers possessing market power or providing market power when the contention is that there's monopoly power that providers have on the other side of the market.

And, again, it's the same kind of notion that's discussed in retailing. So, the insurer could have countervailing power to counteract the market power of hospitals or doctors and then pass those savings on to consumers.

Now, just a little brief background. The notion and the term are traced back, at least in modern times, to John Kenneth Galbraith, at least in the 1950s, and Galbraith's idea, again, is that the power of the seller would be checked not by other sellers but by strong buyers. And if you read some of Galbraith's works -- not that I recommend doing that -- but if you read that, this is consistent with his notion of how the economy was evolving -- the new industrial state, the modern capitalism -- and, so, that's the notion that he had that the existence of market power in one side would provide incentive for the other side of the market to organize to obtain market power and, then, that would also benefit society.

Now, Galbraith, again, for those of you who aren't at all familiar with any of his writings, writes at sort of a 100,000 foot level, I should probably jack it up a bit more than that, somewhere perhaps at the outside limits of the earth's atmosphere.

And, so, these ideas were never rigorously developed. He just says stuff and then it sounds good and it might be true and it might not, but if it wasn't, that's not the level at which he was operating.

So, these ideas were very, very sharply criticized at the time. There's an article by George Stigler published in the American Economic Review, I believe, in 1954, entitled In Typical Cost to Glaring Fashion - Economist Plays with Blocs, and he just shreds Galbraith's argument.

So, nonetheless, I think you can understand why the notion has some appeal. Let me talk about how perhaps we might think about this a little bit more carefully. So, I don't really necessarily want to take things away from Galbraith. He didn't work any ideas out, but he did think a little bit about it.

But let me first start with some basics. So, basics -- first, competition is best. I think it's very important to state this. If market power exists on one side of a market, the best policy is to diminish it or remove it. The criterion I'm talking about here for best is social welfare, not just consumer welfare. But, in this particular case, that does not matter. So, I think, economics is very, very clear on that.

Now, a second basis is we're talking about countervailing power where there's power on both sides of the market. Looking at price levels isn't going to be very informative. Why is that? Well, it's possible that the firms on both sides of the market could strike a deal in which they produce a certain level -- a certain level of output is produced and sold and, then, all that remains is to bargain about price. The price can go up; the price can go down, without necessarily having any impact on consumers or society, as a whole.

The price being higher or low would simply affect the distribution of gains in this industry between buyers on one side and sellers on another. And while

that may be an issue of some concern, my contention is that's not an issue for antitrust. That's simply distribution of profits or rents.

So, for example, we could look at the market and say, well, prices look like they're low, all right? Do low prices result from monopsony or from competition that's induced by hard bargaining?

Similarly, we could look at a market and say, well, prices seem to be high. Well, are those high prices due to monopoly or do to competition among buyers trying to obtain the services of sellers?

That's a sense in which I don't think looking at prices when there's market power on both sides is informative; as opposed to the situation where we're only looking at market power on one side of the market, in which price is a very important thing to look at.

Okay. So, let me move on. What if there's market power on one side of the market and it can't be removed or it won't be removed? I don't know that there are legal barriers to that, but I'm not going to address that since I'm not a lawyer or a legal scholar.

Then the question becomes, can creating market power on the other side of the market improve matters? Now, this might be possible. We always like to have the first best. We always want competition, we don't want market power on either side of the market. That's not possible. Sometimes economic theory tells us that two wrongs make a right. Fear of the second best tells us if there is an unchangeable failure -- market failure, sometimes another market failure, rather than making things worse can actually improve matters. So, it's not obvious that this would not improve things.

It turns out that answering this question isn't easy. Maybe it shouldn't

be a big surprise, but it's not an easy question to answer. There has actually been a lot of work in economics on this topic, although there has been some.

Price theory -- and what I mean by price theory here is econ 101, the basic economics you learned in your freshman economics course or even in your immediate economics course, or for some of us who go back far enough, even what we learned in our basic econ course in graduate school. It's not particularly useful. This is a bargaining problem between entities that have power on both sides of the market and price theory, again, basic, simple, economic theory -- by this I mean theory that predates modern economic theory; but, again, that's mostly what's presented in undergraduate textbooks, is not well suited for analyzing this problem.

I think it gets us a little bit of the way, but I think modern economic theory is better suited to shedding light on this problem.

Now, this may seem a little arcane, but it does become important in how these things are analyzed and sometimes how arguments are presented. I was not present, but I do understand that a couple of years ago at hearings on the Campbell Bill, Tom Campbell presented a diagram that purported to show what the impacts of his proposed legislation would be, and it was using this kind of theory, and I don't think that it was particularly useful. I don't think it shed light on the matter.

So, what do we know? Well, the two possibilities: Economists always say on the one hand; on the other hand. It's possible that countervailing power would allow the entities to obtain a cooperative bargaining outcome, and it's possible, under these circumstances, that they could achieve the first best. If there are gains on the table and they cooperate, they should always take up all the gains on the table and then just bargain about how the things are split up.

So, if there's market power on one side of the market, having market

power on the other side might actually improve matters. That's the one hand. Now, it's not a given because they have to be able to achieve this cooperative outcome. Or, even if they do, it does not necessarily follow that the first best will be achieved.

So, let's take a retailer -- suppose a retailer and a supplier cooperatively bargain and get all the gains that are available to society from trade -- it doesn't mean the retailer is then going to pass those gains on to consumers.

Similarly, say a supplier -- a supplier will also be buying inputs, as well, to produce -- will not necessarily pass those gains on in the market that's buying it.

So, the other hand is countervailing power will always make things worse when only having market power on one side of the market. Why is that? Well, one way to think about this is the following:

How can you exercise market power as a cartel? The way you exercise market power is by restricting quantities to the other side of the market.

How do you get your price up? You have to withhold quantity or threaten to withhold quantity. That's the only credible threat that a cartel has, and there are some theories which show that if there is power on both sides of the market -- say, cartels on both sides -- that unequivocally makes things worse.

Now, again, there are details to these theories I'm not going to go into. It's not worth going into. But you can get results on either side. The results on this side are, I think, a bit more definite than results with countervailing power being the first best; but either one is a possibility.

So, what kind of evidence do we have? In general, there's not a lot of evidence either on other industries or health care; it's mixed, not very reliable. Health care, there aren't many studies. There are some studies that find that prices are lower in more concentrated health insurance markets than before. I don't think this is

particularly relevant to the issue whether the welfare has improved or not.

Practical questions: First question is, well, is there market power on one side of the market? So, we have to ask the question, if we're looking at insurance, do insurers have monopsony power? Or, if we're looking at providers, do providers have monopoly power? Because if the answer to that is no, then there's no point in even thinking about countervailing power. There's nothing to countervail. It also has to be true that this power is exercised and that it reduces social welfare.

If the answer is no, then if we allow countervailing power again, all we're doing is creating power on one side of the market where there was not one and that will be unequivocally wealth that we do see.

The examination of quantity traded is key. Price impacts here are not particularly revealing. What has to be examined is what happens to quantity. So, those are two key practical issues.

Let me move on to some conclusions. countervailing power is a live issue only insofar as there exists a significant loss of social welfare due to market power on one side of the market.

Now, health care markets are local, so this has to be considered on a market-by-market basis. Now, I think that's very important because that means that we're not going to reach a sweeping conclusion making a one-size-fits-all policy on this issue, necessarily.

If there is a loss to the market power on one side of the market, directly addressing that is best. That is far better than allowing the creation of countervailing power. Countervailing power is inferior to that and it also will not necessarily make things better -- it well could make things worse.

If redress to market power, one, is not possible, than countervailing

power could improve matters or could make things worse. I think it's clear that a blanket exemption to the antitrust laws for the purpose of allowing the creation of countervailing power is inappropriate.

So, on that, let me conclude, and thank you for your attention.

(Applause.)

MR. BERLIN: Next, Jim Langenfeld?

MR. LANGENFELD: Thank you, again, for having me here. This is the second time, so I guess this makes me a recidivist, not only at the FTC, but a recidivist at these hearings, at this stage.

And the first thing I want to say is that Marty Gaynor and I did not -- and we absolutely deny -- colluding on our presentations, although you'll see some similarities.

What I'm going to talk about in 10 minutes -- or as close to 10 minutes as I can possibly make it -- maybe even less. I'm going to skip over some things because we have a panel where people have very interesting things to say here.

I'm going to talk about the basics of bilateral monopolies and oligopolies. I'm going to talk about just some observations I have about the existence of monopsony power and monopoly power in health care markets. I'm going to talk about sort of the conditions that are necessary for these type of bilateral monopolies and oligopsonies to end up improving welfare, and then some policy observations.

And, at the risk of boring the economists and confusing the attorneys, I'm going to put up some graphs, because I am an economist. My students at Loyola love this sort of thing.

Let's remember just where we're starting from here. This is the classic monopoly graph, for those of you who have been forced to look at this. The key point

here, without discussing all of the exciting issues in this, is that how does a monopolist raise price? And why is it bad?

Well, a monopolist raises prices, Marty says, by restricting output. In a competitive market, I think most of us believe, but we don't understand quite why, that when supply and demand equal each other, in a competitive market, that gives you what economists and the antitrust laws tend to believe is an efficient market. Given scarce resources, this is the best outcome for everybody involved.

So, if you think of marginal costs up here as the supply curve and the demand curve is the demand curve, then you end up with a price that's PC, the competitive price, and PC price always; and a QC. What a monopolist does is they restrict output, as Marty says, and that enables them to raise price. And by restricting output, the conditions are that they set marginal revenue equal to marginal cost, but the key thing here is they restrict output and price is higher than it would be in a competitive market.

So, what happens? Let's think about what monopsony or oligopsony is. Once again, if it's a highly concentrated market, it doesn't need to be a monopoly. You'll see these same general types of outcomes, unless you're using an unusual model, which, of course, economists are very good at doing these days.

So, here it is -- and this is what a monopsonist or oligopsonist is. This is why countervailing power sort of matters and why we're sorry about monopsony. A monopsonist does a very similar thing to what a monopolist does. They're buying, they -- in a competitive market, they'll bid up prices to a certain level and a certain amount will be produced.

How do they gain extra and less competitive profits? They restrict the amount they buy -- that goes to QS for monopsony, rather than monopoly, and they

restrict -- and that means that they can buy cheaper, they're going to buy as much. And, without going through the math, what they'll do -- similar to margin revenue equaling marginal cost, what a monopsonist does is looks at their marginal expenditure curve, they equate it to the average marginal value curve here, depending on the assumptions you make on the production function, and what happens is prices go below. But the way they do it is they restrict output, too. That's how they get their -- that's how they get their profits, because they're buying stuff cheaper.

Why can they do that? Because there's a lack of competition. Competition would, typically, force prices up to a higher level.

Okay. So, what's countervailing power? Wow! Well, here we are with the miracles of modern technology. I have superimposed both of those graphs, making some simplifying assumptions, and what do we find? Well, ideally you'd like that PC, that politically correct, competitive price, up there, right? Okay?

But, what you could see is if you had a monopolist, the price would be higher; and if you had a monopsonist, you'd have a price that would be lower.

The one common feature is you get less output, as Marty pointed out. And with less output, the ultimate consumers are going to end up paying more and there will be fewer than the competitive amount of health services that are provided.

So, I hope I've achieved my goal of boring the economists and confusing the attorneys at this state.

All right. So, what are the necessary conditions for these two offsetting things to happen? Well, let me go back one. Actually, let me do this. If I can remember how to go back. Okay, I'm on point here.

So, what is the issue? How does countervailing power matter here? Countervailing power matters because, presumably, if you have these two large

concentrated markets -- or two concentrated forces that have market power on both the buyer and seller side, they're going to strike a bargain that's going to be someplace between PS and PP on this. That's what they're going to do, you create that.

And why is that better? Because, under many conditions, although not every economic model will predict this, they can end up with a price that is going to be someplace in the middle with an output that's likely to be higher. It may end up being the competitive price, but pretty much any price that's negotiated, depending on the other aspects of the contract, will end up increasing output. And, so, in that sense it will be pro-competitive.

So, that's the whole rationale that you're going to move from QS or QP closer to QC, and where that will be will depend on the relative -- usually considered to be the relative bargaining powers of each side in the negotiation.

Okay. So, what are the conditions for monopsony? Well, starting from the -- because monopsony is less popular in antitrust, obviously, but still there, you need, similar to the buyer's side, similar to a monopoly seller, a monopoly buyer or a concentrated group of monopsonistic buyers, have to have market power in some well-defined markets. You've got to know what you're talking about. You know, wealth concentrated in what? A monopoly over what?

Typically, you need few buyers, if not a single buyer. You need barriers to entry for those buyers, because if the prices are forced down low enough, people will see the opportunity to come in, bid up the prices somewhat and the monopsony or the buyer power will go away, because then there will be more buyers for the suppliers to sell their products to. Also, technically, you need a well to the inelastic supply and demand curves. That means people have to want the product and that costs have to -- or the supply curve has to shift up, otherwise you're not going to

get any of this going.

So, you need somewhat specialized inputs, you know, doctor training, things like this. And you need a demand for health care, which is fairly inelastic, relatively inelastic, and that's certainly the thing that we observe here.

So, let's look at one of those aspects of a oligopsony or buyer power here. And this is not meant to say that I necessarily believe that these MSAs are markets, but I do agree with Marty that health care markets are local.

But what I've done here, and it's not to say that necessarily even managed care may be exactly the relevant antitrust market, but I've taken some public data here and what I've done is I have looked at a series of MSAs, and I've taken the easy information -- what's the easy information? I can get the largest HMO, as a percentage of the insured lives and I've gotten the largest PPO. And where they're the same company, I've added them together; and where they're not, I haven't.

So, in some sense, depending on how you define the market, these market shares would understate -- any market shares calculated like this -- would understate what the actual market shares were.

Here what I've done is I've just put the number of MSAs on the left and the market share either of the combined HMO/PPO or just the largest HMO/PPO or just the largest HMO or largest PPO, and just counted up the number of MSAs that have market shares -- assuming these are markets in the ranges listed across the bottom. And one thing you notice, there's a big variation. Most of these larger SMSAs, the largest purchaser is about 20 to 30 percent, not necessarily an overwhelming -- certainly not a monopoly. This doesn't calculate -- and then some are even smaller, so concentration may not be that high in those, but you can look at a number. There are a number that have 30 percent or more and some over half or close

to half.

So, the first point is if there are four -- addressing one of the issues. Marty raises if there is a large -- a necessary condition is that there is at least concentration and the possibility of concentrated markets with market power on the buyer side, and in some markets it doesn't look like it; in other localities, it looks like there could be.

So, to put this into context, first of all you have to decide whether managed care is a separate market, even if it's a larger market. Many of the people that I was counting in the earlier slide have nonmanaged care products, so there still could easily be concentration on the buyer side, in some of these markets, but certainly not most of them, in a level that you'd raise a competitive concern.

Also, you have to address the issue about entry and expansion and new payers. Clearly, there are some issues about product differentiation. State regulations can affect how many insurance companies can come in. There could even be an implicit and explicit agreement amongst folks to divide up the market or to set prices. All those things could affect whether someone would come in the market or could come in the market. Also, some issues about the minimum viable scale. You need a certain minimum number of people to be insured to make it go in a different area. But the key point here is all these things are going to vary by geographic location.

In the -- I won't talk much about the other side of the market. There are parallel conditions here, and there's clear evidence that this panel has heard in past hearings that some geographic areas have highly concentrated physician practices and hospitals; others not. It seems to vary over time.

So, let's think about, for me, what's the necessary condition for bilateral monopoly, because antitrust usually can deal with market power on the supplier side.

It seems to have no legal restrictions on it and, obviously, they worry a lot about that.

So, let's look just for the moment at the payer side. First of all, you need the high concentration of payers; you need them to have collectively or one individually have a substantial lot of market power; and it has to be large relative to whatever market power exists on the -- on the payers and on the physician and the hospital side. You want to give me the relative inelastic supply and demand curves.

And, so, you need to address those things, but these things -- the key point here is that these things are local, as -- as Marty has indicated -- and, so, sort of across-the-board legislation does not seem appropriate, based on the evidence that we have here, applying the normal economics in a competitive situation, if we're really concerned about efficiency in consumer welfare.

If payers have monopsony power because they're colluding in some way, then presumably the antitrust laws can address that, with the exception that there is the McCarran-Ferguson Act and there are restrictions. It's not clear to me, as an economist, and I talked with some attorneys before this even -- the attorneys aren't sure exactly how far that exemption goes. And, I mean, clearly they can share information but how far -- where is that line drawn is a key issue, because there may be restrictions on what exactly antitrust can do in those instances where there is substantial market power on the buyer side.

If it turns out, though, that the market just turns out to be very concentrated and there isn't collusion, there still could be a great deal of oligopsony power. Unless there's some antitrust act that takes place, collusion or something like that, then there's very little the antitrust agencies, typically, will do about it. They don't -- the antitrust agencies have not attacked structural oligopolies since the -- what -- the 70s. So, there is some possibility that there would be some buyer power here

that, absent some countervailing power, could be exploited.

So, what would be the policy issues here? Well, one is, looking on the physician and on the hospital side, when the FTC and the Department of Justice consider doing business review letters and things like that, a lot of times those letters don't, or those actions don't, explicitly take into account buyer power in the local area.

And I think, as an economist, that's probably a mistake. Countervailing power should be taken into account on a case-by-case basis where a specific group of physicians or hospitals are considering putting together a joint venture or some other agreement. It's something that should be taken into account. It is taken into account in merger analyses and other antitrust analyses when allowing concentration to take place in most markets.

I believe in the health care area that's the appropriate place to try and address the buyer power issue on a case-by-case basis.

Thank you.

(Applause.)

MR. BERLIN: Stephen Foreman is next.

MR. FOREMAN: Once more, I have to deny there was any collusion. A lot of what we've talked about already, I want to agree with and, I guess, maybe it will help get through this a little quicker in our 10-minute time limit.

First of all, from an overview standpoint, I'm going to talk about countervailing power as perhaps a first-best or a next-best solution to a dilemma. I'm going to describe the solution that a profit-maximizing-monopsony-monopoly health insurer has, and, then, deal with some countervailing power issues.

The setting we're talking about here is a health insurer with the monopoly power as a given. We've talked about the monopsony and monopoly issues

in some of the past sessions here. And, as Marty pointed out, you know, if you've got a competitive market, basically, you don't even get to the issue of countervailing power because it can make things worse.

Basically, we don't think this is the forum to talk about the competitive issues again, and I'm going to start with the premise that we have a monopoly/monopsony health insurer.

And, also, in agreement with both prior presentations, perfect competition would be best here. If we have monopoly/monopsony power at the health insurer level -- and I'm going to focus on that as an example -- the best solution would be to deal with that in a way that would return competition to the market, I mean, without saying.

However, if for any reason we don't want to restructure, what do we do? And that presents the dilemma that I talked about and the menu of choices is not so happy, but countervailing power can be the best of these solutions. Certainly it's better than price and quantity regulation.

Let's take a look. The profit-maximizing health insurer decides how much to produce. That means they consider employer's demand for health insurance and they consider physician's and hospital's supply of medical care. By the way, this theory actually goes back to the '30s with Chamberlain and Bohle. Scherer and Ross developed it some in the '60s and '70s, and Roger Blair's book has a pretty decent exposition of bilateral monopoly in it.

In effect, though, the mathematical decision here is tri-lateral monopoly, if you think about it. There's the employer, there's the health insurer and, then, there's the hospital or physician, as provider. So, basically, there are three parties to consider here and what the profit-maximizing health insurer is going to do is take a

look at the quantity that ought to be produced. I mean, this is sort of a cartoon -- in considering the price of the health insurance, the wage rate for physicians, and, then, determine an appropriate quantity to maximize the profits of the health insurer. And, in fact, when you do that, where you end up is some of the things we've talked about before.

Yeah, I've got the employers and the physicians flipped there.

Basically, what this, then, ends up considering, is the slope of the employer's demand curve and the slope of the physician's supply curve. So, the inelastic behavior of the employer's and the physician's, you know, that we heard about before -- I'm just going to skip through some of this example.

Basically, then, what the health insurer is relying on is that the demand of the employer for health insurance is relatively unresponsive to price increases and, in some way, the desire of the physician or the hospital to provide medical care, is relatively unresponsive to decreases in price. And that's really the underpinnings in all of this.

So, what happens? In that mid-year, giving countervailing power to physicians, you know, who currently have no ability to exercise that kind of countervailing power, absent integration, provides, first of all, a more level playing field. It provides a more elastic supply curve, if you track through the example. And it actually can promote welfare increases by greater quantities produced. If you cut to the chase, access to medical care is actually improved and that improves welfare.

Parenthetically, employers, by and large, and we heard this from Jeff Miles a couple of weeks ago, already have the ability to join together in buying cooperatives. So on one side of the equation, employers already have some level over access to countervailing power, while physicians, on the other side, don't.

And, in fact, if we have both physicians and employers with countervailing power, we get increases in quantity supplied and welfare. The outcomes are closer to a competitive solution, depending on the relative power of the participants, and this result is actually a market-driven result that doesn't have to be monitored, you know, on a realtime basis. In fact, you can avoid price and quantity regulation, which is a real plus.

Finally, I want to deal with the concept of the idea that giving countervailing power to physicians will increase health care prices. I call this the fallacy of the wage pass-through. In effect, it presumes that health insurer monopolist/monopsonist will pass along all reductions in physician prices or in hospital prices. It's possible, it would be efficient in terms of the monopsony behavior, and it could occur, but it would be rare.

Again, you would have to take a look at the market, in particular, tying in with what we've heard before, that firm would have all of the market share in the market. If you think about it, if they're passing that through, then the other firms in the market wouldn't be able to do it. So, the firm would gain most of the share in the market, but would show very little profit. Prices in that market would be substantially below those in other markets, and I'm talking about downstream with the health insurer.

In effect, if you take a look at what's happening around the country, profit-maximizing monopolists are already charging what the market will bear. If you take a look at a lot of markets, their very large health insurers are deriving substantially large amounts of profits.

If that's the case, if you think about it, if the monopsonist/monopolist is already charging employers what the market will bear, increased -- decreased prices

won't be passed along, and if the price increase comes about, the price increase can't be passed along because the monopolist is already charging what the market will bear.

What we think could be the worst outcome here is if the regulator fails to deal with the monopolist/ monopsonist and enforces the antitrust laws strictly against physicians. First of all, it seems a little one-sided, which it is. But in actuality what you're doing is preserving the market power of the monopolist/ monopsonist health insurer. That allows market distortions to continue and, in some ways, stems the philosophy that the antitrust laws are on its ears or on its head.

Basically, you've got enforcement conduct against a couple of physicians, who are just trying to get by in dealing with health insurers, with millions of enrollees and literally billions of dollars in annual profits.

So, we believe, at least in terms of the physician component of the equation, when a health insurer has a monopoly and a monopsony power, restoring competition would be the ideal situation. We firmly believe that and we've talked about that in the past.

If we're not going to restore competition to these markets by breaking up large health insurers, then the menu of remedies needs to read like countervailing power, price and conduct regulation and other forms of state regulation.

We think that countervailing power is at least a next-best remedy to that kind of setting, and we think that it could be done either by legislation or by regulation.

So, thank you for your time.

(Applause.)

MR. BERLIN: Monica?

MS. NOETHER: Well, as the fourth of the economist in a panel with

four economists, I will also say we haven't colluded. One might think my presentation is quite different and one might think that we have, in fact, colluded and segmented the market into different things, but I assure you we have not.

I'm going to talk about sort of two major themes. One is to summarize, very quickly, an analysis that Charles Rivers Associates did now about three years ago on the potential costs of allowing physicians to negotiate collectively, i.e., to exercise countervailing market power. And, second, to review current market conditions. In fact, trends that happened in the last three to four years that I think are relevant to framing the whole debate on how negotiations between providers and plans can most effectively be carried out to maximize consumer welfare.

Turning quickly to the CRA analysis of the National Cost of Physician Antitrust Waivers, this was a study that was done on behalf of the Health Insurance Association of America. First, I think, we started it in 1999, when some of the legislation first was showing up on the Hill and did a re-analysis in 2000. The Quality Health Care Coalition Act of 1999 is the Campbell Bill that's been referred to several times.

A summary of our quick findings and then I'll discuss a little bit the methodology. We found that if the Quality Health Care Coalition Act or any kind of legislative initiative with similar provisions were enacted enabling physicians, essentially, to negotiate collectively with managed care plans, that personal health care expenditures would likely increase fairly wide range, depending on assumptions one makes from somewhere -- anywhere -- from 2.5 to 8 percent; private health insurance premiums would see the biggest brunt of that and would increase by 5 to 13 percent. And these effects would stem from increases in provider fees and, more importantly, relax utilization controls, which is the other tool that managed care has used.

The underlying model that we use to make these predictions relies on the way that we saw the managed care world. We saw that managed care reduced the rate of expenditure growth through the '90s using two major tools. One by reducing prices by encouraging competition among providers through threats of selective contracting. Previous analyses, not done by CRA, suggested that provider discounts, in response to managed care, range from 6 to 25 percent. We've incorporated that range of assumptions into our model.

The second tool that managed care has traditionally used is to manage utilization, much of which is directed by physicians. So, we're looking not only at the utilization of physician services itself but any services that are -- a physician is, essentially, acting as an agent on behalf of patients.

And, again, we relied on previous analyses that suggested that utilization review and utilization management savings from 8 to 22 percent. And, also, underlying the model, an important feature is that competition among managed care organizations ensures that savings are passed onto employers in the contract pricing. And our suggestion was that, at least, for most markets, this seemed to be the case.

Data that we relied on came from a combination of HCFA, National Health Expenditure Projections and some data on Medicare for public payments, and the Kaiser Hospital Research and Educational Trust Health Benefits Survey. As I said, we looked at a range of different scenarios, using different assumptions about the amount of discounts that would be turned around if physicians were allowed to bargain collectively and what would happen to the utilization controls that had been effected by managed care.

And we also assumed that while the effect on private payers was going to be most significant, that there would be some effect on public payers through spill-

over effects where providers, essentially, don't behave that differently, depending on who the patient is -- who the payer is that covers the patient.

And, once again, the summary of our results is that we came up with a total effect ranging from 2.5 to 8.3 percent increase in personal health care expenditures where the change in utilization that comes out of allowing physicians to collectively bargain with plans and govern not only the pricing terms but the utilization terms, is about two-thirds of the effect.

Turning now from that study, which, as I said, was done three years ago when there was much more talk about passing legislation that would enable physicians to bargain collectively and exercise countervailing power. If we look at what has happened in the last few years, current market conditions suggest that the market has, in fact, produced some of the same results, without the legislative intervention, but more from various different factors.

So, I'm going to spend the rest of my presentation making observations on some of what I believe are the trends in the market, and where it's gotten us -- bottom line, a shift in the balance of power from the plans to the providers. Not to say that either one of them, necessarily/universally had power before or has power now, but just that there has been a general shift.

Managed care has become kinder and gentler, to quote a phrase cited by Paul Ginsburg and colleagues at the Center for Studying Health System Change and there's been a significant decrease in health plan use of capitation to pay physicians nationwide. These are numbers, again, that come from the Center for Studying Health System Change, from 57.4 percent of physicians in 1997 to 48.6 in 2001, deriving some revenue from capitations are now less than half of all physicians get any revenue at all from capitated system.

The majority of physicians now are affected by some kind of what are called care management tools, as opposed to more stricter uses. These are guidelines, patient satisfaction surveys, to some extent profiling. The majority of physicians that are affected by these care management tools report positive effects.

Moreover, younger physicians are both more affected by these kinds of tools. That is, they experience them more regularly in their dealings with managed care because they are more heavily involved in managed care and they also have more positive feedback with respect to those tools.

There's less emphasis, generally, by managed care to influence physician behavior and control fees; more emphasis -- and we'll talk about this in a minute -- on controlling patient behavior through cost-sharing. That's just sort of a new trend on the managed care side.

Conversely, if we look to what's happening on the provider side, providers have increasing clout in their negotiations with managed care plans. Less than half of all physician revenues stem from managed care. These are data from the American Medical Association, corroborated by the Center for Studying Health System Change.

Generally, in most markets -- and this is consistent with the data that Jim Langenfeld showed -- no single managed care organization generally accounts for a substantial portion of private revenue to physicians, and private revenue is not all the revenue.

The average physician contracts with 13 managed care plans. Now, it's possible that you could have one big one and a bunch of little ones, but remember that only half of the total revenue or less than half of their total revenue is even coming from private managed care.

Physicians are finding ways to increase their revenues, generally. A story in the American Medical News earlier this year, physicians are adding fees for services that were once free. This suggests that they've got some ability to increase their sources of revenues.

And per capita spending on provider services has increased at a more rapid rate in the last few years than it had for all of the '90s. And this next slide demonstrates some of that. The blue bars are hospital per capital spending; the yellow bars are physician. And you can see that during the '90s changing in spending were sort of below 5 percent and, then, even below 3 percent, if you look at the last three years, both on the hospital -- particularly on the hospital side -- but also on the physician side, spending has gone up. These bars, obviously, don't tell you whether it's price increases or utilization increases. It's likely both.

So, where does this get us today in terms of the effect on the ultimate consumers, which in this case are, obviously are ultimately patients. But in terms of framing the debate in terms of managed care, the employers are the one that are, essentially, having to negotiate first with the managed care companies as buyers of managed care services with managed care acting as sellers.

Cost to employers have increased by double-digit rates in the last three years. Premiums in 2003 are nearly 13 percent higher than in 2002 and the average employee will spend 16 percent more in out-of-pocket expenditures. That's a very recent survey based on a relatively small sample of 30 large companies, but it's consistent with the much larger Kaiser Survey that's done annually, that showed similar results for changes from 2000 to 2001 and then 2001 to 2002.

Moreover, as the Kaiser Survey points out, the cost increases to services to self-insured employees are similar, suggesting that most of the increase in

premiums for the insured are coming through provider cost increases rather than some kind of underwriting cycle.

This just shows you the trend from the late '80s to the present on increases in private premiums. This is the black -- the black line is the health insurance premium line, the others are medical inflation, overall inflation and workers' earnings. And you can see this is sort of the trend of what's happened in managed care. Managed care began in response to that blip in the late '80s when premiums had been going up very rapidly. It was quite effective through the mid-'90s, even through the late '90s, though there was some increase in premium expenditures then, but, then you see in the last three years that expenditures for premiums have really taken off again. So, this is kind of the summary of what's been happening.

On the employee side, as I mentioned, employees are paying more out-of-pocket just as labor market softens. For awhile, employers, when the market was very strong, were eager to compete for employees and they did their best to shield employees from out-of-pocket expenditures, in addition to giving them very generous converge. This is when the kinder, gentler managed care with less selectivity of plans came into effect.

If you look, though, just at the last couple of years -- again, these are Kaiser data -- what Kaiser seems to have done is looked at the most protected single coverage preferred providers, so this is going to be, presumably, where the lowest out-of-pocket expenditures are going to occur; and, then, family coverage of a nonpreferred provider, where you'd expect the largest out-of-pocket expenditures to occur. And they looked at PPOs and POS plans.

If you look at PPO plans, which they estimate are half of all plans and increasing over time, you had a 20 to 37 percent increase just in one year in out-of-

pocket expenditures for insurees. The POS plans, the individual single coverage preferred provider, actually went down and family coverage went up just a little bit, but the POS plans are a small and shrinking number of the total plans.

Similarly, with deductibles or, sorry, co-payments for physician visits for HMO enrollees, the percentage of employees paying either at least $10 a visit or at least $15 a visit, also increased substantially between 2001 and 2002. So, employees are feeling the pinch as well.

So, where are we today? In the balance of power between plans and providers, providers do not -- there doesn't seem to be a lot of evidence that they are at a disadvantage. They are certainly gaining advantage relative to several years. Circumstances in particular, markets may vary, I need to, obviously, agree with all of my colleagues here that you can't make generalizations, health care markets are local, and one does need to look at the situations in particular markets.

But these are situations in which the antitrust authorities should intervene to restore competitive behavior on both sides, obviously, focusing on one side or the other is inappropriate. But, if one looks at both sides, then, hopefully, if the situations are limited enough, one can get to something close to a first-best outcome.

Demand-based pressures that have been significant in the last few years, have largely benefitted providers. As I mentioned, tight labor markets and a healthy economy made employers want to meet employee demands for broader networks. This has taken away one of the primary tools of managed care, i.e., selective contracting, forcing providers to compete with each other.

Also, more freedom of choice has led to reduction in access restrictions, the other control of managed care on utilization. The result, as we've

seen, is premiums increasing at much higher rates than they had in the '90s. And, in fact, if you just do the math, it may be coincidental, premium increases have increased in the last three years at a rate that's 7.5 percent higher than they had, on average, throughout the '90s. That's a number that's sort of in the mid-range of the number that the CRA study came up with as to what the effects of collective bargaining would be.

Where do we go from here? This is obviously looking into the crystal ball, and we don't exactly know what's going to happen, but the situation that I see it now is that employers are starting to feel the crunch of higher premiums and starting to complain about them again. At this point, there doesn't seem to be a huge amount of pressure to go back to the old days of lots of selective contracting and tight utilization control. So, rather, managed care plans are currently meeting employer concerns through direction of cost sharing toward the ultimate consumers -- trying to make the employee/patients more sensitive to the cost of the services that they're consuming.

However, I'm not clear how far we're going to get there, so I could see that we could get to a re-acceptance of more limited networks and utilization controls. Selective contracting, perhaps not, but we are seeing some tiered networks and some increase of UR and UM.

The question that I'll leave you with is just, is there a need to sanction countervailing market power in some kind of official way? My answer is no. The antitrust agencies, obviously, need to use appropriate enforcement to ensure that monopsony power is not exercised by plans and situations in which providers cannot walk away. But, this is not necessarily going to be relevant, even if a seller has monopsony power -- if a plan has seller market power, because the seller -- the market in which plans sell is not necessarily the same as the market in which plans buy,

because there are lots of other sources of revenue to providers; namely, the public payers.

And, finally, the situations in which monopsony power exists and is likely to result in a reduction of consumer welfare are fairly rare in my mind in health care markets.

Thank you.

(Applause.)

MR. BERLIN: Next we have Don Crane.

MR. CRANE: Thank you. Good morning, it's a pleasure to be here. My name is Don Crane, I'm the CEO of the California Association of Physician Groups, that's a correction to the record. We consolidated with another trade association in California last January and, so, our new name is California Association of Physician Groups. We are a trade association, composed of all of the large IPAs and multi-specialty medical groups all across California, all of whom are devoted to the managed care system. We have something on the order of 117 members now, which members contract with or employ approximately 37,000 physicians in the State of California -- roughly half the physicians in the State of California.

Our members are responsible for something on the order of 11.5 million managed care lives in California. Since we are the only association in California that is devoted solely and exclusively to managed care, we actually, I think, justly lay claim to having -- speaking for all 18 million managed care lives in California.

We've heard from four economists talking, I think, macro. I'm going to move into a very micro situation. The essence of my presentation, really, is to, essentially, request that the FTC and DOJ re-examine a very small slice of this whole pie, which is sample 2 of statement 8 in the Statements of Antitrust Enforcement in the

Health Care Area.

That sample sets forth a hypothetical involving IPAs, which predominantly do risk contracting and are fully integrated financially and clinically for HMO work, where they might, under this hypothetical, enjoy rule-of-reason analysis in doing some PPO contracting. It's a new, sort of an initiative in California, a fair number of my members want to do that kind of contracting and get into the fee-for-service and PPO arena. That particular sample provides poor guidance, in our view right now, and I'll get to that in a minute.

In terms of sort of structure, what I thought I would first do is talk briefly about the market conditions in California as they exist right now; then, talk slightly about this sample and the sort of halo effect, as we are calling it now or the spill-over effect that occurs when managed care physicians are working side-by-side with PPO physicians -- where managed care work and all the efficient utilization controls, et cetera, et cetera, spill on over into fee-for-service work.

Then, thirdly and finally, I'll try and suggest some arguments as to why that sample ought to be rewritten, in our view.

Nationally HMOs really are in retreat; the penetration has declined. In California, the numbers are fairly stable, but in regions, there are marked declines particularly in some rural areas and in some counties. The HMO penetration has evaporated entirely in a number of areas.

This is due to a lot of factors; certainly one of them, in our view, is health plan consolidation. Where once, in 1994 we counted some 34 plans, subsequent mergers and consolidations have resulted in about -- in 2002 -- in roughly six plans. This is an enormous concentration of market power in our view. A real kind of a textbook example of monopsony power, and it's making a lot of difference.

You know, in California, these health plans do an awful lot of direct contracting with our physicians for fee-for-service work. Given these powers, we have a lot of anecdotal evidence of physicians, particularly in contracting with Blue Cross on their prudent-buyer product, of accepting something on the order of 65 percent of what Medicare RB/RVS schedules would pay.

In other words, given the relative dynamics there, the pay schedules have dropped markedly. And the interesting dynamic this creates is that at some point in time, and we're now witnessing this, the panel, the PPO panels, are actually shrinking as some physicians chose to exit this low compensation.

When that happens, the consumer is hurt because those enrollees are then obliged to go out of network to find their services. When they go out of network, they're obliged to pay 200/300 percent of what they would pay were they to purchase those services in network. So, we've got a real adverse impact on enrollees because of that kind of shrinkage.

If my members are looking at the decline in HMO, wanting to diversify their portfolios, are looking at fee-for-service work and noticing the kind of halo effect I'll speak about in a minute. And they want to do some fee-for-service work, you know, at the moment probably 90 percent of the aggregated revenues of my members are derived from prepaid capitation. That is where their bread is buttered.

But, they're getting increasingly sophisticated in getting better at delivering integrated, coordinated care. They have a full panoply of the utilization kind of controls that achieve so much efficiency -- credentialing and QM and protocols and they're data crunching and they're benchmarking and so forth -- yields a broad number of efficiencies that are to the benefit of consumers.

All of that kind of efficiency-producing initiative can be translated, to a

very large extent, into fee-for-service delivery systems, and that's a place where we want to go.

But, sample two, which is the sole roadmap right now for us, doesn't permit us to go there as well as we would like, frankly, because we think that it's criteria are somewhat unrealistically drawn.

Let me talk a little bit about this, sort of, spill-over effect. It has not yet been well documented, but it's generally accepted as kind of an article of faith and is regarded as true, is that when you take PPO, fee-for-service work, or PPO physicians and you put them side by side with HMO physicians, a curious thing occurs. They continue -- they start to practice in the same sort of rational way, with appropriate levels of utilization. There just is an automatic kind of spill-over effect.

The health plans have noticed this. They enjoy the reduced and appropriate amount of utilization that occurs in their PPO products, when they're juxtaposed to HMO products, and they're able to, you know, enjoy considerable higher profit margin a result.

Statement 8 recognizes this, frankly. It's an acknowledgement of this kind of halo effect. And it describes a hypothetical where an IPA wishing to do this kind of fee-for-service work, an IPA that would not on its own be fully financially integrated and would have minimal clinical integration, would be allowed to do this kind of fee-for-service work, if it met a number of criteria.

The IPA would need to use the same panel of physicians as they do with their HMO product. They would have to employ the same kind of utilization controls. Third, they would need to pay the same kind of rates to these fee-for-service PPO physicians as they would on the HMO side. And last, the network would need to be nonexclusive.

Now, we look at those four criteria and think that they don't cross-walk quite well from HMO to PPO. Certainly my members could use the same panel, they might even be better advised to use a subset of the same panel, but in either case -- and a subset perhaps even those that are sort of better utilized, those that meet the profile better -- but, nonetheless, they could achieve that criteria.

In terms of the same utilization controls, we think that the sample provides poor guidance. PPO products just have a different benefit package. There's coverage issues, enrollees are allowed to directly refer to specialists. And, so, you can't have precisely the same utilization controls. You can have many of the same utilization controls. You can have all of the same kind of credentialing, site visits, grievance kind of procedures. You know, you can have many of the same protocols and initiatives, but you can't have all of them. You can have many but not all, and we think that the sample needs to be adjusted to conform with that.

In terms of the third criteria, paying the same rates for fee-for-service work as we do for capitated work. There again, there's not a good cross-walk. In the full-risk context, so many of the primary care physicians are actually capitated and to flip that into a fee-for-service model is tricky in terms of equivalency.

After the specialists -- some there, again, are capitated; some are paid fee-for-service -- but the benefit designs are different. And, so, there again, it's hard to achieve the same kind of exactitude in, you know, the same rates.

And, finally, in terms of the network being exclusive or nonexclusive, as soon as you have a nonexclusive network -- it's kind of an unrealistic requirement -- you get the free rides and so many of the physicians, then, will be able to join other IPAs, who will then be able to kind of ride on the coat-tails of the utilization controls of the subject IPA, et cetera, et cetera.

And, so, you get this delusion in terms of the salutary effects of all of these efficiency-inducing measures. And, so, that's a hard criterion to match.

So, you know, our goal is to somehow achieve new regulation or to inform the policymakers at the DOJ and the FTC to rewrite that sample and broaden it to enable IPAs to compete in this market. We think of it as actually pro-competitive.

As it is right now, IPAs can't engage in collective bargaining unless they're fully financially integrated or they have full integration -- clinical integration -- in sort of a Med-South context when they're not doing any HMO work. And that's a very, sort of, narrow, stiff set of parameters. We think it's actually anticompetitive. We think that actually having the kind of managed PPO product, as we're recommending, produces benefit to the consumer and it actually sets up a different product that should be viewed differently. That which we're trying to achieve by doing managed PPO work, really, if it does result in a higher price schedule, it's because there's more value being delivered. The purchaser isn't just getting simple, PPO fee-for-service, they're getting PPO fee-for-service, but they're getting that with the whole, sort of, range of utilization controls and HMO practices that come behind it, the credentialing, and all the QM and QI that goes with it. So, for all those reasons, we think it makes sense.

We also note that, in Congress and in the Administration right now, there's an awful lot of talk, of course, about prescription drug benefits and an overhaul of Medicare and certainly the initial proposals by the Administration -- those that were going to offer up a prescription drug benefit -- did so by encouraging, maybe forcing, enrollees to go into private managed care plans. We think that that reflects an understanding that it's through managed care that you get these greater efficiencies.

And, so, we think the whole thrust of the overhaul and re-engineering

of Medicare is going to require an integrated group approach where these efficiencies are, the California model, if you will.

We also note that the CMS has got one or more pilot projects underway where they're using organized groups for PPO work. All of this suggests that, you know, those in the know -- those payers in government -- know that through integrated, coordinated groups there are economies that can be achieved.

And, so, with all of that, we simply would recommend that the FTC and the DOJ take a hard look at sample two and allow IPAs to enter into the PPO contracting arena.

Thank you.

(Applause.)

MR. BERLIN: Thank you. Bob?

MR. LEIBENLUFT: Good morning. I'm speaking here this morning on behalf of the group called the Antitrust Coalition for Consumer Choice in Health Care. It's a mouthful. It's a group of health care payers, providers and employers who are concerned about having adequate antitrust in the health care field, and particularly they have been at the forefront of opposing exemptions that would allow physicians to negotiate collectively with health plans, including the Campbell bill.

And in those debates often the issue of countervailing market power comes up, so we're very familiar to that argument, and that's what I would like to address here in the macro level.

As I'll describe, providing a pass to cartels -- because that's what they are -- to exercise countervailing market power is unnecessary. It would be virtually impossible to implement and, most importantly, would have the end result of reducing innovation, driving up health care costs, and harming consumers.

Now, at the outset let's recognize how radical a proposal this would be. Allowing an unintegrated group of providers to collectively negotiate with health plans would, essentially, immunize what we view as per se illegal. What we consider as subject to criminal prosecution.

Moreover, the courts have repeatedly considered and rejected the argument that there's a need to acquire countervailing market power to justify what would otherwise be an illegal arrangement.

I think perhaps the most relevant case here is the aptly named Cartel case. It is Cartel vs. Blue Shield of Massachusetts, which involved a challenge by several Massachusetts physicians to the practice of Blue Shield prohibiting balanced billing; that is, the requirement that physicians accept Blue Shield's reimbursement as payment in full.

But the physicians argued, among other things, that Blue Shield had substantial market power and that it's balanced billing plan had the effect of reducing quality, discouraging the entry of new doctors, and discouraging doctors from introducing new, highly desirable medical techniques. These are all the arguments that we hear now to justify countervailing market power.

In his decision for the First Circuit, then-Judge Breyer -- first of all, he declined to address the issue of whether Blue Shield had market power. He just assumed it for the sake of argument. In fact, in a nice line, he said that he was unwilling to evaluate the record on that market power that the District Court had described as, "two competing mountains of mostly meaningless papers." With all due respect to the economists, I think this sort of reflects a little bit of difficulty one would have to even assess whether a plan had market power. But he assumed that was the case.

But, then he said, look, the antitrust laws don't prohibit monopoly pricing absent evidence that the prices are predatory, and they don't require the impossible task of determining what might be a competitive or a reasonable price.

And he noted that in this case what the physicians were complaining about were prices that were deemed to be too low. And he observed that the Sherman Act had been enacted to protect consumers against prices that were too high. Judge Breyer declared, "The relevant economic considerations may be very different when low prices, rather than high prices, are at issue. These facts suggest the courts, at least, should be cautious and reluctant to condemn too speedily an arrangement that, on its face, appears to bring low price benefits to the consumer."

And I would suggest that -- and Judge Breyer suggests -- there's no need to blaze new trails in this area. I would suggest, as I described below, that that same caution should apply in considering any kind of special treatment along the accounting and market power exemption.

Before addressing the practicalities and policy considerations of such an exemption, let's first ask whether it's really needed to enable physicians to effectively bargain with health plans. And the answer, for a number of reasons, is no.

First, given the large number of competing health plans and the importance of government payers who provide, let's say, about half of the revenue for most physicians, it's doubtful if there are any markets in which a single private health plan has a monopsony power. And I'm not going to go into that whole debate, which has been addressed a fair amount here already, but it's certainly clear that even in the most highly concentrated health plan markets, the largest health plan accounts provide a minority of revenues to providers.

Second, and Monica pointed to this in her presentation, it's often the

case that physicians are the ones in the market that have substantial market power. Certainly in rural areas, physicians can constitute a majority -- sometimes 100 percent -- of the physicians in a given specialty and there may be no substitutes to whom payers can turn to. And that can also apply in urban areas, where there are now single specialty practice groups that can comprise 20, 30 or more of single specialty, and they're really a must-have for health plans to be able to effectively compete.

Moreover, the recent trend in which consumers have been expressing strong preferences for broad provider networks, has significantly limited the ability of health plans to market networks that do not include a very wide selection of providers. And, in fact, that's also a reflection of the fact that the health plans have to -- basically they're being affected by market pressures and they're having to change the kinds of products that they offer.

Third, the FTC/DOJ statements of antitrust enforcement policy make it clear that physicians can collaborate under existing antitrust laws in a number of ways.

First of all, statement four provides that they can express their concerns about patient quality and care issues to each other and to health plans. There's a safety zone for that under another section of the guidelines. They can communicate with each other about price and fee-related issues. They can take surveys and, in fact, recently DOJ and FTC each issued an advisory opinion or business review letter, essentially, blessing efforts by -- in one case in Washington State and another case in Ohio -- efforts for doctors to survey each other and actually publish their average reimbursement rates from specific payers.

Fourth, the antitrust laws can allow providers to share information with each other so they can make better-informed decisions when they contract with plans. They can provide -- get objective information about the interpretation of contract

terms and they can have contract terms arrayed against each other. The AMA, for example, has a staff and a website that provides advice and offers to consult with health plans and how they can assess contracts.

And, lastly, physicians can and do form together to form partially integrated joint ventures that allow them to remain an independent practice or they can merge, but they can also just stay in an independent practice and form IPAs or other ventures to collectively negotiate with health plans.

And some of these IPAs can consist of 500 or 1,000 or even more doctors. As we see with MedSouth, the groups don't even need to be financially integrated, they can be clinically integrated.

But these ventures, unlike cartels, have at least potential for efficiency. I'm going to return to that point in a bit.

And, finally, the health insurers, themselves, are regulated. These regulations often address their provider/insurer relationship and, so, they insure that health plans, no matter what their size or market share, will be closely scrutinized.

So, I don't think there's a need for a countervailing market exemption. But let's say we wanted to do it. Let's turn to could it be done? Is it practical? And I think the answer is really no. First of all, we have to start out by acknowledging, as I think all the panelists said, that this is not a one-size-fit-all solution. Even if you buy the notion of a countervailing market power exemption, we have to find a health plan that has market power and just fit it to that health plan.

Well, how would one decide that? There's certainly been a lot of debate already about whether health plans anywhere have a monopsony power or market power. So, you'd have to go into a market power assessment in a specific market about whether that plan has market power.

Who would do that? How would anybody in my position, who's counseling providers as well as health plans, how would we assess whether, on a going-forward basis, the health plan had market power? How would we give advice to our clients whether it's okay to engage in conduct which, if we were wrong, is per se illegal and may be subject to criminal prosecution?

Maybe we ask Mark Tobey for an advisory opinion. He's going to address doing this in Texas. The agencies are making advisory opinions. The business review writers typically don't try to make any kind of judgment about whether a plan or a provider has market power. They accept as given the facts of the requester and say assuming that, this is what we think our present intentions are with respect to enforcement. This has been an extremely difficult proposition to undertake.

We would also have to consider how many physicians and what physicians should engage in countervailing market power. Should we give them all an exemption, 100 percent, or some portion of that? I've seen one article by a Warren Grimes who talks about -- favorably, he's an advocate of market power exemption -- and he says let's limit that to 20 percent. Well, 20 percent of what? Each physician by each specialty? How would we define that market? How do we do that prospectively?

Even if we were able to determine that we wanted to do that and could do it, we'd have to talk about what would we do in terms of supervising the bargain that was struck. This would allow a countervailing market power exemption that could shift all the power to the providers and they could raise their prices to monopoly levels. And they could also do other things like disadvantage their own competitors.

In our coalition, we have nurse midwives and nurse anesthetists who are concerned that with joint negotiations they're going to be the ones left out, and

allowing physicians to jointly negotiate with health plans would allow them to be subject to that kind of discrimination.

There's also the issue of spill-over effects. Even if we accept that there is a large dominant health plan, presumably we only want to have the physician group that's negotiating with them just to have the ability to collectively negotiate with that dominant plan. What happens when they go to all the other plans in the market? Do they just forget the rates that they have just been talking about and negotiating together with the dominant plan?

I would suggest that no, in fact, what they would do is take that rate which would then become at least the floor for any other plan with which they are negotiating, and it would actually have the effect of making other plans -- making it more difficult for them to enter and compete. Thus, the net result would be higher prices for all health plans, whether they're large or small.

Finally, coming to the final point, as you may have surmised, my view is that providing countervailing market power exemption is simply bad public policy. It would result in higher prices for consumers for two reasons. First of all, I think physicians would undoubtedly be able to raise their negotiated fees, and for the most part, these fees would not reflect increased output or quality but simply a transfer of wealth from consumers to doctors.

And, second, a countervailing market power exemption would dull the incentives that existing antitrust laws currently provide to physicians to form joint ventures that at least have the potential to produce substantial efficiencies. In practice, we often have providers come and say we'd like to negotiate collectively, and we go through a discussion of what you need to do, and maybe they're brought kind of kicking and screaming, but they realize that if they want to negotiate collectively, they do need to

form joint ventures that have some potential to create efficiencies, and that's a good thing. If we take away that incentive, then all we have is physicians coming together and creating a cartel with no potential efficiencies to be produced.

In conclusion, you know, our health care system is increasingly relying on a competitive marketplace to reduce health care costs and improve quality. Toward this end, our focus should be on more vigorous antitrust enforcement, not less. A countervailing market power exemption would be a giant step in the wrong direction. It's not necessary. It's impractical. It would ultimately be harmful to consumers.

Thank you.

(Applause.)

MR. BERLIN: Mark Tobey?

MR. TOBEY: Thank you all for inviting me. I guess I'm the first one that has to give a disclaimer. I work for the Texas Attorney General's Office and any observations or views that I have or will make here today are my own and do not necessarily reflect those of the Texas Attorney General's Office.

Let me give you an overview of what I hope to talk about today. I'm going to talk about the real world. I'm going to talk about the Texas Physician Negotiation Statute, which was passed in 1999 and the approach that we've taken with that statute. I want to talk about the one application and review what we have done since the statute was passed.

It involved a group of 11 physicians in rural East Texas who wanted to negotiate with Blue Cross and Blue Shield. We did the analysis that was required by our statute and set forth in administrative rules that we developed, and we found that Blue Cross and Blue Shield had substantial market power in that market. We're talking about a local market, a three-county market in East Texas. And we found that the physicians,

based on the data that we reviewed, the interviews that we conducted, the information that we gathered, did not have enough market power to worry about their jointly negotiating with Blue Cross and Blue Shield.

I'll get to the end of the story. The end of the story is under our statute, joint negotiations are voluntary on the part of health benefit plans, and Blue Cross and Blue Shield chose not to negotiate. There were some negotiations that occurred outside of the scope of the statute, but they chose not to negotiate. So, that's the story I'm going to tell. That's the real world. That's the world from what we call east Texas, behind the pine curtain. So, I hope to share some of our experiences with you.

Let me talk a little bit first about the statute. It is expressly an attempt to address what is viewed as monopsony power by health benefit plans. It allows physicians to apply to the Attorney General's Office, and I'm in charge of the antitrust section there, and I'm in charge of implementing our statute. They apply to the Attorney General's Office for authorization based upon the state action approach to jointly negotiate with specific health benefit plans over specific terms and conditions. Those terms and conditions can include fee and nonfee.

If they want to negotiate over fee conditions, they have to show two different things. They have to show first that the health benefit plan has this term "substantial market power," and they have to show that those fee-related terms and conditions have adversely affected or threatened to adversely affect the quality and availability of patient care. The statute leaves it up to the Attorney General's Office to decide what is substantial market power on the part of a health benefit plan.

The Attorney General's Office has to make a determination based on a standard set forth in the statute. That standard is the Attorney General has to determine that the applicants, the people who want to jointly negotiate, have demonstrated that the

likely benefits resulting from the joint negotiation, or we also review any contracts that result, outweigh the disadvantages attributable to a reduction in competition that may result.

Just a side note, I believe our statute was based on an AMA model statute. There were a number of states that considered statutes of this type in 1999. Texas was the first one that passed such a statute, and a number of states, I guess, are still actively considering this approach, this legislative approach using state action to deal with countervailing power. It has been passed in New Jersey. It has been passed in Alaska. It's my understanding that there is a type of statute like this that precedes the Texas statute in Washington State.

Now, back to the Texas statute, and then I'll talk a little bit about how we implement it, the statute itself says, in terms of the physician group that wants to negotiate, it gives some limits and a bit of discretion to the Attorney General's Office. The limits are that the physician group can be no more than 10 percent of the physicians in the health benefit plan's defined geographic service area, and that the Attorney General can vary that number up and down and directs the Attorney General to consider distribution by specialty. So, we have some guidance from the legislature on how big the group can be.

It sets forth a process that the physicians that are jointly negotiating must abide by, and that process is one in which there are also some safeguards. Among them, there has to be an opportunity for the health benefit plans to contract individually and on different terms with members of the group. In other words, the group can't be an exclusive negotiating vehicle expressly. And then, again, it is not set forth in the Act, but its absence indicates that there is no requirement on the part of health benefit plans to participate.

A number of other parts of the statute -- and I'm covering these really because of the concerns that had been raised about unbounded cartel conduct authorized through legislation -- a number of other features of the statute have protective aspects. There's an express prohibition in the statute against jointly coordinating any cessation, reduction or limitation in health care services. And the physician's representative, who is actually the negotiator for the group, is required to warn the physicians that any conduct outside of the scope of the statute may be subject to legal action.

There's another provision in the statute that says, "Joint negotiations cannot be used to restrict non-physician health care providers," and I'm quoting here, "based substantially on the fact that the health care provider is not a licensed physician."

The approval process is one in which the Attorney General has 30 days in which to decide. We have written rules that give us some flexibility on 30 days. And if we -- we have to approve or disapprove. If we disapprove, then we have to state what the deficiencies of the application are and how those deficiencies could be remedied. An approval shall be effective for all subsequent negotiations, and there is a plan that we have in place for dealing with subsequent contracts, subsequent negotiations, and lapses in the negotiations.

The Texas rules -- and I'll just hit on a couple of points here -- really take as their basis the health care guidelines from the Justice Department and Federal Trade Commission, the advisory opinions and, as was mentioned, the State of Texas -- and I don't mean to say that we were the only ones involved in the Aetna-Prudential matter, it was primarily conducted by the fine folks at the Department of Justice -- but the analysis -- the monopsony analysis from the Aetna-Prudential case, that was a case that was going on, a review that was going on at the time our legislature was debating this statute. That monopsony analysis really wasn't touched on for how we chose to

write our rules in order to look at each physician's book of business and try to determine whether the subject health plan had the ability to lock those physicians in.

In my prepared remarks, I talk both about the evidence that I think we saw in the Aetna-Prudential case of doctors in Dallas and Houston being locked in and the evidence that we gathered from interviews in the Henderson matter of physicians in the joint negotiation group in Henderson being locked in. This is an effect of monopsony pricing.

Our approach is that we granted this application because we found, based on the available evidence, that Blue Cross and Blue Shield in this three-county market had both monopoly power on the selling side, they were by far the dominant seller of commercial health insurance in that market, and monopsony buying power on the buying side, and as in the Aetna-Prudential case, we found in the case of the Henderson physicians that under those circumstances, and because of the nature of the medical practice, with the high switching costs and the long time in which it takes to replace patients and the fact that physician services cannot be stored, that the stories that these physicians told us about having to cut services, to spend less time with patients, to use more non-medical personnel in treating patients, were credible, were consistent with what we understand to be the theory of monopsony effects.

The Henderson group received our authorization to negotiate in late August of 2001. No negotiations ever took place. We withdrew our authority in the fall of 2001. There have been no other applications to the Attorney General's Office to jointly negotiate. There have been proposals to change the Texas law. There have been issues raised -- and I cover this a bit in my observations -- about whether the rules are too burdensome, about this issue of physician -- or rather, health plan participation being voluntary. It is my belief that the legislature is in session right now,

that the Texas statute will be continued through 2007 in its present form without substantial changes.

I think there are some things to be said about the approach that Texas and several other states have taken. I think it's a reasonable experiment. It's an experiment that's worth trying. As was discussed here, instead of it being a national strategy, it is a case-by-case approach dealing with local markets. It is one in which there are a lot of safeguards built into at least the Texas statute. I've described some of those. I believe I have seen in the Aetna case and in the Henderson review anecdotal evidence of lock-in that can affect or seems to be able to affect quality of care.

A couple of other points, I guess I am all ears today. At this point, I have not seen really solid economic evidence that if countervailing power is given to jointly negotiating physicians that it will necessarily result in benefits to patients in terms of quality of care, but I'm all ears and hope that I hear some interesting information at this hearing and the other hearings the FTC and DOJ are conducting.

I don't think it's practical to require health benefit plans or HMOs to mandatorily negotiate, and I can go into that some if there's interest in that. Our rules are considered to be burdensome, but I will tell you that we worked very hard over nine months to deal with that and that that is inherent in the state action approach. I think there may be some other issues, some other ways to deal with some of the doctor contracting problems that we continue to hear about that are outside of the sphere of countervailing power, even outside of the sphere of antitrust law, and again, if the discussion turns that way, I'll be happy to go into those matters.

Thank you.

(Applause.)

MR. BERLIN: I'd like to thank each of the panelists for cutting down their

presentations. I know everybody had a lot more to say, and actually, I apologize for not letting people go on longer here, but we do have some time, we will take a ten-minute break, come back at 11:15, and that will give us an hour for a round table discussion.

(A brief recess was taken.)

MR. BERLIN: We'll try to get started if everybody can wander back to their seat or the table.

Okay, I guess I'll start off with the first question, and this one I guess goes a little bit more to the practical than the theoretical, but I have some of those, too. I'm more likely to be confused on those. This really is for anyone, and perhaps we'll go in the same order if anyone wants to comment.

What mechanisms are there or could there be to give providers countervailing market power other than collective bargaining under some statute, which has been the focus of most presentations and most attention in the media and whatnot? And how would those other mechanisms compare, what are their relative benefits or draw-backs? And I'll just throw out a few that we've heard here, like one would be some sort of integrated joint venture, like Don talked about and, you know, perhaps that's superior because of the halo effect that it might have in terms of efficiencies.

A new safe harbor and a new health care policy statement or safety zone, I guess we called them, use of business review letters, price and conduct regulation, like Stephen Foreman mentioned, or maybe some non-antitrust-related solution, but what other mechanisms could there be out there that we ought to be thinking about?

And, Marty, I'll give you the first chance to either accept or pass.

MR. GAYNOR: Well, just briefly, to reiterate, obviously integration is an option, and I thought Steve's mention of regulation was important for a couple

reasons. If we think about collective bargaining, as we normally think about it, that is a very heavily regulated process. The labor laws have very, very specific regulations and requirements, restraints on what the parties on both sides have to do, not that that necessarily has to be a perfect model, but if we don't think that the market alone can do it, then regulation of some sort is an issue.

I want to reiterate, I don't think that unregulated collusion is a good option, though.

MR. BERLIN: Okay.

MR. LANGENFELD: The main policy prescription that I offered up in my comments was to be -- was focused on business review letters and advisory opinions as an initial step. I think that taking into account where it may arguably at least exist where you have monopsony power, that that should be taken into account in making determinations as to what's allowed explicitly, and to the extent that -- because that really is a case-by-case approach, which would be the only justification in my mind given the information that's out there as to how the markets work.

In terms of adjusting the safe harbors, that might be -- it might be a possibility, but that I'd be more cautious on, because once again, I just don't see in the evidence that I've reviewed over the years that there is a systematic problem here across all of these local markets.

MR. BERLIN: Steve?

MR. FOREMAN: Yeah, I think in some ways the monopsony/monopoly problem, which we think is actually a problem in a lot of markets, is a problem in search of a solution. The things that we've started to offer are, you know, ways to start thinking about this. Some kind of countervailing power response has the advantage of being a market type of solution that doesn't require constant review and

regulation, I mean, so that's why we gravitate in that direction.

There's something else probably that's worth throwing on the table, and that is in an enforcement context, where you have a monopolist -- a monopsonist/monopolist player, some kind of unclean hands/equitable estoppel doctrine probably ought to apply to that player, because you know, the flip side of that is if you then are enforcing actions against, you know, that smaller player who is that victim in the first step, you know, now in some ways you're actually extending and enforcing the monopoly/monopsony conduct. So, we think it's probably worth exploring, you know, some kind of estoppel type of approach.

MR. BERLIN: Okay. Monica?

MS. NOETHER: I think the notion of developing integrated joint ventures where one can demonstrate effectively that there are pro-competitive efficiency benefits from, say, clinical integration or risk-sharing or things like that. But at the same time these joint ventures may potentially give the group of providers somewhat greater negotiating authority, but it's, as I say, offset with these pro-competitive benefits, can certainly have a place in making markets work better, but I think, as with everything, one has to weigh the pros and cons of the enhancement of market power versus the efficiencies.

They are individual situations depending on the local markets, so I think the continued use of the business review letters and the advisory opinions to flesh out the particular circumstances that lead to recommendations for particular markets is certainly helpful to all of us in thinking about these issues.

MR. BERLIN: Thanks. Don?

MR. CRANE: I would agree with Monica. Yeah, we're urging a more enlightened, I guess, advisory opinion process, as I was earlier arguing, and clearly

where you're linking kind of the collective bargaining to the efficiencies that come from clinical integration and a harnessing, as we've suggested, basically the halo effect is a specific recommendation we'd make. All of that has to be contrasted with, you know, just bare, naked cartel, where collective bargaining is unconnected with any kind of efficiency, any clinical integration, that we obviously, you know, would argue forcefully against. So, I think it's the advisory opinion process, yeah.

MR. LEIBENLUFT: I guess I would like to say I don't think it is the advisory opinion process, seeing Judy Moreland out there. I think, having been the author of some of those opinions and knowing that process, it is very difficult I think for the staff, at least in the Federal agencies, to really understand the market to the level they would need to to make a reasoned advisory opinion on market power issues.

I mean, that really requires a lengthy inquiry, lots of investigation, lots of economic input, and then at the end of the day, in many cases -- maybe we're talking about ten physicians in -- what was it, East Texas? -- that might be an easy case. But even that might not be an easy case when we start looking at what specialties those physicians are and who are the alternatives, because even a couple of physicians could have market power. So, I think it's really very difficult on a prospective advisory opinion basis.

I think on the individual consideration -- I could understand, for example, with merger review or reviews under the rule of reason where the providers might want to make the argument that there won't be competitive effects because of the dynamics and who they're negotiating with, and I think that's possibly an area where that could come into play, but other than that, I would be very reluctant up front and I think it's hard to give a fast market power analysis or something in a practical way.

MR. TOBEY: I don't think I have anything to add on the big question. I just

wanted to respond to Bob's suggestion that perhaps he should ask us for a business review type letter. We don't do them.

MR. LEIBENLUFT: I know.

MR. BERLIN: And before I let Sarah ask a question, I think there are probably a lot of people back in my office that will thank Bob for throwing some cold water on the whole business review idea.

MR. MATHIAS: I have kind of a similar I guess practical question. Let's assume that Congress does decide to allow physicians to get countervailing market power and the agencies would have to decide very quickly, let's presume within 30 days, like Texas, whether or not they're going to allow the physicians to organize to negotiate.

Are there one or two indicia that we could look at to say yes or no on market power and the considerations here, because it would -- you know, and I'm just looking for any suggestions that people might have that we could weigh and consider if we ever were faced with that situation, and it looks like Jim has an answer.

MR. LANGENFELD: Well, I'll start, and then I'm sure we'll hear from everybody.

I think the answer to that is -- and let me step back, similar to Monica, I and LECG did an analysis that predicted price increases through across-the-board antitrust exemption, and so that's my background, and it was post the initial study that Monica and CRA did, but it found similar results using slightly different methodology, but I'm not for that.

But if that was -- if it was -- if you're looking for criteria similar to the type of thing that Mark tries to do and has done in Texas, there are -- I think the first step is to try to figure out what the market is, and that's the type of thing that perhaps the

agencies could come to some rough and ready conclusions on.

In general, it's either going to be managed care, whether you can exclude the Federal programs or not, if you're really interested in private, which frequently in hospital analyses you're focusing just on the private aspects of it. You can -- some rough cuts should be made across the board on what the product market is.

The geographic market is going to be more difficult, but you can do the same type of -- you can look at the same type of indicia that you look at in a merger. You can look at how concentrated the market is. I mean, one of the problems in dealing with -- and I think this was raised at least by a couple of people -- one of the problems in dealing with any monopsony power, assuming it exists in any of these markets, is that it may not have been gotten through any anticompetitive behavior, but that doesn't mean necessarily that a concentrated, small number of bargainers won't be able to exert some type of power there. And so, looking at concentration would be another quick thing to look at, obviously.

A third thing would be to look at barriers to entry. Some states have -- it varies from state to state, but some states have more difficult -- have more complex and harder rules for someone to get into a market as a payer. So, you would want to look and see the basics to make sure whether those necessary conditions were there.

Beyond doing that, I think that it would be difficult to do any of those things, anything more sophisticated than that in 30 days. Gosh, I've been through this process, okay, and I still think that your staff should take that additional step and address these issues when doing business review letters, but -- and I can sympathize that you don't want to, but I do think that you could look at those basic, necessary conditions, and at least that would give you a filter to say whether you would even consider allowing the exemption.

MR. MATHIAS: Okay, just one quick administrative thing, and I think a couple of different people may want to answer this.

It helps us just to keep the order if you turn your tent so we know to call on you. It sounds silly, but that way we don't ignore you, and when my back is sometimes turned, I could then see your desire to participate. I already knew that Steve wanted to talk, so we will let Steve go and then Marty.

Go ahead.

MR. FOREMAN: I wanted to agree with that in large part and also note that, number one, this analysis is essentially comparative. I really believe that market power concerns both the power of the seller and the power of the buyer, and that's probably a little bit of a new concept.

In some of the work I've done, the core to profit levels is a combination of size and market share. Either one independently won't get you large levels of profits, but if you have both, you get them.

So, as a sort of rough rule of thumb, if you wanted to consider market share of the monopolist/monopsonist sort of as some kind of bell weather and then size, you know, to make that work, and then consider from the physician group what proportion of physicians has come together and how that compares to the size and share of the monopsonist firm.

MR. MATHIAS: Marty?

MR. GAYNOR: Just two points. I'm not going to cover everything.

One, I want to emphasize again that it's absolutely critical to try to determine insofar as possible whether, indeed, in this case there is monopsony power on the part of insurers, and allow me to make two quick points about that.

The critical measures in terms of traditional market share are market share of

services purchased, services bought, not market share of insurance products sold, and the reason I mention that, that can lead to very different measures. So, think of a doctor's practice. A doctor practice sells to a bunch of private insurers, say a Blue Cross plan, an HMO, a PPO, they also sell to Medicare and Medicaid. Depending on the exact product market, the exact nature of the service, there may also be other buyers. And so that's critical to consider. The product market has to be carefully defined -- again, remember, this is for product being purchased -- and market shares then measured.

One other point, again, it's not necessarily true that countervailing power will improve matters even in the presence of monopsony power. It can be true, but it does not have to be true. Whether -- one -- a precondition is that the bargaining between the cartels on both sides of the market or the entities on both sides of the market will get the efficient solution, but that's not necessary, not sufficient, and let me talk about sufficient.

Sufficient in this case means that the health insurer will then pass on any savings to consumers, and one thing that could be examined then is the nature of conduct and competition in the end retail market, in this case for health insurance. If it doesn't look like that's a very competitive market, you can have all the countervailing power you want, both upstream and down stream, but it's not ultimately going to benefit consumers.

MR. MATHIAS: Monica?

MS. NOETHER: Well, again, two points. The first one is really reiterating Marty's first point, that looking -- you do need to look at -- when you're thinking about whether plans have monopsony power, you need to look at what their importance is to particular physicians. And so in this case maybe perhaps the quickest

indicia that you might get is to look at the physician group in question and try to get information on the share of revenues that particular plans represent of their total revenues, because here, you know, while there may be a market for private health insurance from the perspective of employers, from the perspective of the physicians, one should be thinking about all of their sources of revenue in here, so the public payers are going to be important.

So, getting information on shares of the revenue of the private plans in question relative to the -- where the denominator is essentially all sources of revenue to the physician practice.

Second, looking at the physician market to see whether, in fact, they are -- whether there is competition among the physicians at the beginning and trying to look in the particular market -- and this is where you have to take into account the particular definition of the local market in question -- what's the distribution of physicians across practices, by specialty, those kinds of things that at least give you some indication of is there a particular physician group that -- sort of a must-have physician group in a particular community? Does it already likely, probably, have very good bargaining power if it's, you know, one that everybody wants on its network, or is it the case that you've got a, you know, very disparate set of physicians?

And, finally, I will echo Marty's caution that even if you have situations where it suggests that health plans could exert monopsony power and physicians, in fact, have no market power at all, that doesn't necessarily mean that you're going to get to a better outcome.

MR. MATHIAS: Mark?

MR. TOBEY: That's all very good advice. Let me just give the practical side of it. Don't be in a box to do this in 30 days. Our statute doesn't require it. The way we

interpret it -- I've seen some other state proposed statutes that try to tighten the requirement up. Let me explain a few practical problems that I think, you know, may mean that you can't do it in that time regardless of whether you focus on the right things that the economists tell you you should be focusing on.

We have to get our data from the doctors, basically, and I will tell you, many of the doctors that we've dealt with don't even have their contracts. They don't know what they're supposed to be paid. And, sure, you would like to know what the reimbursement trends across insurers are in the marketplace, that's very important, and you'd like to know what each of those insurers pay each of the doctors in the negotiation group. That takes a long time. Even data that you think or that I thought would be easy to get, like concentration data on PPOs, is not all that easy.

So, I would urge any of -- anyone in a position of having to do one of these quickly to try to get relief.

(Laughter.)

MR. BERLIN: Okay, as I promised, I will attempt to move from a practical to a more theoretical question, and as someone said, if you don't remember it, at the beginning, this is where lawyers, particularly I, get confused.

My general question, though, is how would permitting collective bargaining or perhaps one of these other mechanisms for giving providers countervailing market power benefit consumers? It's easier for me anyway to see how providers would benefit from the situation in the form of higher payments from payers, but how does the higher input cost potentially benefit consumers at the other end?

If I can link that up with some other questions and just really leave it to you all to address it in turn or address it in some other way, but Steve I know said that a price increase to providers wouldn't be passed through and result in higher consumer prices

when it's being passed through by a monopolist or monopsonist, so I'm not sure if that makes a distinction, so that's an idea to be debated here on this point.

Or, if you accept the fact that there are higher prices but the rationale is that it's just a re-allocation -- and I might really be getting in trouble with the economists here -- a re-allocation that's not welfare-reducing, if I'm right about that or if you accept that, is it somehow, however, still bad public or bad social policy to have it be re-allocated to higher prices to consumers, if that's something you think will happen?

And finally I'll throw out, I think Mark raised this at the end of his talk, you know, are there quality of care implications as well in this whole equation?

So, I guess we'll start with Marty.

MR. GAYNOR: Okay, yes, so, as Bill rightly understood, the question is not whether it works in practice but will it work in theory, and so let me try to address that briefly.

What's the possible gain? Well, think about it this way. Suppose there exists monopsony power on one side of a market, what does the monopsonist do? It restricts quantity. And in particular, it restricts it below the quantity that consumers would like. So, there are goods or services to be sold for which the benefits exceed the costs.

Well, if you give countervailing power on the other side of the market, if you allow monopoly power on the other side of the market, potentially the entity with monopoly power and the entity with monopsony power can reach an agreement to provide those services for which the benefits exceed the costs, because those are going to be profitable, and then the only question is how they split those things up. So, that's the potential. That's how potentially it could work.

Now, as I said, I want to emphasize, it does not -- this does not have to happen.

That will only happen under certain circumstances. I think one thing to think about in the eventuality that this is real is practically how would you make that happen? And I think that while it's not an antitrust matter, looking at the -- how collective bargaining agreements are enforced and where they work well and where they don't is something to think carefully about.

Now, again, that's not what we conventionally think of as an antitrust issue, but if we're going to implement regulations -- like it's probably more a regulatory issue, it's something that we will have to consider. Although the Texas statute does not have binding arbitration in any way, shape or form, it might be that a form of binding arbitration actually would be important if we wanted to try and achieve these gains. And I want to emphasize, "if, if, if" in all of these.

Second, let me reiterate that even if that's the case, whether consumers are going to gain will ultimately depend how competitive the output market for health insurance is, and actually Steve and I had a brief discussion offline at the break. I think we agree that it's not a question really of whether a health insurer with monopoly power will pass on or pass through a cost. They will. Theory, indeed, tells us that they will. They just won't pass through as much of them as a perfect competitor would.

So, be that as it may, the more competitive that market is, the more gains consumers realize. So, again, that's actually not just a theoretical but a practical matter to think about.

MR. BERLIN: Jim?

MR. LANGENFELD: Considering we're going to talk about the theory, the key things that drives the output expansion, which is what you're looking for, if output expands, then in virtually all economic models, you're going to end up with consumers eventually benefiting, all right? So, your question as I take it from a theoretical point

of view is, how could that happen? It's very simple.

If you have an upward sloping supply curve, that is to say, if more supply is introduced in the market because of higher prices offered, you're going to induce that shift. You're going to get the output that's going to come from that increased supply at a higher price, and that's really the driving mechanism. That's why -- and because you're directly offsetting that reduction in sloping down the supply curve, you're getting around the artificial restriction on quantity by paying basically a lower price.

MR. BERLIN: Steve?

MR. FOREMAN: Having been accused of being a cross-over, let me disabuse everyone of that.

A couple of points here. How would better physician prices result in benefit to consumers? I'm going to go back to the practical for a second and then talk about the economic theory.

Better physician prices will induce better people to go to medical school, will induce all kinds of physician investment in technology and innovation, and this will have a consumer effect, and in fact, more physicians that may come into the profession, improving access to care. So, there can be effects there.

Now, from a welfare standpoint, the welfare equation includes both consumer surplus and producer surplus. So, one should look at both of those. The supply effect is, you know, what Jim and Marty have already discussed. But you know, even if this is welfare-neutral, now the question is, do we have a preference as between insurance companies and physicians? And sort of the status quo says we have a preference for insurance companies. You know, I'm not sure that's a good preference. We actually think that as between the two, you ought to at least be value-neutral or prefer physicians.

MR. BERLIN: Okay, Monica?

MS. NOETHER: A final sort of footnote on the argument that's been expressed already that the major beneficial effect to consumers will be an increase in quantity of services provided if -- in situations where monopsony has led to shortage relative to a welfare-maximizing amount, and some might argue that the utilization tools that managed care tried to put in place and did put in place in the nineties to ratchet down expenditures essentially were monopsony actions that reduced output below competitively optimal levels.

However, I think in health care we have to remember that what the right quantity of service consumed is is in some sense in the eyes of the beholder. It's not a homogeneous product where -- and the consumers are certainly not homogeneous, so that coming up with the sort of welfare-maximizing quantity of output is not an easy concept. So, I think that's just a wrinkle, perhaps a practical wrinkle to the theoretical debate, but something that is, I think, a difficult thing to get one's hands around.

MR. MATHIAS: Marty?

MR. GAYNOR: I'm sorry, just briefly, one response.

I want to -- it's -- I don't completely agree that higher prices necessarily call forth a greater supply. The question is, how did you get the higher prices? And one way to get higher prices is by restricting supply. So, it's not necessarily true. That can be true, but it does not have to be true.

Also, I don't necessarily agree that better prices -- or I'll just say higher prices -- lead to better doctors, necessarily, more doctors or better technology. That can be the case, but that is not necessarily the case. So, these are possibilities, but far from definite.

MR. LEIBENLUFT: Just to echo a little bit of what Monica was saying, in

Judge Breyer's opinion, one of the reasons why he said let's not jump into efforts to tinker with what we normally don't try to do, which is to try to give more concerns about prices being too low, was he mentioned -- this was a case involving medical care and medical care has a lot of complexities, and I think we really have to be careful about concluding that increased utilization, more services, is a good thing.

In fact, particularly where physicians have so much power as to how much services are being rendered, one of the things that managed care has tried to do is constrain unnecessary services. Concluding that the increase in services is a good thing, I think is not necessarily the case, nor particularly in the case of more doctors. I mean, there's a real maldistribution many people think of doctors across different specialties, and I'm not sure how increasing prices to groups would necessarily remedy that in terms of a good public policy goal.

MR. MATHIAS: I have a potentially quick question for Mark.

Why is it that you think that your statute's not really being utilized by the physician groups?

MR. TOBEY: I have heard that they feel that our rules are too burdensome, that the process is too expensive for them both in terms of time that they have to put in and potentially economists or something like that that they would have to hire. I do take issue with that, not with the notion that it's not a good idea to hire economists, but with the notion that our rules are unduly burdensome.

As I said in my prepared remarks, I think that's an inherent feature of the state action approach. If push comes to shove and physicians to whom we've given the authority to jointly negotiate are hauled in front of a court, accused of price-fixing by whomever, it will ultimately come down to what we did in the way of active supervision. So, I think that's what I've heard at least.

MR. BERLIN: Actually, Sarah's question is a good segue into the one I had down next, as well, and you'd think that we were colluding, we probably ought to be since we're the co-moderators, but haven't been either, and my question is actually back to you, Mark.

What specific problems do you see or whether or not you endorse them have you heard about the statute there in Texas that you're enforcing, and I was going to ask the question broadly as to problems for providers, for plans or for you as an enforcer --

MR. MATHIAS: Or consumers.

MR. BERLIN: -- or consumers, if you've heard that, and then turn the question to Stephen and see if you have any insight on the situation in New Jersey, given proximity, if nothing else, to Pennsylvania.

MR. TOBEY: Well, we've heard of problems raised that, hey, what is the point of going through the burdensome rulemaking process if the health plans don't have to negotiate? And my response to that is -- and again, I will base this not on theory but on what actually happened in the situation with the Henderson doctors.

Yes, Blue Cross and Blue Shield did not negotiate. They did not negotiate within the framework of Chapter 29 of the Insurance Code, which was our joint negotiation statute, but they did initiate some messenger model negotiations with the Henderson PHO that a number of these doctors were members to.

They were very concerned about public opinion and even some -- the opinion of some members of the Texas Legislature that they should be engaging in the process. That was a very, very strong factor and a very strong force on Blue Cross and the potential threat that something more serious would happen if the insurers don't play ball.

My other response to the issue of, you know, it's not mandatory -- and I'm

intrigued by Marty Gaynor's, you know, observation that maybe you have to have mandatory arbitration to ensure that the benefits are realized in a process like this, at least in theory -- but my other response is that I don't know as a practical matter how you do that. There was a California statute that went nowhere that essentially set up an agency in California that would study, would have experts, would impose terms, and you know, that might be one way to do it, but I think that that's a way that involves a highly regulatory, very bureaucratic approach to all of this.

MR. BERLIN: Steve, I'll turn it to you, and I'll actually add to the question to save time, and you're --

MR. FOREMAN: On the fly.

MR. BERLIN: -- exactly, and you probably would have responded to this anyways, but your views on a good faith bargaining requirement, and if that's the type of mechanism we ought to impose on the plans, should we at the same time impose it on the physicians as well?

MR. FOREMAN: Let me set the context for this in two ways. Number one, I have worked with the New Jersey Medical Society sort of modeling the economic impact of the New Jersey statute, I don't know if I told you that or not, but just to agree in some ways, if at the end of this it's totally voluntary on the part of the insurer whether or not it's going to negotiate, you're asking the physicians to spend a lot of time, a lot of expense, and then the insurer just sort of shrugs and walks away. That's kind of not much of an act. I mean, I understand the public view of it, but, you know, by and large, I mean, the investment involved for a possible return here is, you know, not something that I think you'd ever advise a client on, hiring economists notwithstanding.

Parenthetically, there is no duty of good faith and fair dealing on the part of

insurance companies. In fact, we have a case at the Common Pleas Court level. You knew they were bad people because you've continued to deal with them for ten years, so don't come complaining to us now, that the way they interpret their contracts is unfair. So, you know, that sort of says to me, well, maybe they should have a duty of good faith and fair dealing. We all do, I thought, at least I sort of think physicians do.

So, to add to the end of that, yeah, I think physicians ought to be, you know, working from a good faith and fair dealing standpoint if that's responsive to your question, and you know, sort of the tag end of it, to put the rest of the context on it, you know, most of the physician contracts in New Jersey and Pennsylvania are imposed, they're not negotiated. So, you know, maybe -- at least as a going-in proposition that, you know, at least requires a negotiation, you get an improved -- some kind of improved result here rather than just a fee contract that's imposed at a level that's, you know, that's really questionable.

MR. BERLIN: Sarah?

MR. MATHIAS: This question is for Monica, and on your chart on one of your graphs, you had the payment of premiums increasing since probably about, I think, it was '98.

MS. NOETHER: '98 -- yeah.

MR. MATHIAS: Yeah. Actually, starting in about '96 it looks like. And it seemed to -- and maybe this is wrong -- but to me, I kind of took away that you were saying most of that increase was solely attributable to higher payments going to the providers, and I was wondering if there were other factors that come into play into the rising premiums that we should be looking at and not just saying it's providers, or maybe I took it too simply, but...

MS. NOETHER: I think the general understanding is that a lot of it does -- is

resultant -- from people who have studied it more carefully than I, is a result of higher payments to providers, both -- not just higher prices necessarily, but presumably also increased utilization, as some of the utilization controls have been relaxed.

There is this insurance underwriting cycle that lots of people talk about, and it's not clear that it's ever been well understood, where profits tend to go down. They reach a point where all the plans are losing money, and then things start to turn around, and there may be some of that going on, but if we look at insurance company profits, while they may be slightly more healthy than they were a few years ago, they are certainly not robust at this point in time. So, the suggestion is that it's mainly a cost-driven phenomenon.

MR. MATHIAS: Don?

MR. CRANE: I would like to add to that discussion about the increased premiums we started to incur in '96 and beyond. In 2002, as I understand a study in California, the medical cost inflation was something like 15 percent or something like that. Of that, something on the order of 51 percent of that increase was allocable to hospital cost increases or price increases, a large percentage of it was attributable to pharmacy increases, and of all sort of segments, the lowest percentage was attributable to increases in physician costs.

So, it's -- physicians are getting paid more, but other billers are getting paid more yet, and then also much of it has to do with the, you know, increasing costs of technology and drugs, so I think that's important to make that point.

MR. MATHIAS: Steve?

MR. FOREMAN: Yeah, I'd like to take issue with the robustness. The ten biggest insurers in this country made $4.5 billion in profits last year. I understand in 2003, their first quarter numbers are up higher. The ten biggest nonprofit insurers

made $1.5 billion in profits last year. If you compare those levels to 1996, it's a huge jump. Administrative costs for insurers are way up.

And the last piece of it, from a factual standpoint, is physicians didn't get it. I mean, physicians got no more than 2 to 5 percent nationally. In Pennsylvania, real physician income, discounting for inflation, is down over ten years. So, at the same point in time, the insurers in Pennsylvania have been making more than $500 million a year in profits. So, if that's not robust, America's a great place.

MR. BERLIN: Don, I have another question for you, and first of all, correct me if I'm wrong, I understood your position to be that your group was generally opposed to the concept of collective bargaining statute or considered it an inferior mechanism vis-a-vis integrated physician group.

MR. CRANE: True. I mean, naked collective bargaining we would oppose. When, however, it's connected with an integrated group that's either financially integrated and/or clinically integrated, then you have got something to talk about, because you are picking up efficiencies that the world and consumers want, but for mere cartel conduct to occur in specialty IPAs and so on where it's just an effort to, you know, increase fees, we would oppose that.

MR. BERLIN: Okay, let me ask you a follow-up and then throw that open to anybody else to comment.

So, I understand that your organization is one of larger medical groups or IPAs. Do you think the -- your view on the utility of countervailing power in the form of collective bargaining might be or ought to be different for small groups or perhaps solo physicians?

MR. CRANE: I don't see small groups or solo physicians -- I don't see that altering regulations or enacting laws to create countervailing power for individual

physicians or small groups of physicians to be the way to go, frankly, because those groupings of physicians don't have the critical mass necessary to develop protocols and all of the efficiency promoting kind of initiatives involving data sharing and electronic medical records and so on. So, there's not at that size kind of grouping efficiencies. So, I don't -- I wouldn't recommend that we give them countervailing market power.

MR. BERLIN: Okay. Sarah?

MR. MATHIAS: This question is back to Tobey again or Mark Tobey. Are there any remedies that the State of Texas has if you -- if it were to happen that you allowed this and the insurance companies actually negotiated with the physicians? Are there any remedies if it ends up that there are unintended consequences or bad results for consumers? Is there any action that the State can take, or is -- you know, what happens?

MR. TOBEY: There's a feature of the law that I think was intended to get at that. And the legislative history of the law, interestingly enough, was that it was not desired by our legislature to raise physician reimbursement rates enormously across the state in enacting this law. So there's a provision in the Act that says that our Insurance Department is supposed to study, on an annual basis, the effect of this law on average physician rates across the State of Texas.

In terms of remedies, you know, I -- there isn't anything within the express terms of the statute as far as a review of our previous grants of authority, as best I can recollect, but there are some safeguards in there about spill-over effects, and the 10 percent provision that can be varied up or down by the Attorney General's Office. Ten percent of the number of physicians in a given health benefit plan's geographic service area, is some limitation or is some I think indication on the part of our legislature that they did not want to huge group of physicians to be given that power.

MR. BERLIN: This question really is for anyone and everyone, and that is, where do hospitals fit into this debate? Most of the time and I think most of this discussion has focused on physicians and collective bargaining by physicians. Three questions -- I'm incapable than doing anything other than asking a compound question, as you can see.

One, what is the -- for those of you that have looked at some of the data, have some feel for it, what is the prevalence of markets where hospitals have market power versus plans, or in addition to where there's overlap? How does this impact physicians in those markets, I think particularly where there's an overlap of market power or where both hospitals and plans have it? And, finally, what does the presence of a hospital, hospital system with market power, do to anyone's analysis of countervailing market power and its applicability?

MR. MATHIAS: Marty?

MR. BERLIN: And we're taking volunteers.

MR. GAYNOR: Yeah, I think -- I think it's a very important fact to consider. There's been a lot of focus on physicians versus insurers because of the request for legislative change, but I think actually as a practical matter, looking at markets where there is countervailing power, that's where you're going to find it, and practically, in considering, say, a hospital merger, this is something that may want to be considered.

Now, I live in a market that's dominated -- Pittsburgh, Pennsylvania -- it's dominated by a very large health insurer on one side of the market, High Mark/Blue Cross and Blue Shield has about two-thirds of private covered lives, and on the other side, we have University of Pittsburgh Medical Center, which dominates the hospital market.

Subsequent to a recent merger on the hospital side, there was bargaining between

these entities. They could not reach agreement. The hospital threatened to withdraw from the insurer's network. They eventually reached an agreement in which prices were increased substantially for the hospital, and a few hundred million dollars were transferred from the insurance company to the hospital, and health insurance premiums are rising.

That doesn't sound to me like a good outcome in the market that I live in. That doesn't mean it's representative, of course, of all other markets, but I think that this is a very important area here, and it's one that actually, as a practical matter, will probably be considered on a regular basis much more frequently than in physician markets.

MR. LANGENFELD: The discussions here I think by and large you can just transfer over to hospitals. I mean, there is obviously an issue about market power in certain areas, not that the Federal Trade Commission or the Department of Justice has had a great track record, the State of California has had a great track record in preventing mergers that they think reduce competition in the hospital area, but I think that's sort of a separate issue in some sense.

But it is true that, you know, that it's appropriate to look to see what type of, as the merger guidelines explicitly state, look and see what type of buyer power there is in an area. My recommendations are that if you have a situation where you have evidence, for example, and Marty and I disagree on this particular merger, but if you look at it and see that there's buyer power, I think that's something that you have to take into account for not only hospital mergers, but any associations within an area.

And of course, I think -- I'm sure Marty with agree with me that if there was -- there's still an issue, with all the caveats that Monica raised, about you can't just look at whether services go up. They have to be the appropriate services. And it's a complicated market. But just because there was a transfer of funds to a hospital

system that it certainly believed needed more to continue to invest and provide quality services there, that doesn't -- and that health care premiums may have gone up, that doesn't tell you that this -- that the offset of -- that that type of market situation is necessarily bad considering the alternative, which was basically a very large insurer in the area pretty much getting its way up until then.

MS. NOETHER: I think there are a number of markets where one's seeing the fact that consumers no longer want to have selective networks. They no longer want to belong to a plan where you can only go to one hospital system in a three hospital system town. Inevitably, it shifts the balance of bargaining power towards the hospital systems if they know they're going to have to be included in the plans or networks. That certainly shifts the nature of the bargaining and gives the hospitals more of an upper hand than they might have.

That being said, I think one still has to look market by market. There certainly have justifiable efficiency reasons in some situations either for permitting hospital mergers or permitting some kind of integrated clinical joint venture where one can share tertiary services. There are clear quality enhancements and efficiencies that can occur in those kinds of situations. So, once again, I think it's a fact-specific kind of analysis that has to be undertaken on a market-by-market basis.

MR. BERLIN: Steve, go ahead.

MR. FOREMAN: Yeah, I just wanted to weigh in. For once I'm a little neutral, because I studied that market, Marty. It's the Pittsburgh High Mark market. A couple of added facts just to tie in with what we discussed earlier.

Premiums in Pittsburgh have been increasing at 15 percent a year before the merger. They've been increasing at 15 percent a year after the merger. The side payment, as I understand it, was in the nature of $250 million that was transferred

from High Mark to the hospital, but it came out of their reserves, which are $2.3 billion. So, I mean, all in all, what I'm trying to say is I think the hospital's response here was understandable given the structure of the market, and maybe actually it illustrates some of the points that we've been making earlier.

MR. BERLIN: I have a follow-up again for anybody that wants to answer. I think this was lost in my series of muddled questions before.

So, I think what I'm hearing, though, is that we should treat the physician market and the hospital market as two separate product markets, as we obviously typically would, in terms of deciding whether or not there might be the need to permit countervailing power.

In other words, the fact that you have a hospital system with its own market power in no way ameliorates the situation for the physicians that might be in that market, you know, or does it, if anybody disagrees with that?

Nobody likes that question at all?

MR. LANGENFELD: Just so that somebody responds --

MR. BERLIN: Thank you.

MR. LANGENFELD: -- it's a complicated -- I mean, it depends on obviously the interaction between the hospitals and the physicians. They're not always happy with one another either, you know, and so it's hard to have a simple answer to that. It's something that I suppose you'd want to take into consideration, looking at what's happening on the hospital side or what's happening on the physician side, but it is true that someone else earlier said, you know, there are typically at least three sets of major players here, discounting those of us who actually use health care, and they fit together differently almost -- well, quite literally on a market-by-market basis.

MR. BERLIN: Yeah, I think probably any other question we ask would take us

past our time, so I would just like to thank all our panelists again for taking the time to be here, and if we could all give them a hand.

(Applause.)

(Whereupon, at 12:14 p.m., a lunch recess was taken.)

AFTERNOON SESSION

(2:05 p.m.)

(Sound system malfunction, one minute.)

MR. JACOBS: -- physicians health plan and its challenge to the MFN clause imposed by Blue Cross and Blue Shield of Rhode Island, and in 1996, he defended Delta Dental of Rhode Island in an action brought by the Department of Justice.

Next will be Jonathan Baker, who is a professor of law at the American University's Washington College of Law. He's worked at both the -- thank you -- both at the FTC and at the Department of Justice, most recently as the Director of the Bureau of Economics at the FTC in the -- between 1995 and 1998, and he holds both a JD degree and a Ph.D. in economics. In the MFN area, he wrote an article that was published in the Antitrust Law Journal concerning MFNs in 1996.

Following John will be Tom Overstreet, who is Vice President of Charles River Associates, where he has worked for the past 15 years. Before that, he was an economist at the FTC for ten years, holding various positions, including the Assistant Director for Antitrust in the Bureau of Economics. In the Delta Dental of Rhode Island litigation, he was retained as a testifying expert by the Department of Justice.

Next will be Steve Snow, who is an attorney and a founding member of the law firm of Partridge, Snow & Hahn in Providence, Rhode Island. Steve has had 20 years of experience representing health insurers, hospitals and other health care providers.

He successfully defended Blue Cross and Blue Shield of Rhode Island in the Ocean State litigation.

And our final speaker will be Bob McNair, who is an attorney with Drinker, Biddle & Reath in Philadelphia, where he co-chairs that firm's health law practice group. He has represented health care providers for over 20 years both as an attorney in the law firm setting and before that as inside counsel to the Allegheny Health System.

With that, I'll thank all of our speakers for appearing today and turn it over to Bill Kopit.

MR. KOPIT: Well, thank you for giving me the opportunity to speak today on this issue. As you said, I have been involved with this issue for a long time now, actually about as long as the Federal agencies have, which is roughly 15 or 16 years. As you will see in a couple minutes, regrettably from my standpoint with only limited success, but that's -- but let me start by saying that attention to this issue, which I do believe is an important issue, the credit for focusing our attention on this important issue that I think otherwise, at least when we started, was going unnoticed, the credit really is deserved here, and I think we need to recognize the contribution of the Justice Department in developing this issue through a number of years now, and particularly one person, if I can name a person -- of course he's not here, so I can say anything I want behind his back -- but Steve Kramer, who's been a long-time staff member of the Department of Justice in the Antitrust Division has probably done more than anybody else to focus attention within the Government on what I think is a very important issue.

I think at least in part, as a result of Steve's efforts and others, of course, in the Department of Justice, we -- there is now, if you bother to look on Lexus or Westlaw,

you'll now see that there's been a number of successful consent decrees that have been brought by the Department of Justice, and they've gotten them in a number of contexts, and some of them actually we represented complaining parties that brought these matters to the Justice Department.

And in addition to a number of consent decrees where conduct has been held -- MFN conduct, most favored nation conduct has been held to violate the antitrust laws or at least so the complaint was, and defendant rather than fighting it agreed to consent to stop the conduct. In addition to those kinds of consent decrees, I think you'll find that in certain instances the Department of Justice has actually done things more informal, more along the lines of what the FTC does, you know, when somebody in a local government makes a request for a policy position.

The Justice Department has actually written several letters that I'm aware of to state regulatory agencies articulating -- where the regulatory agency was looking to approve or not approve a provider contract, typically hospital contracts, at least the ones I'm aware of, with MFN clauses, and at least on two occasions that I'm aware of and that I was involved in, the Department of Justice has sent very helpful letters to those state agencies, insurance departments in this case, saying, you know, there are serious competitive issues in relationship to the enforcement or implementation of this kind of a contract.

What I think we still have to recognize, though, with all this activity -- and there has been a fair amount of activity and over a fairly long period of time now, as I say, roughly 15 or 16 years -- what I think we have to recognize is that there's really not a great deal of case law. If you sort of reduce that a little further and look at well-reasoned case law, there's even less, because there are some cases -- I remember one case, it was actually a client of mine, although we didn't work on the case, the

Kitsap Physicians Services case involved in MFN. I mean, I still don't understand -- I don't remember who -- the MFN was held to be legal, and I still don't understand what the reasoning was.

There's several cases like that where the courts sort of blow off the notion that an MFN can be anticompetitive, but they really don't contribute much. In fact, if you want to look at cases, at least if you want to look at cases at the circuit court level, federal circuit court level, I may even have missed some, but I can think of only two, and one is the Ocean State case, and I'll get to that in a minute because I was involved in that, and the other one is the Marshfield Clinic case, where the Blue Cross and Blue Shield of Wisconsin sued the Marshfield Clinic. And in that case, not at the trial court level but in the appellate level -- Blue Cross won at the trial court level, Blue Cross, the plaintiff -- and at the appellate level, it was reversed in an opinion written by Judge Posner. If you read Judge Posner's opinion, which says all kinds of wonderful things about all kinds of wonderful things, and I don't have time and this isn't the place and I'd be digressing much too much to talk about them, but what he said initially about MFNs was, oh, of course, they're pro-competitive. One of the interesting things about that is there was no MFN in the case. I mean, it wasn't a fact in the case. So, to say it was gratuitous, I'd say that's a fair statement.

In any event, after that was said in passing in the -- and it was really only in passing -- in the Marshfield case, the Justice Department and the FTC filed, I believe it was, a joint petition for rehearing en banc arguing MFNs can be anticompetitive, and therefore, this case -- not necessarily arguing it ought to be a different result in the case, but on that issue, an issue which was really never tried, that there ought to be consideration of the anticompetitive -- potential anticompetitive -- consequences of MFNs. That was the basis, at least in the view of the Justice Department and the FTC,

in their request for rehearing en banc to have this case reheard.

Well, the case wasn't reheard en banc -- surprise -- but Judge Posner amended his opinion. So, if you look at the opinion now, it doesn't say what I just said it said, because he changed it. Again, I think we've got to credit the FTC and the Justice Department for that. What he said, and I'm paraphrasing, is well, of course there may be MFNs that are anticompetitive, but this isn't one of them. So, I mean, he slid by it quite easily, and that's really, you know, all that the case says about MFNs, not an awful lot.

Now, Ocean State is quite different. Ocean State focused on the MFN. There were some other issues in the case as well, but again, I don't think we have time and you probably don't have the interest to talk about them, but the main issue, I think it's fair to say, is the MFN or what Blue Cross called it at that time the prudent buyer concept.

Interestingly enough, Steve, you'll be pleased to know that Blue Cross has not given up the notion of calling these things "prudent buyer." I just was reviewing cases -- excuse me, contracts in a case for a deposition tomorrow, and this is where Excellus in New York, and they have a prudent buyer, so I mean, nothing changes.

Anyway, for those of us who are not versed in the prudent buyer concept, we thought of them as most favored nation clauses, and I think it's fair to say that it was.

But before I get into the Ocean State case, I want to say a little bit about the history of that case, because we didn't bring that case initially. I mean, it ended up in private litigation, and I'm sure Steve will talk about it, too, but initially we went to the Justice Department with a complaint with the Ocean State Physicians Health Plan. And we said this most favored nations clause has been imposed on us, and we really think it's anticompetitive, and we really think you, Justice Department, should take a

look at it. And we went to Steve Kramer with it, and I had met Steve a couple of years before when I was defending a North Dakota Hospital Association case -- this was in 1984, really ancient history -- and I met Rich Martin and Steve Kramer, who was prosecuting the case for the Government.

Because the Justice Department has always been interested in efficiencies, we shared a rental car as we traversed North Dakota from Bismark to Fargo and back again -- I think those are the only places in North Dakota -- but anyway, we went back and forth in the same rental car, and there are those who say we were just huddling together for warmth. Suffice it to say after a while the case did settle, and of course, if you go through a winter in North Dakota, you'll understand that.

But in any event, I had met him at that time, and so when this thing came up with Ocean State, we went to Steve and we told him about it. The Justice Department actually was interested and opened an investigation and that investigation lasted for about six months. Then my client was getting really antsy, they said we're getting hurt here and we really can't wait, and Steve said, well, you know, this is the Government, and we don't move all that fast. So, we ended up bringing private litigation on our own.

Now, I have a number of vivid recollections of that case and of that trial, but I've got to tell you -- to digress again -- that my most two vivid recollections of that trial have nothing to do with the law. The first one is in the middle of the case, local counsel called me back to counsel table to tell me that my wife had just given birth to our son, my only son, and of course, he knows this story now, and he wants to know why I wasn't there, and I'm not sure I have a good explanation. So, that was the most vivid recollection.

The second one was the closing argument. I don't know if Steve is going to

remember this, but Steve Snow introduced me to his father on the day of the closing argument. His father had come to hear Steve make the closing argument, and he was obviously proud of Steve. After Steve walked away, his father was standing with me, and he says, so, how's he doing? And I said -- and I can say truthfully -- I said he's doing very well, and he was a proud father. Then I thought, you know, I hope he comes in at least second. So, anyway, those are my two most vivid recollections of the case.

But getting back to the law, let me say that we ultimately did win a jury verdict in that case, although it's never been clear and it will never be clear whether we won the jury verdict on the antitrust claim, which if we had would have been on the MFN, or whether we won on a tortious interference claim that we had also brought. After obviously the verdict, I thought why did I ever do that? Because, of course, under the antitrust laws, it's treble damages, and under state law there there wasn't, and there were some punitive damages, but they were nowhere close to what treble damages would have been.

But, anyway, we won a verdict, although it wasn't clear what we won it on, but that sort of mooted out pretty quickly, because Steve filed a motion for a JNOV, which the trial court granted. The Court said two things in granting the JNOV, which I think are worth talking about, and I think they're both wrong. I still think they're wrong all these years later.

The first thing the Court said was, well, if a small market participant could do this, could impose a most favored nation and say -- for those of you -- I'm assuming -- I guess I should start I'm assuming that everybody understands what it is, but for those of you who maybe don't, just real briefly, a most favored nation clause or a prudent buyer concept is sometimes called -- in its simplest form says it is a contract,

it's a contract usually between an insurer and some providers, usually hospitals or physicians, sometimes both, and what the insurer is saying is if you give anybody a better price or as good a price -- they vary some -- but if you give anybody a better price than you give me, you've got to lower my price to theirs. That's simply most favored nation, which I guess comes out of trade talk. Anyway, that's what it is.

What the Judge said in the JNOV is, well, if a small player can do it, can put that in a contract, why can't a large, a dominant player? It seems to me they ought to be able to play by the same rules. That was the first thing he said. The second thing he said is and since in this case what happened is Blue Cross really did, as a result of the operation of this clause, Blue Cross got a lower price, because of that, it seems to me -- and of course, remember, we won a jury verdict, so what the defendant -- what Steve argued was this has to be per se legal, because if it's not, if the jury has discretion -- I mean, we won, assuming we won on that rather than the state claim, but in any event, and the judge said, it's per se legal, because there's a lower price. A lower price can never, never be anticompetitive. Getting a lower price can never be anticompetitive. So, that's the two things that the trial court said.

Now, we appealed to the First Circuit, and we did get the First Circuit to say on the first point, no -- no, it is not true that just because a smaller player could do it lawfully, a larger player, one with market power, can do it. In fact, you know, market power is probably the essence of antitrust analysis, and that's the difference between yes and no. That's the difference between violations and not. If you have an exercise in market power, you have the potential at least for anticompetitive effects. If you have no exercise in market power, then how can there be any anticompetitive effects?

So that the size, the existence or lack of market power, is obviously a crucial point, the crucial point perhaps, and the fact that the judge didn't recognize that, the

Court of Appeals said no, that's wrong.

They went on to say, however, but it doesn't matter, because the trial court was right in saying if you get a lower price, it's per se legal, and so that's -- that's how, you know, we ended up in Ocean State.

Now, after that time, as I've said a minute or a few minutes ago, we -- I was involved in a number of other cases where we were on the plaintiff's side largely bringing stuff to the attention of the Justice Department, which they acted on, a number of these things resulting in consent decrees. But then we got a call and we were asked to represent Delta Dental of Rhode Island, and Delta Dental of Rhode Island was being looked at by the Justice Department for its MFN.

Now, the background of that is that Delta Dental of Rhode Island, like a lot of other Delta Dental plans across the country at that time, was operated by Blue Cross of Rhode Island or had been historically operated by Blue Cross of Rhode Island, and it was -- if it wasn't the only prepaid dental plan in Rhode Island, it was close enough. I mean, you wouldn't know who number two was. So, it dominated prepaid dental in Rhode Island.

Then there was a dispute, which I honestly know nothing about, between Delta Dental and Blue Cross, and they were operating this under a management contract, and the contract terminated, and I don't know the specifics of the termination, but then they were separate. And once they became separate, Blue Cross went into competition with Delta Dental, not just for medical insurance, which, of course, they had provided for many years, but for its own prepaid dental plan. And while it is true that at the time of the Justice Department investigation, Delta Dental had a larger market share than Blue Cross, Blue Cross was coming up real quick and was a very close number two, at least the way our statistics looked.

And so, when the Justice Department investigated us, investigated Delta Dental, interestingly enough, I never said that we thought that the MFN that Delta Dental had was pro-competitive. I didn't believe it was pro-competitive, as a matter of fact. What I said is we'll give this MFN up in a heartbeat as soon as you take it away from Blue Cross, because if we don't have an MFN and they do, that gives them an unfair competitive advantage, and we don't want to do that.

So, if you go after them and get them to give up theirs, we'll surely give up ours, you know, without any problem, because we wouldn't need it, except now it's a question of competing on equal footing with Blue Cross.

Well, that's what we said. That was our argument. We went up, and Anne Bingaman, who was the head of the division at that time, and she had some sympathy for what I was making, which was a pragmatic argument. Suffice it to say Joel Klein had none. He could have cared less and they sued us. But that wasn't the end of it, because we thought, well, I've got the magic words.

So, we went up when the case was brought in court, and actually, the case was argued before a magistrate, and this was on our motion to dismiss, because I thought the case was plainly dismissable, and Steve Kramer argued on the other side, but I had the magic words.

What I said when I got up was "Ocean State." I said this has been decided by the First Circuit -- the First Circuit has said that these clauses are per se legal, and whether or not that's pro or anti-competitive, I mean, it's stare decisis, the Court has ruled, and by the way, again, I didn't take a position that was inconsistent with previous -- with my previous positions, again, because I didn't -- I thought the clause was anticompetitive, and I also thought that the Court had ruled, but I've since found out that lawyers can now take -- they have changed the canons of ethics, and lawyers can

now take inconsistent positions, and that says a lot about lawyers' ethics, I think, and perhaps turning them into an oxymoron.

But in any event, we did make the argument, and the magistrate said no. Ocean State was a Section 2 monopolization case. This is a Section 1 contract case. So, Ocean State doesn't apply to this.

Secondly, Ocean State involved a situation where there was a lower price. Blue Cross did get a lower price there, and that's pro-competitive, whereas in the Delta Dental case, the facts were different. The facts were in Delta Dental were that some new entrants to the market -- and remember, there are really only two in the market at a time -- but there were a couple of new entrants, and the new entrants said we have dentists who said they would otherwise give us a lower discount, but they couldn't because they'd have to give it to Delta Dental, and they weren't going to be able to do that.

So, the Court distinguished the two situations and said, so, in my view, this case is not dismissable. Now, after that, the case settled, and Delta Dental agreed to a consent decree, but the opinion of the magistrate, and ultimately we appealed it to the trial court, the district court, and he wrote an opinion, too, but I commend to you not the trial court's opinion but the magistrate's opinion, which notwithstanding the fact that I lost -- and you have now noticed that I have the dubious distinction of being on losing sides on both sides of this issue, but I think notwithstanding that, that the trial court's -- excuse me, the magistrate's determination and opinion is quite good in that case. But I don't think -- I don't think that it accurately -- well, forget -- I don't think it accurately makes a legitimate distinction between Section 1 and Section 2 cases, nor do I think it's quite as simple as the Court said, which is, well, if you get a lower price, it's pro-competitive, and if you don't, it's anticompetitive.

So, they're flashing the time on me, so let me just conclude by saying a couple of things. One is what then are the differences conceptually? And you know, I really can't do that by saying -- first you've got to understand, while I've been talking about what most of these cases are, which are vertical cases, you can have situations where MFNs come up in what's really a horizontal case. Typically when you see that you have like a dominant insurer -- could be a small insurer, but as a practical matter, you see a dominant insurer, and a dominant insurer has an MFN with a number of, let's say, hospitals, but the hospitals are all talking to each other or talking to the insurer, and they all know that the other hospitals are doing it, too, and if there's any kind of communication between them, it's in the -- it's certainly in the insurer's best interests, because it's a floor on discount. It's in the hospitals' best interests, because they're putting a floor on discounts if they want to agree. It's essentially a hub and spoke conspiracy to fix prices.

It seems to me if you have those facts, that's exactly how the case ought to be analyzed. Let me just go on to say that while you would likely see this situation come up where you have a dominant insurer, the reality is if it happened with the smallest insurer in the market, it wouldn't make any difference in my view. It would still be per se horizontal price fixing, if you've got those -- that kind of facts where you can show that kind of communication.

But let's go to the harder case, which is the purely vertical case, and most of the cases -- Ocean State was a vertical case, Delta Dental was a vertical case, most of these consent decrees as far as I can recall were also vertical cases.

How do you distinguish between the situations, if it's not per se legal, how do you distinguish between the situations where it is a problem and the situations where it's not? Well, I'll say this real quick or try to.

The first thing obviously is you need market power. I mean, the thing that the judge didn't recognize -- the trial court didn't recognize in Ocean State is the critical point. A small player, one without market power with an MFN, is benign at worst, but the player with market power can impose anticompetitive effects by the use of that market power through the MFN.

And one other point I want to make about market power is it's really not -- people think of market power of the insurer, you know, in the sale of insurance, but we're looking back in the purchasing of the physician or the hospital services from the providers. That's the market power. It would be monopsony power, except it doesn't have to, you know, be to that proportion it seems to me, but the point is it's the power over the providers that's the important thing, and why does it matter other than somebody might want to be technical?

Well, it matters because it seems to me that the market shares -- the absolute market shares have to be -- don't have to be nearly as high. Absolute market share in a situation like that is not nearly as important as relative market share. So, if you have a player with 30-35 percent market share and it imposes an MFN on its providers and the next biggest player, the next biggest player has 5 percent of the market or less, what do you think's going to happen? I mean, so, it's the relative difference in market share and therefore market power that I think is the most significant thing when you're looking at MFNs.

But okay, let's assume that we've now decided that there's an insurer or HMO who does have market power. Then how do you determine whether the MFN is an exercise of that market power that creates an anti-competitive effect? Well, I do think that in that sense, the Ocean State case is somewhat easier, because in Ocean State you say, well, look, not all the doctors dropped out of Ocean State after Blue Cross

imposed the MFN. About a third did, if I remember correctly. But that means two-thirds stayed in, and those two-thirds actually gave Blue Cross lower prices, reduced fees, so that's pro-competitive. That's why the Court said, well, it's per se legal.

My view is, sure, they got a lower price, and that is by itself a pro-competitive consequence, but let's look what happened to the Ocean State network. It was substantially degraded, by about a third of the doctors who left. And by the way, today, the lack of a large and broad panel is probably more important even than it was then, but, you know, having a smaller physician or hospital panel if you're a managed care plan is significant, and it's a significant disadvantage.

So, what you really have to do, it seems to me, is to weigh that, but how can you? I mean, you know you can calculate the value of the price decrease to Blue Cross, but how can you possibly calculate the value of the degradation of the panel to Ocean State?

Now, you can -- for damage purposes, you can see what difference it made, you can project that, but that doesn't, I think, show you the actual degradation. So, it seems to me while you have to weigh that, the actual weighing of those kinds of things is virtually impossible in the real world, which creates a real problem.

In contrast to that, by the way, if you look at the other case, if you look at Delta Dental, there it was pretty clear. There, the -- you have no new entry. I mean, the Government was right. You have no new entry. That new entry -- the lack of new entry was a result of the imposition of the MFN, so that seems to me to be pretty clearly anticompetitive, but in an Ocean State type case, how do you do that weighing? Well, the short answer is I don't know, but let me suggest something to you before I sit down.

That is, I think we can borrow from the Robinson-Patman Act. What -- the Robinson-Patman Act, can you borrow anything from the Robinson-Patman Act? Yeah, I think so. If you recall, the Robinson-Patman Act doesn't say that volume discounts are illegal, per se. It says that a volume discount is legal if you can justify it on the basis of cost. I think that if you had somebody with market power who exercises that market power through the operation of an MFN and that person cannot justify that exercise of market power on the basis that it really reduced costs, okay, then I think that is grounds to argue that that's an anticompetitive effect and it's an anticompetitive exercise of market power.

Then the only other thing I want to say about that is it is not true what a lot of lawyers and non-lawyers say is intuitive and equitable, which is, well, wait a second -- I mean, it goes back to prudent buyer. Isn't it true that if you're the biggest buyer, you have a right to the best discount? Not as a matter of economics, no. I mean, it may be true as a matter of equity. It may be true as a matter of market power. But as a matter of equity, it's actually the opposite, if you think about it.

The example, you have a charter plane with 100 people on it, it has 100 seats, a charter, and some travel agency sells 98 of the seats for 100 bucks each, okay, so it's $9,800 that the charter company is making on the flight, and that's -- and it's very profitable, and an hour before the plane is going to take off, two bums stumble into the office where the plane is and say, you know, we can wrestle up 20 bucks between us if you let us on the flight. I understand there's two more seats. Well, that would -- I mean, why not? I mean, at the margin, that's still profitable. I mean, what's the additional cost of letting those two bums on the plane, right? A couple of bags of peanuts, a couple of gallons of gasoline. Twenty bucks is more than going to cover that, okay?

So, the point is really the same I think when you're talking about small buyers. Sometimes a provider is more likely willing to give a small buyer a deeper discount simply because it doesn't matter that much. It's at the margin.

And then the other thing is, of course, this -- the provider also might think, well, I have another -- I have an economic reason for giving a smaller buyer a bigger discount, and I also have sort of a political/economic reason, which is I don't really like the idea that this other guy is dominant, and if we have more small buyers get bigger, maybe I'll refuse to give them lower discounts -- deeper discounts anymore, but at least there will be more competition at that level, and that's good for me, too. A lot of providers think that way.

So, for all of those reasons, I don't think it's true, as a matter of economics, that you can simply say, well, the bigger buyer is entitled to the better discount. No, I don't think so, not as a matter of economics. What I would insist on is evidence where the -- where the buyer does have market power to show that the imposition of this thing is really cost-justified, and if it isn't, I think there's a good argument that it's anticompetitive.

Thank you.

MR. JACOBS: Thank you, Bill.

(Applause.)

MR. JACOBS: Our next speaker will be Jonathan Baker.

MR. BAKER: Thank you, Jon and Matthew for inviting me. It's nice to be back to the FTC, even if it's a building different from the one I remember. I am going to talk about competitive effects of most favored nations clauses in health care markets with a little survey and -- whoops, whoops, how do I do that? Go to previous, okay.

We'll talk about most favored nations clause, that seems to be the terminology of

the week here at the FTC, although these are also called most favored customer clauses, which I like a little better, it's more intuitive about what's going on in the transaction, or nondiscrimination clauses.

I'll begin by just framing the common health care setting where these -- where the cases seem to be most often appearing, highlight the leading anticompetitive theories, talk about efficiency justifications, and then survey quickly the way that these clauses have been treated in the health care market litigation.

So, where are the cases? What we usually see in the case law where antitrust review of most favored nations clauses occurs, there's a dominant health plan, and it's contracting with providers, with providers, maybe hospitals, doctors, dentists, pharmacists, all sorts of things, and the providers are agreeing that if they give a discount to some other health plan, they will give the same discount to the dominant health plan. This is another way of saying that the providers agree not to accept a lower reimbursement from rival health plans.

Now, there are several -- really two or three leading anticompetitive theories on what the problem is, and this literature -- the economics literature on where -- why most favored nations clauses might be harmful to competition really got going with the work at the Federal Trade Commission around the Ethyl litigation, which was not a health care case, in the early 1980s, and the FTC economists particularly started to understand how most favored nations clauses could facilitate coordination among providers.

There's a more recent literature that I won't spend any time on that gets to a similar place with the interaction. It develops more of a static oligopoly model than a coordination kind of story, where one firm adopts the most favored nations clause, and it turns out that that leads the other firm to act less aggressively and competition is

dampened between the two of them.

There's also, though, a whole other area of anticompetitive difficulty involving exclusion that is perhaps even more important in the health care arena than the coordination problem. That is where the clauses exclude rival health payment plans or entrants or more generally raise rivals' costs in order to help maintain or achieve higher than competitive prices, and I will talk briefly about that theory as well.

So, let's turn first to how MFNs can facilitate coordination among providers. The basic story is that the provider has less of an incentive to cheat on a tacitly collusive arrangement, less incentive to accept a lower reimbursement rate from another health plan. The provider is -- because if it -- if it cuts price -- if it cuts price in order to get more business from a rival health plan, why it has to turn around and cut price to the dominant health plan as well, and that's very expensive. So, the provider has less incentive to cheat on the cartel among providers. It ties its own hands, if you like.

The rival health plans have less incentive to bargain hard with providers, because they can't obtain a competitive advantage. They're not going to get any lower rates than what the dominant plan gets, for example, if it's a dominant plan setting.

One example of how this might work in the health care market came up in the RxCare of Tennessee case that the FTC, I think, decided with a consent settlement -- reached a consent settlement in 1996. Most of the MFN cases in the health care area involve exclusion theories. Here, the story is that the MFN reduces the ability of rivals or entrants to obtain lower costs. The small rival, the rival health plan, doesn't necessarily exit from the market. It's just hobbled. It can't compete as aggressively. That allows the dominant health plan to maintain or achieve prices above the competitive level.

Some examples of this are suggested by the Reazin case, the Tenth Circuit case -- I'll talk a bit more about that in a moment -- in 1990, and multiple Justice Department consent settlements involve this theory.

Now, there are efficiency justifications for most favored nations clauses, although the striking feature of the stories is that the best stories for these clauses don't fit so well in the most common health care setting that I was talking about. There are situations where the firms are unable to write a long-term contract because -- easily -- they need to write a long-term contract because they're in a relationship where the assets are long-lived, but they're worried about opportunism down the road, where someone could be taken advantage of.

They want to write a long-term contract, but there's no futures price that they can -- they can't set the price every year in the future. They just don't know how prices might change, how conditions might change.

An MFN clause can essentially substitute and be a way of ensuring that a party is not taken advantage of in a long-term contract. It's not as -- it's a pipeline story, perhaps, dealing with gas producers or something like that, not health care setting kind of problem.

In another setting where we commonly see or at least occasionally see MFN clauses, the kind of Crazy Eddie story, you know, if you can find a lower price than us, bring it to me, I'll match it at any rate. We'll call it -- if it's an MFN, that kind of provision, you know, in retailing could work to signal that the firm has adopted a low-price strategy to consumers. In a setting where consumer search is costly, it may be a valid signal. It may actually be a low-price firm with lower costs, and there's potentially a signaling equilibrium where this possibly provides an efficiency justification, but again, that's not a particularly attractive story for the most common

health care setting.

So, on the whole, the best efficiency justifications don't really seem to apply very well in the health care world.

How do the courts treat MFNs? Well, up through 1990, there were certainly courts that found there were no antitrust violations on the facts, and Bill talked about both of these cases, actually, the Ocean State case and this Kitsap case in Washington. Other courts recognized the anticompetitive potential. The old polio vaccine case involving Eli Lilly, the Court said, well -- it wasn't passing directly on the MFN clause. It just said that the MFN clause helped explain why prices were high in a way that we didn't need to posit a conspiracy to explain and helped the firms avoid a Section 1 conviction.

In the Reazin case in the Tenth Circuit, the MFN was part -- provided evidence that Blue Cross had market power, but the MFN itself wasn't held anticompetitive.

Since 1990, here's the way I read the legal landscape. The federal agencies are frequently challenging MFN clauses. There are a number of DOJ consent settlements, as Bill highlighted a moment ago, and the FTC case that I mentioned before. What the courts do now is that they decline to declare MFNs legal per se, and that's what I take to be the story in the Delta Dental of Rhode Island case, this Blue Cross case in Ohio, and this Oregon State case. That is, the courts have been asked to say these are legal per se, there is nothing to look at, and the courts declined to do that. They say, no, they could be legal, they could be illegal, we are not going to decide this as a matter of law.

And Judge Posner changes his tune. In the Marshfield Clinic case, this was dicta, Judge Posner assumed that the MFN would help the clinic bargain with the doctors for low prices, assumed it was good, called the price floor theory, which was essentially

some version of one of the anticompetitive theories, ingenious but perverse.

In a recent case involving brand name prescription drugs, his dicta goes just the other way, where he notes in passing that there's authority for prohibiting industry-wide adoption of the MFNs, which make discounting more costly. So, again, even the Posner indicator of how the courts will rule is moving to recognize that there's a potential for a problem.

So, what do I conclude from this survey? That careful agency scrutiny of most favored nations clauses in the common health care market setting is both consistent with the economic literature and consistent with judicial precedent and that the enforcement program of the agencies is perfectly sensible.

Thank you.

(Applause.)

MR. JACOBS: Thank you. Next will be Tom Overstreet.

MR. OVERSTREET: Good afternoon. I also would like to thank Jon and Matthew for inviting me to participate.

This area is kind of an interesting area in the sense that buyers often express a preference for most favored nations clauses, even though in the analysis of the effect of these things, they're not always in buyers' collective interests. And as has been mentioned a couple of times, you know, even someone as intelligent as Judge Posner has viewed these things in an odd way, as ingenious but perverse. And it is very common to find these things referred to by practitioners in very euphemistically sounding things, such as the -- what was the --

UNKNOWN SPEAKER: Prudent buyer.

MR. OVERSTREET: -- prudent buyer. I ran into one that I'm going to talk a little bit more about in detail, what was referred to as a fair payment rate limitation

plan. Despite these kinds of comments, it seems to me that there's not that much controversy in the economic literature about the effects of most favored nations clauses unless there's something that I'm unaware of that's fairly recent. There's a fair consensus among economists that have looked at these things that they can be pro-competitive or anticompetitive depending on the factual circumstances.

Jonathan talked a little bit about the theory. In general, you find these things in the health care setting where there's going to be an effect in two markets, and if you think of upstream and downstream markets, the hospitals or the health care providers would be selling upstream services to an insurer or a company packaging an insurance product that's in the downstream market, and sells insurance, health insurance coverage, to consumers, and in order to evaluate the effect of the clauses, you have to trace out the impact in both the upstream and the downstream market.

What the clauses do, as has been stated, is they interfere with selective discounting. If you want to offer a discount selectively to one purchasing entity, the MFN clause forces you to extend that discount more generally to another or to others, and therefore, it reduces the profits and the incentive to discount, offer the discount.

By interfering with, say, the hospital's incentives to discount, because they burden up selected discounting, the concern in the upstream market is facilitating collusion, because the selective discounting is the sort of thing that tends to undermine collusive agreements on price and causes competitive pricing to break out.

In the downstream market, because you force the discount to be extended more generally, the basic economics of it is the discount won't be as deep if it's extended at all. So, the insurance company that's trying to compete on a price basis is less able to do so, and therefore the concern of the downstream market is the foreclosure or the raising rivals' costs, that they don't get the lower cost they otherwise would get, and so

they have a harder time competing on a price basis.

The concern in the upstream markets is most likely to be a competitive one when that market is concentrated, is subject to oligopoly coordination; in the downstream market, the concern is most likely to be a real issue when the firm imposing the MFN has a large share of the market. And as Bill said -- actually in the modeling of it it turns out to be true -- that their size relative to the smaller player also is important.

Bill Kopit mentioned Robinson-Patman, and I also like to think of this issue in terms of price discrimination, because it's referred to a lot in the health care literature and by practitioners as cost shifting or raising issues about cost shifting, but I think it's more accurately thought of as price discrimination. The most favored nations clauses either dampen the ability or choke off the ability to discriminate in price and, as in price discrimination in the pure theory of it, it can be welfare-enhancing or welfare-diminishing, depending on the circumstances. And that's true with the flip side of that, that prohibiting it can be -- you can go either way in terms of its effect, depending on the circumstances.

I thought I'd talk a little bit about a couple practical examples we were involved in where we had to engage in analyzing the economics of these things. There was a case of the sort that Bill referred to, it wasn't litigated, in western Pennsylvania where Blue Cross of Western Pennsylvania -- this was in the early nineties, I think 1993 was the date that we submitted our paper on this thing, but it was a fairly typical type example where these things would come up.

Blue Cross was the dominant insurer, had been, at that time was offering a fairly traditional indemnity type policy, and managed care insurers were emerging but hadn't caught on very well in that part of Pennsylvania at that time. Blue Cross contracted with most of the -- I think all of the hospitals, and it did very little directing or

managing of patients. It had a managed care product of its own that it was introducing into the marketplace.

It also had an odd form that I would expect probably doesn't exist that much these days, but it had a retrospective cost-based reimbursement system. It had its own perverse effect on incentives at the hospital level. Blue Cross would negotiate at the beginning of an accounting period to pay rates that covered variable cost plus a portion of the average fixed cost of the hospital. So, if the hospital brought in incremental patients and their average fixed cost went down, that effect alone caused them to have to lower rates to Blue Cross, and so they just because of that, having nothing to do directly with the MFN, had a disincentive to compete for incremental patients, even though there was excess capacity at the time. Otherwise, they would have had incentive to go after these patients.

Now, the managed care guys, of course, were directing patients and negotiating discounts, and Blue Cross had this fair payment rate limitation plan, which was the MFN clause, and it wanted to enforce them, and it petitioned the Insurance Department in the State of Pennsylvania to be allowed to insert those clauses. We were hired by a managed care entity that was opposing these and wanted to submit papers to the Insurance Commissioner and, you know, indicate why these things were bad on public policy grounds.

So, the MFN does the same thing as this peculiar form of contracting does, as I had mentioned. If you extend the discount to the managed care, you have to extend it to the Blue Cross folks as well, and so you have the incremental profits you get from patients the managed care company can send your way against the offsets by extending the discount as well to Blue Cross patients at the hospital.

Like in price discrimination, the typical theoretical result is going to be that

you're going to end up -- if you have to pick a single price, because you can't have a high price and a low price, you are going to pick some price intermediate to those two prices. The economics of that are that relative to no MFN, the Blue Cross guys would pay a little less with the MFN than they would otherwise, and the managed care people would pay more than they otherwise would. So, you have some folks that benefit and some that are harmed.

In the facts of this particular case, it seemed to us on the analysis of it that although Blue Cross had a lot of patients, the benefit that they would get as a result of the MFN was quite small; whereas the cost impact on the managed care company was going to be quite large. Therefore, it was going to have an effect in the downstream market for the insurance products by raising the cost of this new entrant, you know, with this innovative way of packaging insurance by a lot, and it would benefit Blue Cross patients and subscribers by only a little.

Then, in addition, they would have this effect of dampening incentives for hospitals to increase utilization, pursue efficiencies at the level of the hospitals.

There were justifications put forward for this. We viewed it as anticompetitive for the reasons I just stated. The justifications, there were three. One was that it would have imposed unfair cost shifting on Blue Cross patients, that it involved free riders -- free riding on Blue Cross' efforts and that it was generally unfair because they were the largest insurer and were therefore deserving of at least as good a rates as everybody else.

All of those justifications -- the cost-shifting one is just a different way of describing price discrimination and who pays for costs. There weren't any costs that were actually shifted around as a result of this. It really had to do with who would pay to cover the cost.

The free riding argument and the fairness arguments really don't flow out of any kind of normal economic or policy considerations, and so they were pretty wanting. In that particular matter, the Justice Department papers, filed papers, the amicus type papers saying pretty much the same thing as I recall it. I don't actually remember -- Bill probably knows this. I'm not sure exactly how this turned out. I think they implemented some kind of a quasi --

MR. KOPIT: Yeah, they didn't implement an MFN. They implemented something else which I guess looking back probably wasn't as bad.

MR. OVERSTREET: It was some half measure, but it was --

MR. KOPIT: I mean, it did have an impact on the Insurance Commissioner.

MR. OVERSTREET: Right.

The other matter that I'll just mention real briefly since it's been mentioned before is Delta Dental of Rhode Island. In that case I was going to testify for the Justice Department, had it gone that far, but you know, that was a matter where I thought it was a good case to bring in that there was a smaller plan that had actually gotten dentists to sign up with it in return for big discounts and patients being steered to these dentists, and that plan had been implemented by an employer up in Rhode Island who had been happy with it, and then Delta threatened to enforce the MFN clause, and the dentists had to unparticipate in the thing because it would have been too costly given the size of the patients that were at issue versus the Delta Dental patients. So, you had an entrant that otherwise would have been successful that was squelched in their efforts on account of the MFN.

In that case, it's interesting. I didn't know this at the time, but I thought it was instructive that there was never an efficiency defense that I saw put forward, and --

MR. KOPIT: And now you know why.

MR. OVERSTREET: -- and now I know why, and I did see some other things that led me to believe that they didn't believe that there really was an efficiency defense.

As I recall this, they had this MFN clause, and it had gone unenforced for years, and it was on the entry of this other competing entity that they trotted it out of the closet and started to enforce it, and so it had very little to do with any efficiencies. The legal defense was put forward, failed on legal defense, and then it was settled. So, that's the way that matter came out.

But again, in analyzing these things, it really turns on the facts of the case, and you can't say that much in general about them, but they can be pro-competitive or anticompetitive.

Thank you.

(Applause.)

MR. JACOBS: Our next speaker will be Steve Snow. MR. SNOW: Good afternoon. I must say as the only member of the panel from Rhode Island, I'm a little shocked to find out that my little state appears to be the hotbed of MFN clauses. I don't think I realized that until today.

I'd like to talk about some practical situations and try to explain why I believe that the use of an MFN clause, even by a plan with market power, is often pro-competitive. Now, I'm not suggesting, as I may have suggested some years ago in the Ocean State case, that it's always pro-competitive. I would agree with Bill that in a situation such as the Delta Dental case where I think it really was being used in an anticompetitive way, and that should be condemned, but there are many instances I would suggest where the use of the clause, even by a plan with market power, can be in consumers' interests.

Before getting into that, I just want to comment just briefly on the Ocean State case in response to some of the things Bill said. One thing I would observe is that after the First Circuit ruled, Blue Cross continued to use a most favored nations clause in its physician contracts for some period of time, although ultimately it abandoned them for public relations purposes, not for legal purposes.

But notwithstanding the fact it continued to use them for a number of years, what was the result? Ocean State, although it had lost some physicians in its network, maintained most of them. It continued to grow. It continued to thrive. In fact, if my memory serves, at the time of the litigation, I think they had about 100,000 subscribers. They've grown today. They are now part of United Healthcare. Today, there are over 250,000 subscribers.

MR. KOPIT: It's actually about 75,000, so --

MR. SNOW: So, it's even bigger numbers. They've thrived. And were physicians overpaid? I doubt that any physician would suggest that they were overpaid, and in fact, if you look at the statistics, the reimbursement to physicians in Rhode Island is among the lowest in the country. So, overall, I would suggest that in the Ocean State case, the bottom line was it did not have an anticompetitive effect. It, in fact, was pro-competitive, because it reduced prices.

Now, you know, MFN has been defined by a number of people here. I would just like to suggest that at least in my experience, and certainly the MFN that was used in the Ocean State case, it had a clause that no one has discussed. It was a condition of the MFN clause that the plan be the largest buyer of that particular service by that particular provider. If you had a situation where the plan was not the largest buyer, the clause did not apply.

I think that's an important element for a pro-competitive MFN, because I at least

view it as primarily a device to prevent price discrimination. I believe that in most cases, the largest buyer is entitled to a quantity discount and to the best price.

Now, the example that Bill gave about the two bums on the aircraft I don't think is really on point, because those two bums are not competing with the other passengers in the airplane. But the smaller competitor who's getting a better price from the same provider is in direct competition with the dominant insurer. And keep in mind that the vast majority of the expenses of that insurer are paid out to providers. So, if they're paying more to providers, ultimately that's going to mean that they are going to have to charge higher premiums, and they are going to become non-competitive. I don't think that's the situation in the airplane example.

In any event, let me give you a hypothetical situation which is fictional, but I'll tell you that it's based on actual facts and things that I have experienced. I am going to refer to this hypothetical fictional plan as Plan Green. Now, Plan Green is the dominant player in its market, which is made up of basically an entire small state, and although it's the largest health insurer in the state, there is, nonetheless, vigorous competition. In fact, the competition is mostly made up of national health plans who are, in fact, much larger companies than Plan Green is, Plan Green being limited to their single market largely because of trademark considerations.

Now, Plan Green is subject to a lot of competing pressures on it. First of all, it's experiencing very high increases in utilization and despite its attempts to manage care it hasn't been able to completely keep that under control.

In addition, it's getting a lot of pressure from providers who complain that their rates are too low. Physician providers complain that their malpractice rates have gone up tremendously because of, you know, the fall of the stock market and insurance companies charging more. Physicians complain they can't recruit new people to their

practice because reimbursement rates are so low. Hospitals complain that because of government cut-backs, they've got to make up their lost revenue from private insurers. The bottom line, they're getting a lot of pressure from providers to increase rates.

The combination of this pressure to increase rates and the increase in utilization means that there's a tremendous upward pressure on their premiums, and in return, they get a lot of pressure from their customers, mostly large group employers who don't want to absorb these, you know, double-digit increases in premium, so they're getting a lot of pressure from them as well.

But Plan Green does not operate in a pure market economy. It operates in a heavily regulated environment. Its premiums are regulated by the state, and the state regulator looks at not only the business needs of Plan Green, but also looks at the affordability of its product to its subscribers in deciding whether or not to approve premium increases.

In addition, the state regulates the quality of the product, and I think this is very important, because one of the things the state regulates is the adequacy of the provider network. And Plan Green has a situation where it has certain providers who, in fact, have a great deal of power in the market by virtue of the fact that they provide highly specialized services, and there are very few providers who provide those same services, and those providers, if they do not participate in Plan Green, realize that the state is going to require Plan Green to pay their charges in full because there's no one else in the area who can provide those services. That gives them a great deal of power in the market.

In addition to the regulators, the state legislature gets involved to a large extent in Plan Green's business, mandating benefits, passing legislation concerning networks, any willing provider legislation, et cetera. As a result, Plan Green operates in a very

difficult business environment.

Now, Plan Green does not have an MFN clause in their provider contracts, and they discover that one of their smaller national competitors is beating them in the marketplace, charging lower premiums, because they've been able to negotiate lower reimbursement rates from providers than Plan Green, despite the fact that Plan Green is the largest purchaser of those same services from these providers.

Now, you might ask, how could that happen? How could providers be willing to provide a lower price to a smaller competitor than it would to their largest customer? And the answer appears to be just what Bill was talking about, because the smaller people are only operating at the margins. The providers have excess capacity, and they say that they can afford to give a very small buyer a lower price, whereas they can't afford to give their biggest customer that same lower price, because the biggest customer pays all the fixed costs, and the smaller customer is only operating at the margins with incremental costs.

Well, that may sound great to the smaller competitor, but from Plan Green's point of view, it's paying more for the same services, and if it does that, it's going to become noncompetitive in the marketplace, because 88 percent of its premium dollars goes directly into paying providers. So, how does Plan Green respond? They don't have a most favored nations clause.

Well, what Plan Green does is they unilaterally lower their reimbursement rates to the providers to approximate the level that they think their smaller competitor is at. I don't think anyone would suggest there's anything unlawful about that.

But what is the practical result when they do that? Well, I can tell you. The providers react with outrage, because here is their biggest customer cutting their rates. How are they going to pay their fixed costs?

Now, those smaller providers in specialized fields, for example, something like pediatric surgery, where there is only a handful of pediatric surgeons in this market, they react by sending notices to Plan Green that they're disaffiliating from a plan, because they know that Plan Green is going to have to provide those services to its subscribers, because the state regulators are going to require it, and therefore, they're going to be able to get their charges, whatever they want, within reason.

Now, primary care docs aren't in the same position, so they don't disaffiliate, but what happens is they come up with other ways to make up the difference, and if there was a 7 percent across-the-board cut in reimbursement rates by Plan Green, you can be assured there will be within three months a 7 percent increase in utilization by those same providers, and as long as they're not too piggish about it, it's very, very difficult for Plan Green to do anything about that increase in utilization.

So, as a result of the across-the-board decrease in reimbursement, Plan Green actually encounters an increase in their costs, not a decrease, and that's a true story.

Now, I would suggest to you that if Plan Green had a most favored nations clause in their provider contract, the result would have been better. Consumer welfare would have been better, because what would have happened is the providers would not have, for the most part, cut that deal with the smaller competitor for that lower price. The smaller competitor would have had to pay competitive reimbursement rates in order to get the business; or they would have had to go to a smaller network, negotiate with certain providers so that they are the largest buyer as to that smaller network, and therefore, they're entitled to get the better price. And Plan Green would have had no problem with that, even with the most favored nations clause of the type that I spoke of.

I would suggest that that is a fairly common result of using a most favored nation

clause, and I think it's pro-competitive. Consumer welfare would be enhanced under those situations.

Thank you.

(Applause.)

MR. JACOBS: Thank you. Bob McNair?

MR. McNAIR: Thank you, Jon. When you hear my comments, you may think that Steve and I colluded to write our comments on opposite sides of the same issue, but I assure you we haven't talked to each other before today. I'm hopeful you'll find the comments interesting. As Jon said, I'm a partner in the Philadelphia-based law firm of Drinker, Biddle & Reath, and unlike the other people up here, I'm not an antitrust lawyer. I'm a health care transactional lawyer. I've practiced health law for more than 26 years all over the country, first on the West Coast, then in D.C., and most recently in Philadelphia.

I've represented all kinds of health care concerns, including payers, although not much recently. I'm here today primarily because I have represented providers in dozens if not hundreds of negotiations of payer contracts, and I think I have a somewhat different perspective on most favored nation clauses, particularly in marketplaces dominated by one payer, than Steve does. I'm also here as a consumer of health care, and interestingly enough, as an individual purchaser of health care insurance, which those of you who are partners in law firms will recognize, I have some interesting anecdotal evidence on the effects of most favored nations clauses.

The topics of most favored nations clauses, others have defined it, but my view is a most favored nations clause amounts to little more than a contractual requirement by a health care payer for the lowest price that a provider of services offers to any payer. Contrary to what was asserted earlier, it's very common in contracts I've negotiated

that the payer requires retroactive adjustments if the provider subsequently offers a lower price to a competitor than it offers to the holder of the MFN.

My comments today are going to focus in three areas, the core problems with MFNs based on the two marketplaces that I know best, which are Philadelphia and Pittsburgh. Two, the harmful anticompetitive effects of MFNs, again, in the markets with which I'm most familiar. And three, what we think the answers for those problems are from the FTC and the Department of Justice's standpoint.

First, the core issue. When backed by market power, both in selling health insurance coverage and in buying health services -- and those two are inextricably entwined as you will see here in just a minute -- MFN clauses are little more than mechanisms for preserving market power and preserving the ability to limit competition and maintain artificially high prices to health care consumers. The reality, most MFN clauses are wielded by payers with the market power in question to both sell health coverage and to buy services. The sword metaphor is intentional.

At this point, I'm going to digress from what I had originally thought I was going to say to point out why that is. Health care in some ways is a unique marketplace. When a provider is dealing with a payer, they don't see themselves as dealing with the payer. They see themselves as dealing with the subscriber of that payer. They are dealing with the payer to deliver that patient to their front door.

It's almost as though a provider, someone buying a car from General Motors would be dealing with Delphi Auto Parts to deliver that car to their front door. GM is little more than a middle man.

This is an important distinction. Why? Because only payers with the requisite market power can demand and receive most favored nations status from their service suppliers. Any such demand from a less than dominant purchaser would be consigned

to the refuse bin along with all the other crazy things that providers hear by any coherent provider of services. Why? Because it simply wouldn't make sense from their standpoint. They give the MFN to a dominant payer because that dominant payer is the dominant payer. It sounds kind of circular, but it's true.

As to that proposition, let's look at the two marketplaces with which I'm most familiar, and I probably couldn't have chosen two more highly dominated marketplaces than Pittsburgh and Philadelphia, although I don't know how familiar you are with the statistics in those marketplaces, but it's really pretty stunning when you look at them.

Both markets have dominant Blue Cross plans. By the way, there's a continuous theme here, and you'll notice that Blue Cross tends to be behind a lot of these most favored nations clauses. It almost sounds like it's coming out of Chicago from the Blue Cross Association, although I don't want to suggest anything to that effect. Independence Blue Cross or IBC in Philadelphia and High Mark in Pittsburgh, which is the successor to Blue Cross of Western Pennsylvania, which was involved in the 1993 most favored nation clause matter.

Now, at the present time, the IBC share of the Philadelphia metropolitan area private health coverage market for 2003 is estimated to be approximately 75 percent, 2.9 million out of 3.7 million insureds in that marketplace. The next largest payer, Aetna/U.S. Healthcare, no small player, is at approximately 18 percent. The equivalent High Mark share of the Pittsburgh metropolitan market stood at 64 percent in 1998, and it shows no signs of reduction since then. Indeed, current estimates of High Mark's share of the nongovernmental payers marketplace shows its total percentage of the Pittsburgh insured market at 76 percent with the next competitor at 7 percent. Pretty stunning numbers in terms of concentration, and those respective market shares are calculated without considering those two payers' respective

dominant positions in managed care, in Medicare HMO products, and in the case of Independence Blue Cross, in Medicaid HMO competition. Philadelphia now provides Medicaid services exclusively through HMOs.

Both IBC and High Mark have used what amount to MFNs in the past. Bill was correct, High Mark's has got a high gloss on it but has the same effect. IBC has used them continuously since approximately 1993 when they were first introduced. High Mark has proposed re-adopting MFNs very recently, after first adopting them in approximately 1993 and then abandoning them in 1998 in their negotiated settlement with the Pennsylvania Department of Insurance. So, that's the background of how those marketplaces look.

To our second point, what difference does it make that market-dominant payers like IBC and High Mark can use MFN clauses. Which is to say, what are the practical effects of those clauses? For my money, it makes a world of difference. From my standpoint, the classic objection to most favored nation clauses is they produce marketplaces in which new competitors are simply unable to survive because they can't compete on price by undercutting the dominant player in that market on pricing, period.

The way that you enter a health care market in the first instance is through price. You can't sell quality, because you don't have a reputation to sell. I would -- we can discuss that later on if you want to, but that's my view of it. In turn, the inability of new players to enter the marketplace permits dominant sellers to maintain artificially high floor prices for medical goods and services. That's a classic objection to MFNs, but it's a compelling one. The facts are clear.

Philadelphia and Pittsburgh have remarkably similar health insurance markets; a single dominant Blue Cross plan with a secondary insurer that survives essentially at

the forbearance of the dominant player. Aetna/U.S. Healthcare in Philadelphia, UPMC Health Plan in Pittsburgh, but either of those could be easily eliminated at the whim of the dominant player, and lots of other small, inconsequential competitors.

Who's affected by this market dominance? First, rival players trying to enter or stay in the market. Listen very carefully to this list of unsuccessful competitors to IBC in the Philadelphia health coverage marketplace in the past decade and a half. Qualmed, Oxford Health Plans, CIGNA, Horizon Blue Cross of New Jersey, Travelers, Prudential, John Hancock and Maxicare. That's pretty much the universe of health insurers in this country, at least as far as I'm concerned, and virtually none of those are essentially still in the Philadelphia marketplace. Although I don't have a similar list for Pittsburgh, I'm told reliably that the experience with Blue Cross of Western Pennsylvania and with High Mark, its successor, is similar.

Second on the list of victims, purchasers of health insurance, mostly employers. Now, for those of you who are lawyers, I am going to reveal a nasty little unknown fact here. Partners in law firms pay for their own health insurance out of their own pockets. I am self-employed as a partner. So, on a whim, I asked my human resources department to get me the rates for partners' group health insurance over the past several years -- actually it was seven years, beginning in 1997, ending in 2003. The results were staggering.

For IBC, Independence Blue Cross, Personal Choice, which is a point-of-service PPO that includes prescription and dental coverage. In 1997, family coverage for that kind of coverage was $531 a month. In 2003, it is $1,290, an increase of 143 percent in seven years or a simple rate of increase of over 20 percent per year. Pretty staggering numbers.

Third on the hit list, patients as consumers of services. There can be no objection

to the proposition that artificially high prices for health coverage -- and I'm talking now premium prices -- limit access to such coverage, and that's the experience in both Philadelphia and Pittsburgh in recent years. Substantially declining numbers of subscribers are covered by private health insurance.

Also, the maintenance of the noncompetitive marketplace may have the effect of artificially increasing co-payments and deductibles which are paid for out of pocket by health consumers in the form of patients.

Fourth in the parade of victims, health care providers. This may seem counter-intuitive, but I think it's correct. Stuck in a marketplace with an overwhelmingly dominant payer, they're forced to agree to a take-it-or-leave-it pricing policy with a dominant payer, and I have been in dozens of these negotiations. You walk into the room with Independence Blue Cross, they say here's your contract, sign it if you want to, don't sign it if you don't want to. MFNs help to preserve that kind of dominance.

The evidence for that proposition, surely it can't be mere coincidence that the most catastrophic nonprofit financial collapse ever in the national health care system involved Allegheny Health Education and Research Foundation, a system located in and only in Pittsburgh and Philadelphia. Now, there are some other complicated reasons for that happening, but that's one of the major ones. Or that the University of Pennsylvania, one of the nation's most prestigious and revered health care providers and training institutions, went to the brink of financial collapse stemming from its location in the Philadelphia marketplace and its inability to secure favorable rates even though it was entitled to those rates on the basis of its status in the market.

I could point to other predictable results, including distortions in gaming the system. And I'd like to talk to Dr. Baker later on about an example I ran across where

the provider and the smaller payer didn't become less collusive, they simply became more secretive about what they were doing in terms of hiding the actual pricing, which led to some very unusual consequences. I think the point is made clearly through the foregoing examples.

What's the solution? Well, the solution is for the Department of Justice and the Federal Trade Commission to use their considerable arsenal of tools to attack and lessen or eliminate this problem in payer-dominant marketplaces where MFNs are used by the dominant payers. IBC and High Mark and others of their ilk -- and there are a substantial number of them, it's estimated that a number of the health care marketplace, this health care payer marketplace in the United States have very dominant single health care payers -- should be taken to the woodshed.

DOJ is well aware of this problem. As was earlier noted, it was in 1993, DOJ went on record with the Pennsylvania Department of Insurance opposing the MFN proposed by High Mark at that time. A year later in 1994 -- and this is not as well known -- DOJ dropped an investigation of the anticompetitive effects of IBC's most favored nations clause, curiously citing a "lack of jurisdiction over the issue." Don't ask me. And as recently as last September, Deputy Assistant General -- Majoris? -- Majoris reiterated her concern about High Mark's latest attempt to resurrect the MFN clause that it had abandoned in the late nineties. So, the need for action in dealing with MFNs from our standpoint, from the providers' side of the table, is compelling, and the awareness is surely there on the part of both FTC and DOJ.

What are the remedies? First, DOJ or FTC should openly oppose the re-adoption of the most favored nations clause by High Mark with appropriate comments to the Pennsylvania Department of Insurance. If you have already done that, kudos to you. Like comment would be welcome on the Independence Blue Cross most favored

nations clause.

Second, DOJ or FTC should initiate an investigation into the anticompetitive practices of both Independence Blue Cross and High Mark, including particularly with respect to the effects of their existing and proposed most favored nation clauses.

Third, DOJ can and should intervene as an amicus curai in the antitrust action presently pending in the Eastern District of Pennsylvania and brought by Chester County Hospital, a suburban Philadelphia hospital of impeccable reputation, against IBC alleging various transgressions of antitrust law, including violations of Section 2 of the Sherman Act.

Fourth, DOJ should bring separate actions against IBC and High Mark under the Sherman Act, including under Section 2, if the results of the investigation we propose above suggest the need for such enforcement actions. This would be a departure for DOJ in the area of MFNs involving insurers where it's my understanding that actions to date appear to have been limited to Section 1; however, the recent Lapage's en banc decision in the Third Circuit certainly provides sufficient precedental support for such an initiative.

Alternatively, if Justice cares not to proceed in this manner, the FTC could and should bring separate actions against both IBC and High Mark and others of a similar persuasion under Section 5 of the FTC Act for unfair trade practices if the investigation suggested above revealed the need for corrective action. A Section 5 action would be a novel proposal for the FTC but appears to be a tool well suited to the circumstances presented here.

I think based on my experience, the need for some kind of corrective action is relatively substantial. I think the FTC and the Department of Justice have the tools with which they can deal with this, and I'm hopeful that they will. I'm very hopeful

that as a result of these kinds of hearings, some attention will be focused, some light will be shed on these matters, and that further corrective action can be expected, we would hope in the near future.

With that, I thank you for your time and attention. The time is yours. Thank you.

MR. JACOBS: Thank you, Bob.

Why don't we take a 15-minute break now and we will come back for our question-and-answer session.

(A brief recess was taken.)

MR. BYE: We'll start back now. Moving to the panel discussion, I first want to say that we always welcome public comments, so if anyone has a different perspective on any of the issues discussed today, please submit them either to the DOJ or FTC.

We might start with the hypothetical that Steven worked with, and I think Jonathan Baker wanted to comment on that.

MR. BAKER: Thank you, Matthew.

Yes, I enjoyed listening to Steven Snow talk, and if you look in your biographies list, you'll see why he learned to talk so well. He went to a terrific law school.

I listened carefully to his example. We have a dominant health plan that introduces a most favored nations clause that prevents providers from lowering their rate to the rival health plan, and the result of this, as I understand the example, is that it precludes the rival from adopting a strategy it wanted to adopt.

The rival wants to make deals with providers, and the deals it wants to make is that the providers will lower their rates to the rival health plan, and the health plan will then, in exchange, direct a lot of patients to those providers, and this is a benefit to both of those parties. The rival health plan gets low costs and can charge low rates to

consumers and can attract the patients or the employers and can attract the patients that it directs to the providers and can bring lower rates, you know, to the marketplace.

This sounds like healthy competition being suppressed, and I listened carefully to the example and did not at the end of the day hear any good reason why it's good for consumers to allow the dominant health plan to impose a most favored nations clause that stops this kind of competition.

MR. SNOW: Well, let me respond. First of all, in my hypothetical, the plan, in fact, was not using a most favored nation clause. They instead implemented an across-the-board rate reduction, and my argument was they would have been better off and consumers would have been better off had they used a most favored nation clause of the type that I spoke about. And the one that I spoke about is a conditional most favored nation clause, and it only applies when the dominant plan is, in fact, the largest purchaser of services from that provider. So, there's nothing in that clause that would prevent a competitor from negotiating more favorable deals with providers as long as they become the largest customer of that provider.

MR. BAKER: But it seems to me that the original situation, though, the competitive rate reduction, that was good, and that that was going to be stopped by the introduction of the most favored nations clause provision, and the mere fact that it's limited to being a dominant provider just means that it applies in this case.

MR. SNOW: Well, my point was what happened with the across-the-board rate reduction is it ended up increasing the plan's costs, because you had those providers with the ability to do so, basically those who were in, you know, subspecialties where they had market power, were able to disaffiliate from the plan knowing that the plan was going to be forced to buy their services anyway, because if nothing else, the

regulator was going to make them buy it.

For example, pediatric surgeons. In this particular case, there were only a few pediatric surgeons. They all practiced together, and they as a group disaffiliated. Now, the plan could have sent or attempted to send its subscribers who needed pediatric surgery out of state, but the state regulator wouldn't allow it.

MR. BAKER: But why weren't the pediatric surgeons exercising their market power in the first place, and for example, not giving discounts to the small rival?

MR. SNOW: Well, that's a good question, and in fact, I think in most industries you would expect that to happen. For some reason, some elements of health care, particularly physicians, don't react the way that you see people react in other businesses. I can tell you as a lawyer in private practice that my largest clients expect to get our best hourly rate, and if I gave a better rate to a smaller client and my larger client found out about it, they'd be pretty upset, and I doubt if I'd be doing any further work for them.

Dentists tend to think that way as well. You know, Bill talked about the Delta Dental of Rhode Island case and suggested to the Department of Justice that they'd stop using it if Blue Cross stopped using it. Well, in fact, Blue Cross never used a most favored nations clause in its dental contracts for the simple -- well, for two reasons.

Number one, it wasn't the largest buyer, Delta Dental was, so they didn't think it was appropriate. But number two, at least in my experience, it's never been necessary in the dental field to use a most favored nation clause, because dentists in general tend to be better business people, and they understand that their biggest customer expects to get the best rate. It's very rarely a problem in the dental area. It's a big problem in the medical area where you've got some physicians with surplus capacity, and they're

more than willing to give a smaller competitor a lower rate.

My argument is even a dominant insurer is allowed to compete, and if they're paying super-competitive reimbursement rates, they are going to become non-competitive.

MR. JACOBS: Did you want to follow up on that, John?

MR. BAKER: That's all right.

MR. JACOBS: Let me ask as a --

MR. BAKER: Actually, I just want to say one thing, which is to the extent that the argument is that health care markets are somehow -- the principles of economics don't apply in health care markets, I'm not sure that I would go that far, but that's really all I want to say.

MR. OVERSTREET: Let me just add, that the only thing that I would add to that is that in the formal modeling of this issue, the bigger the entity demanding the MFN, in general, and relative to the discounting firm that's prevented from getting the discount, the more likely the anticompetitive effect is. So the case in which you're defending this and the economics of it is the opposite. I took your comment to be that, well, there's more than one way to skin the cat, and if you prevent the MFNs, they can impose take-it-or-leave-it pricing, which is sort of a higher cost method of getting the same effect, but it doesn't really alter the effect, I don't think.

MR. SNOW: No. Well, there is more than one way to skin a cat. I mean, in situations -- and there are some states that have prohibited MFNs, and what you see is a clause that's not an MFN and simply says if you offer a lower price to a competitor, then we have a right to renegotiate the price in the contract. You end up in the same place.

MR. JACOBS: Let me ask on a related issue a question to Bob and also I guess

a related question to that to everyone.

On this issue of why a provider, a hospital or a physician would want to grant a lower rate to a smaller market player, I take it from your remarks that at least the so-called political reason applies in your experience, that hospitals and physicians would like to offer lower rates to, in the Philadelphia area, IBC's competitors, because they have an interest in fostering competition in the insurance market.

I was wondering if in your experience there were other reasons, economic reasons or other reasons why providers are interested in doing that, which in one sense is counter-intuitive. And then to the -- I guess I'll throw the second question to the entire group, and that is, what should we as enforcement agencies take from the reaction of providers to MFN clauses? We are trying to determine the effect of MFN clauses on the overall price level in the market. At one level, if hospitals or physicians don't like MFNs, that suggests that they may be pro-competitive, that they're keeping prices down. Is that an accurate assumption?

Bob?

MR. McNAIR: First of all, let me say one thing in introduction. I think that hospitals are by far the most pertinent example in the MFN area. I know in some cases physicians sign MFN clauses, but hospitals are clearly the ones who are the most dominantly affected by them, because it's where they get the biggest bang for the least amount of effort.

Second, no, to respond to your last question and then I'll respond to your first question last. No, I don't think they're opposed to all of our prices. What I think they're opposed to is -- I mean, they are caught with a Hobson's choice, which is they either have to avoid getting more utilization by dealing with new entrants to the marketplace or smaller participants in the marketplace whose one and only advantage

compared to somebody like Independent Blue Cross is their ability to price at a lower level. They're put to the Hobson's choice of, well, we either don't take that plan's patients or we expose ourself to catastrophic consequences -- let's assume it's IBC -- with our IBC pricing if we do take them, which leads me to the answer to your original comment.

I don't think most hospitals are that concerned about pricing from a political standpoint. There may be at the margin some small interest in it. What they're really concerned about is filling beds. I mean, it's Bill's example about the bums on the airplane. You know, every day you go without a patient in that bed is a day gone forever, and it doesn't really cost a whole lot for the hospital to put another few patients in the beds. You've got the nurses, you've got the techs, you've got the building, you've got the aspirin, you've got the this, that and the other thing. You may have, you know, food and some procedures that get done.

But when you see the relative cost relative to the economic utility of it, I mean, it's probably one of the industries where marginal pricing is the most relevant -- and I notice Bill is shaking his head in apparent agreement, I'm not entirely clear that he is -- but no, I think the argument that I have made to them and that they sort of make to themselves is, look, every additional patient we get into this institution is good for us. It's going to go almost straight to the bottom line.

In a marketplace where you have got a dominant payer, and I think everybody has pretty much conceded that it's the dominant player who gets the MFN, that that opportunity may, in fact, disappear, and that's why I was making the argument that what this has the effect of doing is creating an artificially high floor price for treatment of those patients.

MR. JACOBS: Bill?

MR. KOPIT: I do agree, and I guess I would say that it's not true that in every market the providers -- and it's typically the hospitals, although sometimes it's the physicians like it was in Ocean State -- the providers may like the MFN, and if I was an enforcement agency, that would have been of more interest to me than the fact that they don't. I mean, I think --

MR. JACOBS: Well, I think the Delta Dental case, they decided that the dentists liked the MFN because they considered it as a price floor.

MR. KOPIT: Right, exactly. And so if you have the providers, you know, strongly supportive of the MFN, I would look at it, because it could be something close to either tacit collusion or actual collusion that you can infer from conversations -- I mean, it's a hub and spoke Toys "R" Us kind of a situation. So, the fact that the providers really like it, if I'm an enforcement agency, would make me nervous.

The fact that the providers don't like it I don't think tells you anything, because --

UNKNOWN SPEAKER: Well, it's anti-competitive.

MR. McNAIR: What it may tell you is that in that marketplace there is vigorous competition between the providers to get the marginal patient.

MR. KOPIT: Well, exactly, and you know, what the providers -- I mean, to get back to Steve's point, the providers not liking it is likely to be, golly, we'd like the freedom to price at the margin to the small buyer.

MR. McNAIR: Exactly.

MR. KOPIT: If you impose this, you will prevent us from doing it. Steve says, well, but it's unfair that you're able to do this; and the providers say we've got to fill our beds. I mean, take your fairness problem somewhere else, I mean, but that's why they don't like them typically.

MR. McNAIR: Exactly, and indeed, the obverse of that may be that in

marketplaces where they do like them, it's because everybody's got their share of the market well defined, and they simply don't want their little apple cart overturned by some competitive pricing strategy that's going to reward the one who arguably is the most efficient.

MR. JACOBS: Okay, well, in determining the -- John, did you want to follow up on that?

MR. BAKER: Yes, I wanted to add a little to the discussion here, that on the question of what if the buyers like the MFN provision, what can you infer from that, and Bill's answer was, well, remember, there are two anticompetitive theories. One is it's facilitating collusion among the providers, and maybe that's what's going on, and they're happy because it's helping them keep prices high, but even in the exclusion context, the other heading, you should recognize that just because buyers want something individually doesn't mean that it's in their collective interests as buyers to obtain it.

Let me give you a little hypothetical example that takes it out of the MFN context to make the point. What I'm thinking of is an article in the economics literature about naked exclusion is what it's called. So, you have a monopolist who goes to its customers and says, I want you to agree not to deal with my one potential rival, and the customers essentially know the way the wind's blowing, that all the other customers are going to sign up. They don't want to be left without the ability to buy the product from the monopolist, and they may compete to sign this clause, even though collectively, what happens when they all sign it is that the entrant doesn't come in and prices are higher than they would be if they could somehow coordinate and some of them buy or some or all of them or many buy from the entrant instead.

So, just because the buyers want to sign up individually, well, they know they're

dealing with a monopolist. They may find it individually rational to compete to sign up in my example to exclude an entrant in an MFN case, to get the MFN clause, even though if they could somehow collectively act, they would realize it's not in their interests to do so.

MR. McNAIR: Can I make another point in response to that, which is really kind of perverse, but that is, the irony of all this is that probably the hospital, if it's a person of reasonable reputation in the community, can get a higher rate from the new entrant than it can from the established dominant entrant, because what they say to them is if you want -- let's take the University of Pennsylvania. If you want my name on your material, you're going to have to pay me for that privilege.

In fact, there was a case -- and Bill, I don't know whether you followed it or not -- about two years ago where Children's Hospital terminated its contract with IBC because they were having a fight about rates, and the first thing they did was they ran into federal court and said you stop using our name on your promotional materials, because that had a halo effect for IBC, and believe me, that case settled and IBC folded up -- I don't know what the terms were, but they folded in a record amount of time, because that was an important part of their marketing.

So, if you're in a particular position, the irony is that you're getting a marginal rate, and you're getting the marginal business, and you're getting a higher rate than you would get from the dominant monopsonist or whatever you want to call them for that service. It's really kind of weird.

MR. KOPIT: Jonathan, I think, if I could just interject, the problem you described is almost like the opposite to a free riding problem.

MR. BAKER: Yes, that's it.

MR. KOPIT: Because when you were describing it, I was thinking about a real

case, and it's really the opposite, that I have now. You had the only hospital in the community, and there's no out-patient surgery other than through the hospital. SurgiCenter wants to come in -- this is a real case, not green, it's New York -- SurgiCenter wants to come in. They have to get a CON to come in, but three payers in the area, Blue Cross, NVP and United -- maybe four if you count CIGNA, but barely -- but anyway, so, you have got four payers in the area.

They all send letters of support to the CON, because they say, you know, this hospital's charging us an arm and a leg. They're the only damned hospital. You need them. So, for both out-patient and in-patient, it's costing us a fortune. Now, if we get competition, and the SurgiCenter is not going to help us with in-patient, but it will sure help us with out-patient, and that will be great. We're fully supportive of this new entrant coming in the market.

So, the SurgiCenter gets the CON, they begin operations, and they go to payer number one, and they say, we're ready to contract, and they say, oh, well, actually, we just signed an exclusive with NVP, so we can't contract with you. They say, well, what about competition? And of course, what's not said is, let Blue Cross and United worry about that. I mean, we're free riding. We're getting the benefit of the low price from the hospital on both out-patient and in-patient, and competition, you know, the hell with that. I mean, we like it, but we want somebody else to pay for it.

Then, of course, Blue Cross says, well, now we're losing business to NVP, and the next time around they sign an exclusive, and whew, that's the end of competition. What I'll be asking the Blue Cross guy tomorrow is, what were you thinking? And the answer is, well, better a bird in the hand than -- you know. I mean, who knew that they were going to stay in the market? I mean, it's just too speculative. We could get a lower price now. Sure, we're for competition in theory, but that's in theory. Same

point.

MR. JACOBS: We'll try to keep the transcript of the remarks off the internet until after tomorrow so you can --

MR. KOPIT: Oh, he won't be listening.

MR. JACOBS: -- maintain surprise.

On the issue of the MFN's effect on the overall average prices in the market, I think Tom's remarks alluded to the fact that obviously the insurer imposing the MFN gets at least slightly lower prices with an MFN than it would without, and the whole premise of the anticompetitive effect theory is that new rivals coming into the market would get perhaps substantially lower prices in the absence of the MFN.

Bill Lynk wrote an article I think in the Antitrust Bulletin where he described the MFN trade-off as shallower discounts to a larger number of consumers versus deeper discounts to a smaller number of consumers. I wondered if, in particular, our two economists had any comment on that trade-off and whether anyone could offer us any advice on how to, as a practical matter, figure out the overall effect of an MFN on prices.

MR. OVERSTREET: Well, I'll just make a couple of comments about that. I think that's in general right, because in the theory of it, if you have to charge one price instead of two prices, you know, just in a simple model where you could have discrimination against an inelastic demand firm and an elastic demand firm who gets the lower price, and compared to that situation, if you're forced to set a single price, that price will be intermediate to the two prices. Someone will pay less, and if it's as a result of the MFN, that's going to be the dominant player, versus that person that would otherwise have paid less.

How do you measure these things? Well, you have got two groups of people

that are benefiting differentially, and you have to compare those things. You can get into some tricky situations doing that. One way to do it is just to look at the magnitude of the effects on the cost. In the Western Pennsylvania case that we analyzed, we worked it out so that it was something like Blue Cross would have gotten the benefit of about 1 percent lower rates, and it would have pushed up the cost to the managed care firm on the order of 20-30 percent. So, there was a big impact there.

Now, you know, it's true that you would have had -- you know, if you had the MFN and it went into effect, that you would have a small benefit to a larger number of people and a big benefit to the -- I mean a big harm imposed on the small firm, admittedly with a small number of patients. You know, you could attempt to kind of size those up in dollar terms, but we were looking at it beyond that into the impact of that on the competitive environment where that difference in cost on the new entrant was really prohibitive. Their idea was to come in and package a price/service package that was different.

You were going to get lower prices in return for restrictions on your ability to go wherever you wanted, and in return for that, you'd get lower prices. That was sort of the method in which they were going to compete in effect through product differentiation, and it was interfered with.

The theory is the price discrimination theory. In order for discrimination to improve welfare, output has to increase, and it has to -- that's necessary but not sufficient, and it has to increase enough to offset the harm to the people who have to pay the higher price. So, then you could kind of crank it out that way as well, I think. I think it's a tough question, but the competitive effect question is a little bit easier.

MR. BAKER: Listening to Tom, I don't recall Dr. Lynk's article in particular --

I remember it's out there, but I don't remember the details of it -- but listening to the way Tom posited the question, it doesn't sound to me that any of the harmful things were going on that I was talking about. That is, there is no -- that the MFN is not operating in this market to facilitate collusion among providers, and it's not operating to exclude entering health plans or to dampen competition among health plans. So, all that's going on is that it is a way of insisting upon a single price as opposed to two different prices. That is to say, it's just about the difference between price discrimination outcomes and single-price outcomes.

MR. OVERSTREET: I think he's silent on the downstream market effect, at least certainly in the --

MR. BAKER: But if that's all that's going on, it sounds like Tom's right, that this is a -- that, you know, if the question is just would a single uniform price be better or worse than letting firms price discriminate, then the welfare consequences are ambiguous. There are circumstances in which it can be good and circumstances when it can be bad, but you have to focus on analyzing MFNs.

Also, on the possibility that it's going to have the other harmful problems that I was presenting before --

MR. McNAIR: Well, and I think that the one that you mentioned is the one that seems to be the most prevalent, which is that it does exclude competitors from entering the marketplace or from staying in the marketplace because they can't price and product-differentiate.

MR. OVERSTREET: Yeah, let me add one other thing to that. In the Western Pennsylvania case, what -- you know, the theory is that this -- if you have the MFN, the price is going to be intermediate to the two prices that otherwise would exist. What the administrators of the major hospitals stated in that case to my recollection

was that if the MFN goes into effect, if the Insurance Commissioner allows it, everyone's rates are going up to Blue Cross' rates.

MR. SNOW: Sure.

MR. OVERSTREET: So, there's the theory and then there's what actually happens.

MR. SNOW: Yeah, absolutely.

MR. BYE: A couple of panelists talked about dominant payers and looking at relative rather than absolute markets shares. I was wondering if any other panelists would comment on that, and also more particularly, how do we determine thresholds?

No takers?

MR. KOPIT: I think I was one of the people who said it. I haven't changed my mind. I think that the issue is not the absolute size of your market share. The issue is -- I mean, the definition of market power in this context is to -- well, let me back up a second. I think what Bob said earlier was absolutely right. I mean, you know, the theory is that any small payer can impose an MFN, and it has no anticompetitive consequences. It's perfectly legal, even the judge in Rhode Island recognized that.

But Bob's practical point sort of trumps it, which is it's perfectly legal, and you'll never get it. So, if you back up to say, okay, what's really going on in MFNs, they are dominant -- if you don't have the collusion issue, it's got to be because they're dominant. Otherwise, they would never get it, okay?

So, then the question is, well, what allows them to get it? It's almost sort of self-fulfilling. What allows them to get it is their size, their ability to send business vis-a-vis the potential for anybody else, because -- and by the way, the same issue comes up in non-MFN cases. It comes up in exclusive -- I mean, the same argument is made with exclusive dealing, which is, well, you know, we said that the buy-out --

we have an exclusive deal with you, you, doctor, you can only sell to -- you can only work for us, but we will give you -- you know, we will give you a slightly lower price if you're not exclusive, okay, and it's a very small differential.

So, in the case that I had in New Hampshire, the defendant argued, well, so, it's -- they called it paper handcuffs, because it's easy, you know, to get out from under that. Not at all. I mean, if you're a new entrant and you have no bodies to offer -- meaning bodies literally --

MR. McNAIR: Lives.

MR. KOPIT: -- lives, right, if you have no lives to offer a provider, right, I mean, it doesn't matter if the differential is minuscule. You have nothing to sell. And this is the same point, I think, that if you have enough power to tell those providers, look, you know, we're going to require you to pay us a lower price if you pay anybody else a lower price, and the providers are sitting there and looking at a bunch of, you know, relative small fries and thinking what can they offer me, so it's worth my while economically to sign on here, I mean, that's the issue it seems to me.

Now, one wrinkle on it, and I think -- I don't remember who said it, but somebody was talking about it, and I think it is true but less important today than it was ten years ago, is if you're talking about narrow-paneled managed care, that issue is less intense, because then you say, okay, as actually in Delta Dental, okay, we can't get a broad panel, but we can pick a few dentists or doctors and give them more, you know, and we'll work it out that way. So, there's a possibility that you might be able to get narrow-paneled competition -- it's certainly more likely that you would get narrow-paneled competition to enter, but the problem with that today -- maybe it will change again -- but the problem with that today is narrow panels don't sell.

MR. McNAIR: Bill, I want to follow up on what you said, because when I was

sitting here this morning kind of putting together my notes, I was having tremendous difficulty with the concept of the monopolist on the selling insurance side and the monopsonist on the buying health care services side, and I think the reason finally came to me was that the monopolist on the health insurance side is automatically a monopsonist on the buying health services side, period, because there are four players in most of these health care transactions.

There's the insurer, there's the employer, there's the patient and there's the provider. The provider is looking right through the insurer and the employer, who's paying for the stuff, right to that patient -- I mean, literally -- I don't mean literally, I mean they look and see hundreds of patients sitting across the table, but that's what they're interested in, and so the minute that IBC or High Mark or whoever it might be, Group Health Association or whoever the dominant player is, walks into the room, they by definition are -- can get what they want. That's just the way it works.

That's economically rational on the part of the institutions that are doing this, because that's where the work comes from. That's what fills the beds. That's what keeps the place turning. So, in one sense, I don't know if there are other industries like this -- there probably are, because every time you say something is unique, somebody comes right out of the woodwork and says, oh, no, no, no, it's the same as this one -- but it's pretty much unique because of the absolutely unique nature of health care insurance, which is that, you know, it's one person buying from another person for the benefit of a third person where the services are rendered by a fourth person, and they're all participants in this thing.

But when you get the provider talking to the insurer, that insurer is for all intents and purposes -- you know, where's Waldo? I mean, you know, thousands of people sitting there that the provider is trying to get access to.

MR. KOPIT: Can I just address the equity point that Steve talked about, which is, well, golly, if we're the biggest, why aren't we entitled to the best discount? And these guys, these little marginal players literally, marginal players are getting a better deal than we are. Well, that's true, okay? The economics explains why it's true, and maybe in some sense it's inequitable, and maybe, you know, like if your client finds out you gave a discount to a small player, you know, you're gone, whatever.

I mean, but the reality is, the market does have some self-correction there, because if those little players do well, there comes a point where they can't get that marginal discount either. So, it's not like, you know, they're going to become a monopolist because that unfairness is going to be carried through even to -- so if you start with 60 percent and they have two, then they are going to have 60 percent and you have two. At some point the providers will say the same thing that they're telling the dominant provider, which is we can't price you at the margin anymore.

MR. SNOW: But the dominant player is still allowed to compete. It doesn't have to just sit there and take it and become uncompetitive.

MR. KOPIT: Well, that's the issue, isn't it?

MR. SNOW: Well, I think the law is pretty clear that even a monopolist is allowed to compete, as long as you're using normal methods of competition, and a normal method of competition is to expect, if you are the largest buyer, to get the best price. That is not unusual. There is nothing remarkable about that. It's not remarkable, but to the extent -- I mean, I think to go back to what Tom said, I think Tom's analysis of the trade-off is I think more thoughtful.

I mean, I like Bill Lynk, and he's done quite a lot, but I do think you have to look at the impact on the cost to the new entrant. That's the point I was trying to make to start with. If the impact of the cost is, as it was in Pennsylvania, so significant that you

say, well, this kind of cost impact, okay, you're not going to have new entrants or much more unlikely, I mean, that certainly has to, it seems to me, lay very heavily, even though on some kind of a trade-off on, you know, Bill's calculus, there's more loss on the other side just in terms of price.

I mean, because, you know, without a cost break so he can compete, you are not going to get effective competition.

MR. McNAIR: Can I offer one more thing, which, Bill, you may have seen examples like this, and this will sort of show you how it really works. The only time that I ever saw either IBC or Aetna/U.S. Healthcare sort of acquiesce to providers was back in about 1996 when Allegheny, which at that time was a very big player in Philadelphia, the University of Pennsylvania and Jefferson Health System, which were the three big tertiary providers, and Temple, which was the fourth, all acquired substantial networks of primary care physicians where they could create a closed system and began putting into place the mechanisms to have their own health insurance plan, so that they could -- it would have been soup to nuts. And at that point, IBC came in and said, okay -- and Aetna/U.S. Healthcare to a lesser extent -- okay, we'll give you what you want to a certain extent in terms of rates, but you cannot -- cannot, cannot, cannot, cannot -- offer your own health insurance product, whether it's an HMO, whether it's an insurance indemnity product, whether it's a hospital service plan or whatever it may be, and it goes to some of the points that are being talked about here in any case.

MR. JACOBS: Steve, you mentioned in the Ocean State case that Blue Cross of Rhode Island had a largest buyer/larger buyer exception to the MFN clause.

MR. SNOW: Right.

MR. JACOBS: I'm wondering how common those exceptions are in MFN

provisions and whether given, as Bill said, that narrow panels aren't favored anymore, that really those kinds of exceptions make any difference.

MR. SNOW: Well, I can't answer how common they are, because I've never seen anybody do a survey on it. I can tell you that in the clauses that I've been involved in, we've always inserted that on the belief that it is primarily an anti-price discrimination clause, and it's basically to mandate a quantity discount, and if you're not the largest purchaser, you're not entitled to it. So, in our way of thinking, it's only fair to include that kind of clause.

I've seen it elsewhere. I don't -- I have never seen anybody do a study as to, you know, precisely what these clauses look like.

MR. KOPIT: Yeah, I would say it's relatively uncommon just from my own experience, but I would also say I'm not sure it makes a hell of a lot of difference, because the purchaser or the payer, the insurer that's likely to be getting this is likely to be the largest.

MR. McNAIR: Well, and that's really right, because the Department of Insurance in Pennsylvania entered into an understanding with IBC in 1998 where they said, look, you can only maintain this until such point as somebody else becomes the provider of 50 percent or more of the services to somebody's patients. Well, that's absurd. I mean, nobody could by definition in that marketplace end up with 50 percent or more of the services unless there was an earthquake, because IBC had so much dominance and so many different lines of business that there was no way for another single payer to get to that point, and I think that's probably true in a lot of places. I don't know that, but I have an intuitive sense it is.

MR. SNOW: Well, would anyone suggest that a clause that allowed the plan to terminate the contract upon discovery of the fact that the provider was giving a better

price to a competitor would be unlawful? Because it seems to me that that's a simple alternative, and I think you end up in exactly the same place. And I don't see how one can make an argument that that's unlawful, but I'd like to hear it if you can.

MR. BAKER: It creeps up towards an exclusive dealing contract, then. It's got that flavor to it. It's not literally one or an MFN. I mean, it's just a less -- it's a provision that accomplishes a similar end to an MFN, and to the extent that the MFN would be a competitive problem, a different provision that gets to the same place should also -- you know, could also be reviewed as anticompetitive in some sort of reasonable analysis.

MR. SNOW: So, what if the contract said it was terminable at will with 30 days notice?

MR. BAKER: They could still do the same thing.

MR. SNOW: That's unlawful?

MR. BAKER: But you see, that's a very different contract. That's not tying your hands and committing not to cut prices, for example, the facilitating collusion threat of the story.

MR. SNOW: But if you have a dominant player, as Bob was suggesting, and they come in and they terminate the contract without cause on 30 days notice, now what do you think the end result is going to be? It's going to be exactly the same.

MR. BAKER: Now you're in the territory of Lapage's.

MR. McNAIR: I will say this, no provider worth its salt would ever negotiate a contract like that, because that's what they want, they want predictability, but the second response to your point is, the underlying economic reality is the same thing, which is that the -- in that case, the payer can bludgeon the provider into submission, because the reality is the provider has to have a contract with that payer, I mean, if

they want to survive in that marketplace. And that's why it begins to look like an exclusive dealing contract.

MR. BAKER: But the mere -- if the only provision were to terminate on 30 days notice and that's all they did, then we're in the sort of situation where, you know, perhaps it ended up making it difficult for the rival to compete, but the antitrust laws may not reach that.

MR. KOPIT: I think that's probably correct.

MR. BAKER: You know, this is the same -- the kind of question about how far do those contract provisions go before we can call them exclusionary and find them, for example, the kind of practice that might support a monopolization case. This is exactly what the stake in Lapage's is and is being hotly debated, you know, as we speak, and you're raising an issue with a very similar flavor.

MR. KOPIT: Well, and just as though MFN cases are, you know, are fact-specific and you can't -- even though some courts have said differently, you have to know the facts before you can make a reasoned determination of what you think the effects are. Certainly it's true with lots of other situations -- you know, that that's also -- it's the same. And to here, I mean to me, the facts that would be relevant, and not the, you know, 30 days termination at will, that's all there is to it, I mean, that's a hard one to go after regardless.

But suppose you have a provision -- and I think somebody mentioned it before -- which says, look, we don't have an MFN, but if you negotiate any price with anybody that's lower than our price, you have an affirmative obligation to report it to us, and we will think about it. I mean, that comes darn close.

MR. McNAIR: And we have the right to terminate on 30 days notice.

MR. KOPIT: Oh, sure, absolutely, when you think about it. And we have the

right to terminate on 30 days notice. I mean, that becomes darn close to an MFN it seems to me in effect.

MR. OVERSTREET: You know, I'm not a lawyer, but it isn't hard for me to see how this could lead you from Section 1 to Section 2. I mean, if you did that kind of thing in a certain context, why wouldn't your conduct be --

MR. McNAIR: Well, that's what the Lapage's case was about.

MR. KOPIT: And that's why my argument that one of the problems between -- if you compare the Delta Dental case and the Ocean State case and say this is anticompetitive conduct under Section 1 but not under Section 2, under Section 2 it's per se legal, that doesn't make any sense. I mean, it seems to me that the standard for whether it's exclusionary or not has to be the same regardless of whether you're talking about Section 1 or Section 2. I mean, it's the character of the conduct.

MR. JACOBS: The final area I wanted to ask about is we've been talking a lot about the situation where the insurer imposing the MFN has market power. Does the competitive analysis differ at all if the hospitals on which the MFN is imposed also have market power? And I guess either the --

MR. McNAIR: No.

MR. JACOBS: -- the competitive effects in the provider market or in the insurer market.

MR. McNAIR: It may vary a little bit. The Children's Hospital example is the obvious one, but at the same time, in my experience, I mean, a hospital has got to have that insurance contract. They need the insurance contract. That's what delivers the patients to the door. And if Children's Hospital doesn't have a contract with Blue Cross, no matter how much people love Children's Hospital, they are not going to show up with their kids at that door.

MR. JACOBS: But the insurer needs them as well. MR. SNOW: I think it's very difficult for the insurer to get a most favored nation clause from a hospital that has market power for the simple reason --

MR. McNAIR: That's probably --

MR. SNOW: -- the insurer needs the hospital at least as much as the hospital needs the insurer.

MR. McNAIR: That's probably correct. I think that's probably correct. I mean in the Philadelphia marketplace, which interestingly enough has five full-service children's hospitals, not one, but one of which is head and shoulders above the rest, I guarantee you that Children's Hospital does not have a most favored nations clause in their contract even though I've never seen it. I assure you of that with absolute certainty.

MR. JACOBS: Well, if the hospital resists the MFN provision and the insurer wants it and they can't live without each other, might one outcome be that the insurer ends up paying a higher rate, and while it doesn't like paying the higher rate, it at least knows that it's not getting a higher rate than its competitors in that market?

MR. McNAIR: To go back, a lot depends on how competitive the marketplace is. If you're in Danville, Pennsylvania, right next to Geisinger Health System, Geisinger Health System can say pretty much what it wants to about what it wants in its contract, and Northeastern Pennsylvania Blue Cross is going to jump to the tune. If you're in Philadelphia where they've got Penn and Jefferson and Hahnemann and Temple and so forth and so on, you may not be happy about the fact that you don't have a contract with Penn, but you're sure going to be able to survive.

Now, you may be very unhappy about the fact that you don't have a Children's -- have a contract with CHOP, which is Children's Hospital of Philadelphia, and that one

may induce you to do it. So, I mean, that's not really responsive to your question, but I think the question of how competitive the marketplace is goes to a lot in terms of what the dominance of the hospital means.

Now, the Mayo Clinic, for example, in Duluth or wherever they're located is another example, and there are hospitals which are one-hospital towns, and in that place, insurers -- you know, the shoe is on the other foot. The insurer wants to sign, and they are going to -- and the hospital is going to get, within reason, what it wants or doesn't want.

MR. SNOW: Frankly, I think if the hospital had market power, it's unlikely that the smaller insurer is going to get a better rate.

MR. McNAIR: That's correct.

MR. SNOW: They're going to meet them.

MR. McNAIR: That's exactly the point, exactly.

MR. JACOBS: Any other comments on this issue?

Did you have any other comments?

Did anyone else want to comment on anything else anything else said?

Okay, with that, I thank you all for coming and thank the audience for coming. We had a lot of good ideas raised here. Thank you very much.

(Applause.)

(Whereupon, at 4:28 p.m., the workshop was adjourned.)

CERTIFICATION OF REPORTER

DOCKET/FILE NUMBER: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW

DATE: MAY 7, 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: 5/23/03

_____

SONIA GONZALEZ

CERTIFICATION OF PROOFREADER

I HEREBY CERTIFY that I proofread the transcript for accuracy in

spelling, hyphenation, punctuation and format.

SUSANNE BERGLING