FEDERAL TRADE COMMISSION

JOINT FTC/DOJ HEARINGS ON HEALTH CARE AND COMPETITION LAW AND POLICY

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FEDERAL TRADE COMMISSION

I N D E X

**P R O C E E D I N G S**

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MR. HYMAN: I'm David Hyman, Special Counsel here at the Federal Trade Commission. Seated immediately to my left is Steve Kramer with the Department of Justice Antitrust Division. I'd like to welcome everyone to the joint hearings sponsored by the Commission and the Department of Justice Division on Health Care and Competition Law and Policy.

We started in February of 2003 and we're wrapping up next week, multi-month, multi-sessions, a series of hearings devoted to a wide array of subjects in health care and competition law and policy.

We're doing a session this morning on physician unionization, which, when we were designing the hearings, was an extremely hot topic in Washington and had been so for a number of years and, I think it's fair to say, remains so on the agenda, although not at the level of intensity that it was when we were designing the hearings originally.

So, we're going to have a session this morning on that. This afternoon, starting at 1:30, we're going to be doing group purchasing organizations, which is a subject that's attracted a lot of interest as well.

We have a very distinguished panel this morning

and, following our general practice of a very short introductions to give people more time for their remarks and for a moderated discussion afterwards, I will just briefly introduce the entire panel in the order in which they'll be speaking. You're free to either use the podium or stay at your seat, depending upon your preference. We're all about maximizing individual preferences here in ways large and small.

Our first speaker is Professor Carl Ameringer, who is at the University of Wisconsin-Oshkosh, and has had a legal career that has taken him from the Maryland Attorney General's Office working at the Department of Health and Mental Hygiene to academics.

Seated immediately to his left is Dr. Michael Connair, who is an orthopedic surgeon, a clinical instructor at a number of hospitals, including Yale-New Haven, and he's testified in the past on the subject we'll be considering this morning.

Mark Flaherty is a lawyer specializing in a range of labor and employment law matters.

Mark Levy, seated to Steve's left, is the Executive Director of the Committee of Interns and Residents. Their, I think, most recent initiative has been, certainly not recent, but ongoing initiative, is advocating shorter hours for medical care providers in

training.

Then, finally, Professor Bill Brewbaker, making a repeat appearance. He spoke at our very first workshop, essentially a year ago, although over in a different building. He's a law professor at the University of Alabama who has written a number of articles on health care regulation and liability, and has most saliently, for our discussion this morning, has an article in the Journal of Health Politics Policy in Law on trying to sort out the likely impact of physician unionization on the performance of the health care market.

There's a much more extensive bio of each of the speakers and of everyone else who is speaking during this week and next week's sessions. We could spend all of our time going through their distinguished biographies, but you didn't come to hear about them; you came to hear from them.

So, without further ado, Professor Ameringer.

If the panel wants to go out and watch the Power Point and then come back when they want to talk, that actually will probably make it a lot easier than trying to turn around look, unless you want to give Dr. Connair business in his capacity as an orthopedic surgeon.

**STATEMENT OF PROFESSOR CARL AMERINGER**

PROFESSOR AMERINGER: Good morning. My name is Carl Ameringer. I'm a Professor of Political Science. I very much appreciate the opportunity to be here and to hopefully provide a different perspective, that is a perspective of a political scientist, which will guide my analysis. As a political scientist, I am most interested in the context for union formation and the power dynamics between unions and organized medicine, which is why I've entitled this Physicians Unions and Organized Medicine.

The first thing, just to give a brief literature review, indicated up there, the book by Budrys, which is the one that is perhaps most widely read and recognized in this area, Budrys is a sociologist, as is Elliot Freidson. Freidson has a more recent book. As many of you know, he published many of his books and articles in the area of professionalism and physicians quite a few years ago. This most recent book is a very interesting analysis, “Professionalism, the Third Logic.” I highly recommend it.

Third is Havighurst, of course, who has written a great deal in this area, coming from the law and economics perspective, writing on professional restraints, on innovation, health care financing. Then, I don't know that I belong in this esteemed company, but,

nevertheless, here's my article from the Journal of Health Politics, Policy and Law, where I recently delved into the topic, particularly considering the legislative efforts back in the early 1980s and then more recently with the Campbell Bill, in an attempt to analyze those two legislative efforts with such a large piece of time separating them.

These are the questions that I want to address, the ones that I want to talk about here, with respect to physicians unions. First is, what explains their appearance. Second is, what have been the barriers to their success. Third, what does the future hold. Obviously, there are a lot of other questions which I'd like to talk about in the session which follows this, but these are the three main ones that I chose for this particular presentation.

Okay, first of all, what explains their appearance. Well, the most common explanation is the economic, social, and organizational disruptions of a post-industrial society. That would be characterized by a shift from a manufacturing to a service economy with large units of production.

Here we're talking about health care produced by organizations rather than individuals, technological innovation, division of labor, and vigorous competition

and profitability. This is coupled with an ideological shift, particularly at the federal level during the 1970s, from regulation to deregulation and the perceived failure, the perceived failure on the part of many physicians of organized medicine to respond adequately to the situation.

Now, Budrys says that there are three ways. The first two can kind of be grouped separately from the last one: early 1970s, which is a response to government legislation, Medicare, Medicaid; expanding access to care; and subsequent efforts at cost containment. Of the 26 physicians unions that organized during the 1970s, only two survive today.

Then she talks about this period from 1983 to 1984 which she calls a response to the perceived crisis in medical malpractice. Of course, we're going through that to some extent again.

Budrys says that these two efforts at unionization, they failed to last and were, essentially, physicians letting off steam. The current way, she says, is more lasting. She characterizes it as a response to managed care, a response to managed care. With the introduction of for-profit medicine, it would more closely, then, resemble the labor management scenario.

I'm very interested in focusing on the

perceived failure of organized medicine and the typical complaints. Now, when I talk about organized medicine, I'm referring to the American Medical Association and the Component Medical Society, the state and local medical societies. So, I want to make that clear.

First is a conservative hierarchy, which is primarily concerned with protecting the status quo; cumbersome procedures and committee structure, a gentleman's debating society if you will, making it difficult to take quick and decisive action; and third is that professional associations, the complaint has been, were not structured for collective bargaining, that there are other goals and missions, of course, such as scientific research and patient welfare.

I like to look at these things from a political scientist's and a historian's perspective; that is, to examine it in a broader context. So, when we're talking about the perceived failure of organized medicine, I think it's important to point out that collective bargaining, or collective negotiation would perhaps be a better word, did not originate with unions. There are a host of historical accounts.

Havighurst has written extensively on this, and he would argue that collective negotiations have been taking place since insurance companies began acting in

the health care field. Havighurst says that the underlying reasons why negotiations between insurers and professional organizations have occurred is the implicit threat of boycott or related difficulty facing any plan that departed from accepted practice without first securing professional approval.

More on the broader context, the appearance of physician unions in the early 1970s was contemporaneous with the appearance of foundations for medical care, or FMCs. Now, why is that important? It's important because organized medicine did respond, but they responded in a different way.

FMCs, of course, were the forerunners to IPAs, and they were sponsored by state and local medical societies. Their essential purpose was to protect fee-for-service medicine, consistent with the notion of pluralism, I might add, and to deter HMOs from getting the foothold in certain regions of the country. The Kaiser-Permanente example, the San Joaquin Valley in California example that has been used, and the Oregon Medical Society case would be another example.

FMCs were more prevalent than physician unions. By one account, there were 112 FMCs in or near operation in 1972 with 87,664 participating physicians. The principle opposition within medicine to the FMCs came

from a relatively small number of physicians who viewed them as bureaucratic and a threat to traditional medical ethics. In other words, FMCs were joining the enemy. This group of physicians who were opposed included unionized physicians.

So, it's not surprising, then, that among the barriers to union formation was organized medicine itself, which saw unions as a threat to professional unity, meaning professional turf, and as antithetical to professional values of individualism and autonomy. This does seem somewhat ironic considering that organized medicine's history of collective action, as was previously mentioned.

The AMA's formal pronouncement against physician unions occurred in 1973 and was repeated on several occasions until it apparently reversed course in 1999. This is itself a subject of some dispute.

A second barrier to union formation is professional norms and values. Now, this may seem similar to what I've just talked about, but it's somewhat different. Here the emphasis is on personal reluctance, all right, personal reluctance versus organizational opposition based on a socialization process, medical school, many years of training, residency training under academic physicians who have been mostly or most

consistently opposed to union formation, which instills a socialization process, of course, instills a high degree of individualism and autonomy that views union involvement as undignified.

According to Budrys, the identity long associated with American unions, which is grounded in industrial unionism, organizing by firm, calling for a working class solidarity and restricting individual opportunity in preference for collective security, clearly holds no appeal for physicians.

Now, I'm not entirely comfortable with the way that she cast this and some others cast this. As I said before, casting is solely in terms of individualism versus collectivism, is not consistent with the profession's history of collective action and identity. I'd prefer to cast it in terms of collegiality versus conflict. I think that physicians as professionals favor collective negotiations but abhor conflict. They most certainly profess opposition to strikes or any disruptions to patient care.

Now, there are, of course, several legal barriers to collective bargaining and these do not necessarily, I should mention, prohibit physicians from joining unions, but they can eliminate an important reason for joining a union.

The first of these is that physicians must be employees and not independent contractors. NLRB has held that physicians having multiple contracts with HMOs do not satisfy the right-to-control test and thus are not de facto employees for purposes of the labor exemption.

In addition, for many years now, physicians have petitioned Congress for an antitrust exemption so that independent contractors can bargain collectively. The most recent, well, it's not the most recent, but the Campbell Bill is perhaps the best known example of that. It came the closest to passing, having passed in the House but did not gain a sponsor in the Senate.

The second criterion is that physicians, even if they are employees, cannot be managers. That is, they cannot exercise a great deal of control over conditions of work and participate to a considerable extent in organizational policy-making. Of course, that's very much the intent with the value of autonomy.

A second criterion is that physicians, even if they are not employees, cannot be managers, cannot be supervisors, rather. In 2001, the Supreme Court in NLRB versus Kentucky River held that professional employees who use independent judgment to direct other employees may be supervisors. This decision created some uncertainty, such that the NLRB has had to try to attempt

to sort it out.

There are a couple of more recent cases involving physician regional director decisions of the NLRB, which I have not seen, but my understanding is that they have ruled in favor of physicians seeking the right to bargain collectively. Those cases, to my knowledge, are still pending.

What's the effect of these legal pronouncements? Well, the number of physicians who can engage in collective bargaining is relatively small. These are AMA estimates based on 1998 data. First is that 325,000 physicians are self employed; 27,000 are supervisors.

So, excluding residents and employees of physician owned groups, the AMA estimated that about 108,000 or 17 percent of allopathic patient care physicians could join an AMA bargaining group and about one-third of these were academic physicians who have expressed most consistently or have been most consistently opposed to union formation.

Then, finally, an obvious one here which would involve any union organizing efforts is the resistance of corporate employers. I won't go into that.

What does the future hold? I'll make no predictions, but I have several observations, both

favorable and unfavorable to physicians unions. The first being weaker resistance from organized medicine. Organized medicine, that is the AMA in this particular instance, has essentially gone into the union business with the formation of PRN, Physicians for Responsible Negotiations, which it won't call a union. This tends to undercut previous arguments opposing union formation based on notions of professionalism.

In addition, I know it's a bit early, but PRN has had a bit of a bumpy road. The AMA Board of Trustees cut its funding in the wake of the Kentucky River decision. It's since been restored, but PRN has a relatively small number of sustaining members, 200 by last count.

Another reason why organized medicine is not as opposed as it once was is that membership in the AMA as a percentage share of physician population continues to decline. It stood at about 60 percent when unions first started to appear in the 1970s, and today it stands at about 25 percent. It's trying to attract young physicians, many of whom favor unions or have been involved or were very much involved in pressuring the AMA to go that direction.

A second observation is that professional norms and values have been slowly adjusting to the corporate

environment, particularly among younger physicians. They tend to be more sophisticated in business related matters. As I said, these were the ones who persuaded the AMA to get in the game.

The third is the trend toward more salaried physicians -- I have a table on this, which I'd be happy to hand out. It's up there and anybody can get it if they'd like -- which some have put at 80 percent of those in practice five years or less.

The fourth is the perceived monopsony power of health plans and insurers. There is a belief that there's an uneven playing field and the quest for countervailing power.

The downside, and I recognize that this first item up here could go either way, but I really think it shades into the unfavorable category, is future court rulings such as those on the status of physician supervisors and new legislation, which I don't see coming down at the Federal level, that is Campbell type legislation, which I explained in my article and I'll be happy to talk about further, and state legislation. There have been, I think, three states that have passed legislation, but the legislation such as that in Texas, for instance, is so diluted, it has to be almost meaningless in this area.

My second unfavorable concern the trend toward self-funded employers who have also been increasing and the potential for direct contracting which can place integrated physicians networks in direct bargaining relationships with employers.

The third is the flip side of the coin from the growing number of salaried physicians, is that employed physicians tend to be more comfortable with managed care than self-employed physicians. This kind of stands to reason. These are often younger physicians who are more familiar with quality oversight and often exert a great deal of control in the workplace.

Finally, I would note that the AMA has succeeded to a great extent in promoting a patients' bill of rights, if not at the federal level, than certainly in all states. That to one degree or another, the state legislation regulates the terms of the managed care contracts. In light of the Court's decision in Kentucky Association of Health Plans versus Miller, holding that ERISA does not preempt any willing provider laws, that state legislation, then, will stand with respect to self-insured employers.

So, those are my thoughts on the matter. As I've indicated, it's from political science perspective probably more than a legal perspective. I look forward

to a discussion afterwards.

(Applause)

MR. HYMAN: Thank you, Carl.

Dr. Connair.

**STATEMENT OF DR. MICHAEL CONNAIR**

DR. CONNAIR: My greetings from our nation's insurance capital, Connecticut, home of Aetna, Travelers, CIGNA and the Hartford. My brother-in-law is actually the vice president of the Travelers. Fortunately, we have different names because we have very different opinions of the insurance industry.

I'm a solo practitioner of orthopedic surgery. I've been in practice for 23 years all together now. I practice in New Haven. I am a member of the American Medical Association, numerous other medical organizations and, for the past few years, a card carrying member of the AFL-CIO, as are several thousand other docs who are not employed docs.

I help organize labor unions of the third party messenger type, as described by the Federal Trade Commission, around the country for private practice physicians, and have had varying success. It's rather tenuous, difficult to accommodate to a system. But when it works, it can have a major impact on insurance company contracting power. I'm currently the Vice President of

the Federation of Physicians and Dentists and the National Union of Hospital and Health Care Employees, both affiliates of AFSCME and the AFL-CIO.

You might ask how did a surgeon from a Republican family end up organizing other Republican physicians into labor unions. Let me tell you about two of the defining events of my professional life. The first was being extorted by Blue Cross of Connecticut, the major commercial insurer. They're now called Anthem Blue Cross. The second was being subpoenaed and deposed and possibly having my phones tapped by the Department of Justice for helping to organize a labor union of orthopedic surgeons in Delaware.

Let me tell you about the first of the two events. A very nice lady from Blue Cross came to my office, Blue Cross had been my indemnity insurer about six or seven years ago for the most part, and she said our future relationship with you will be by contract. We'd like you to sign this contract. You have no opportunity to negotiate it. In fact, the same group of people threatened one of the hospitals with withdrawal of all Blue Cross patients if they didn't sign the contract.

The terms of the contract were not very generous. They gave the insurance company control over patient care, which they shouldn't have, and they paid

rather poorly for that time. I had no choice. I signed the contract so that I would not be excluded, as she threatened, from future products. Basically, if I didn't sign the contract, I would be out of business, since that represents more than 20 percent of the commercial business in Connecticut, much more.

Well, over the next two to three years, this company dropped the terms of reimbursement on several occasions at will -- the contract specifies that can be done -- repeatedly. Synchronously with others, Blue Cross is supposedly independent doing the same thing and in the same manner but at slightly different times.

I was very frustrated and angry. I called around to organized labor and I found the Federation of Physicians and Dentists, which was experimenting with the third party messengering system which had been described by the FTC.

As you may or may not know, the system allows each and every doc to have a representative who can analyze a contract for him, analyze the financial impact, and then pass information between the doc and the insurance company, make offers back and forth, analyze group data, publish it in the aggregate so that everybody knows what the insurer is paying in general.

The nice thing about this system, unlike some

of the other structures described by the DOJ and FTC, is that it doesn't limit the number of docs who can participate. So, potentially, every doc in the community can have the same basic information on how good or bad a contract is, what the insurers are paying in general and how the proposed fee schedule will compare with the other insurers. It gives docs more power than they have, certainly not nearly as much power as with true collective bargaining. But for private docs, it probably works better than anything else when the system is pushed to the limit.

We had some successes in Connecticut in dealing with one of the major insurers, so other groups of docs, especially orthopedists, around the country began imitating it. The doctors of Delaware were confronted by Blue Cross. The orthopedic surgeons were told we have to drop your fees, boys, by 20 percent in order to remain competitive. There was no chance to negotiate this.

One of my former residents was down there and several of us formed a labor union. Almost every single orthopedic surgeon in the State of Delaware joined the orthopedic union. Very strictly by third party messengering, each and every doc had his contract analyzed, had the fee structure analyzed and decided that he would not participate with the Blue Cross contract

anymore.

Blue Cross was stunned, of course. Everyone gave notice and for four to six months, Blue Cross had no orthopedic surgeons in their network, making their HMO product no longer viable and no longer competitive. Blue Cross complained to the Department of Justice and the Department of Justice issued 80 subpoenas, deposed probably 20 docs from around the country, and I was honored to have possibly had my phones tapped by the DOJ.

The result was that after a million and a half dollars of litigation on the part of the union, not paid for by the docs, fortunately, but by the unions, a consent decree was arrived at last fall, which basically reiterated the ability for the docs in Delaware and other docs to use the third party messengering system in a manner similar to what had been already done.

Since the Delaware case, many other states have experimented with this, and we've gotten a little better at it. We've pushed it to its limits. It's supposed to be a procompetitive device where docs are educated as to what contracts they should or should not sign and then make the insurers jump instead of making the docs jump as far as contracting goes.

The docs are desperate, private docs -- this is the foundation of our medical system -- for a way to deal

with a system they consider profit oriented and not responsive to the needs of docs or certainly their patients. The physician walkouts in New Jersey and West Virginia were not just about soaring medical liability premiums.

One reason that doctors in more than 40 states are having difficulties paying their liability insurance and other office overhead now is that doctors cannot effectively negotiate with health care insurers that pay them for their services. The bargaining power of the single physician, even large, corporately related groups of physicians, is dwarfed by the bargaining power of the HMOs.

As a result, these insurers have been able to strong-arm physicians into signing one-sided contracts that give managed care insurers the legal right to deny care, compromise optimal care, and unfairly squeeze doctors financially. As their overhead goes up, rates continue to go down. Medicare, by the way, is one of the biggest offenders and some of the commercial insurers take their cue from Medicare.

Physicians don't have any choice. They have to sign these contracts. Consider Philadelphia, 70 percent plus of the population commercially insured is insured by one monopsony, Independence Blue Cross, which is

intransigent. Docs are leaving Philly because, in part, of this monopsony power. Blue Cross says if you don't want the contract, you know, go away, and you go out of business. More than 1,000 docs have left the Philly area because of the high malpractice and the failure of the monopsony to yield. It can get away with it, and it does.

If docs don't sign the contracts, they run the risk of losing a large block of their patients, in some areas almost all of their patients, and perhaps going out of business. Doctors as well as patients are harmed. It's not just squeezing docs; it is the contractual terms which harm patient care.

Some of the more egregious issues in the contracts is that docs are powerless. Right now there are contracts that discourage primary care docs from referring to specialists, bureaucratic barriers that prevent timely and proper care, forcing patients to change docs or hospitals because of contractual term manipulation by the HMOs, capitation schemes that actually pay docs not to care for patients, they earn more if they don't see the patients, contracts that allow doctors to be fired or de-selected, as it's euphemistically called, without cause, forcing their patients to go to someone else who they don't want to go

to, and contracts that unilaterally can be changed at whim.

Now, there's a clause unfortunately in these contracts that we're forced to sign that says the contract can be changed at any time by the insurers, which is astounding. When docs get paid less per patient, they see more. They spend less time per patient in the office, which increases the chances of errors occurring, especially errors of omission.

The antitrust laws were written to prevent large companies from putting small companies out of business with unfair business practices and from hurting consumers with high pricing. Ironically, those laws are now being used and enforced by the DOJ and FTC to prevent physicians from effectively bargaining for their patients and for their own financial survival.

Public policy over the past three decades has encouraged the existence of managed care as a solution to ever-rising costs. The ERISA laws have immunized insurers from suit, and the vigorous antitrust enforcement laws have nurtured managed care, which seemed to be a good idea initially.

I had the opportunity to testify for Representative Campbell in the House Judiciary hearings for true collective bargaining rights. These would allow

health care providers to participate in contract negotiations that are real negotiations and not simply acceptance of a take-it-or-leave-it contract imposed by a cost- and profit-conscious HMO.

The medical liability reform, if and when it ever comes, won't prevent docs from going out of business. Doctors need to recover all of their overhead costs routinely, automatically, without having to struggle and without having to go to some legislature for relief. If they don't, they go out of business. And the care, each doc typically takes care of several thousand patients. Every lost doc is a significant loss to the community.

What a shame to lose even one physician, now that the cost of four years of medical school is approaching $200,000 and exceeds $200,000 at Georgetown. It takes seven to ten years to train a doc and they're leaving in frustration. Some of the most experienced docs who have the most to offer patients and medical students are leaving. Public policy should focus on ways to retain every single physician as the population ages and as the demands for medical services increases.

John Sherman certainly did not envision his 1890 antitrust legislation being used by huge companies, like the HMOs, to impede patient access to medical care.

He could not have foreseen that insurers would bully doctors into these one-sided contracts that threatens their financial survival and tells them how to take care of their patients, as well as design to protect consumers and little businessmen like me.

If you don't think that the health care system is in trouble, you can look at Philadelphia. More than 1,000 greater eastern Pennsylvania, Philadelphia, docs have left. Some of them have retired. Some of them have crossed the state line into New Jersey and Delaware. Remember, several thousand patients being seen by a thousand docs impacts the care of several million people access, the docs that they have gone to sometimes for many years.

So many obstetricians have fled Philadelphia that the cabbies are now being instructed in how to deliver babies, just in case they can't get to the closest OB in New Jersey or in Delaware in time. Mothers and cabbies are praying that they don't get stuck in rush hour traffic.

One comment on the last speaker's talk about the AMA's reticence to embrace unionism. From inside knowledge, I can tell you that one of the reasons the AMA has been reticent to join forces with the Federation or any other union was the Department of Justice suing and

fear of liability passing on to the AMA, which has deeper pockets than these little unions. Until the matter was resolved by consent decree, the AMA was terrified of even dealing with the unions.

Certainly, there's some ossification which is gradually melting away in the upper echelons of the AMA, but fear that DOJ and FTC enforcement policies by docs in the AMA has given the HMOs free reign.

Thank you.

(Applause)

MR. HYMAN: Thank you, Michael.

Mark.

**STATEMENT BY MARK FLAHERTY**

MR. FLAHERTY: First, let me say I'm pleased to be here, pleased to have been invited, and particularly pleased to be in the company of Mark Levy and Dr. Connair, both of whom have done so much for physician collective bargaining in this country.

I'm a labor lawyer. I have been in practice for more than 25 years. The first 19 of those were on the management side exclusively. I think that provides a rather unique perspective to the discussion here today, not just on the management side but on the management side in health care where I've represented a number of large and national clients in the health care industry,

including hospitals, HMOs, nursing homes, emergency medicine, ambulance services throughout the United States in their collective bargaining.

I was not a union buster. I definitely wouldn't be sitting here if I were that. I was typically the lead negotiator for large national health care companies who had a mature and productive collective bargaining relationship with the labor organizations who represented their employees and who wanted to maintain that productive working relationship by reaching collective agreements with the representatives of their employees.

My practice changed in early 1998 when I was hired as national labor counsel for the American Medical Association and requested to advise the AMA on the possible formation of an AMA-affiliated labor organization dedicated to representing physicians in collective bargaining with employers and others as permitted by law.

The impetus for that effort were requests from the AMAs resident and fellow section, who accurately anticipated that the NLRB would eventually permit residents and fellows to collectively bargain with the teaching hospitals that employ them. The support also came from the self-employed physicians who hoped for some

help in negotiating with payers.

After substantial wrangling, some of which has been referenced here today, between the AMAs Board of Trustees and its, decidedly, more interested House of Delegates, the effort to form a labor organization was approved and funded in the summer of 1999.

Immediately thereafter, a labor organization named Physicians for Responsible Negotiation -- you've seen it and heard it referenced here already today as PRN -- was formed and I became the general counsel to that organization. I continue to serve in that capacity. In addition, I represent, either through PRN or directly, a number of physician organizations in the United States, including IPAs and faculty practice groups. That's my background.

Before I opine on the two specific questions that I understood we were to address today, I want to provide a little sketch of the legal landscape in which we operate. Perhaps when we move into the question and answer section, that will be helpful to all of us, at least I hope it will be. Before this session is over today, someone is bound to ask me if something is legal or not, and I just feel compelled to sketch the rather complex legal situation that confronts us here.

The laws that regulate physician collective

bargaining divide physicians into two major groups, the employed physicians and self-employed physicians. The overwhelming block of the laws that regulate physician collective bargaining regulate the first group, employed physicians, in simple terms, those who get a paycheck from an employer. Some of you will be surprised to learn that we have 52 different sets of laws that regulate collective bargaining by employed physicians, and each of the 52 sets is different.

The first set of laws is under the National Labor Relations Act. That law regulates collective bargaining of physicians employed in the private sector. Typical physician employers in the private sector are hospitals and bricks and mortar HMOs.

The second set of laws that regulate collective bargaining of physicians are those that regulate those employed by the United States Government. This includes the Veterans Administration, the Public Health Service and the Bureau of Prisons. Then we have the 50 sets of states laws that regulate the collective bargaining of physicians who are employed by the 50 states and their mini-political subdivisions. Typical employees in the state public sector are state hospitals, including state university teaching hospitals that employee residents and fellows, state mental hospitals, and city and county

health services. That's the landscape for regulation of collective bargaining by employed physicians.

With respect to the self-employed, their regulation is provided by this agency, the Federal Trade Commission. In certain states, particularly Texas and New Jersey, the regulation is provided by the state attorney generals in those two states.

Within this self-employed group, which even today is approximately one-half of the actual practicing physicians in the United States, there's still two major groups, those who have joined together with other physicians in a jointly-owned group practice that shares financial risks among the owners. The second group of self-employed are those physicians or groups of physicians who are financially and clinically independent but who have associated themselves together for group credentialing, group purchasing or some other related purpose.

The former group, those commonly-owned physician group practices, are generally permitted to negotiate with payers and others as a group, that is, as the group practice, while the latter, those who are independent, not financially or clinically integrated, are not, except under the limited exceptions presented in Texas and New Jersey, not permitted to collectively

negotiate with payers.

With this somewhat lengthy background, which I hope will be a benefit to all of you as we proceed, I'm going to address the specific questions that were addressed, at least to me, and I believe to the other speakers. The first question is, what is known about the effects of unionization, if any, on the cost, quality and availability of health care to consumers.

Let's start by taking the words effective unionization out of that question and ask it again. What is known about the cost, quality and availability of health care to consumers generally? We know a lot about cost, particularly about cost of health care for patients covered by Medicare and Medicaid programs.

We know a lot about how physicians are distributed throughout the United States and which geographic areas are overserved and which are underserved. With respect to quality of care, we certainly have gross indicators, largely in the form of comparisons with other industrialized nations. But currently, and particularly from non-hospital-based physician care, there is, in my view, little hard scientific evidence concerning the quality of care available to U.S. consumers.

I note that the Center for Medicare and

Medicaid Services is making a commendable effort to correct this lack of data, particularly in the ambulatory care setting with respect to the Medicare and Medicaid programs. But their data is generally not yet widely aggregated or available.

Now, let's go back and ask the original question: What is currently known about the effect of unionization, if any, on the cost, quality and availability of health care to consumers. Number one, to my knowledge, there is no scientific evidence either way on the effect of unionization with respect to the cost, quality or availability of health care for consumers.

I think that we can say with great confidence, particularly the Committee of Interns and Residents and Others, efforts to improve excessive work hours for resident physicians has, in a practical matter, even if not yet scientifically measured, improved the quality of medicine practiced in teaching hospitals throughout the United States. Being as candid as I can, I believe that little else either way can be said on this point.

Now, the second question: Does collective negotiation focus on enhanced quality, higher salaries for prices for the services that are being provided, or both? Based upon my personal experience representing physician groups and collective bargaining under the NLRA

and otherwise, the answer is both.

In my first NLRA negotiations on behalf of physicians, the first proposal made to the employer and the bulk of the negotiations were over quality of care issues; that is, the recognition of the parties of patients' rights in the collective bargaining agreement, the right of the physicians to make all decisions related to the practice of medicine, and the participation of physicians in all decisions related to health care where the primary issues were collective bargaining.

There was also bargaining over due process for physician discipline and discharge. There was no effort made by the physicians to increase their physician compensation or benefits. In the context of non-NLRA bargaining, and particularly with respect to faculty practice groups, the issues are similar.

When economic issues arise in that context, it is typically in the area of physician participation or at least access to information concerning the billing and collection practices of the faculty practice group or the sponsoring academic institution.

Those are my answers to the two questions posed, and I will reserve my other comments for the question and answer session.

Thank you.

(Applause)

MR. HYMAN: Mark, do you want to sit or stand?

MR. LEVY: I'll sit.

**STATEMENT OF MARK LEVY**

MR. LEVY: I knew a long time ago I should have written a response to the Budrys book. It's flawed in a number of ways. It looks mainly at one union. One of the ways that it is incorrect is that it says that there were only two unions that survived, and that's just not true. Budrys, in fact, announced the death of my union in that book, and we weren't dead, far from it. There were other unions also.

But anyhow, thank you for inviting me here this morning. My name is Mark Levy. I think I'm the one on this panel who has on the union side the most traditional union experience. I'm happy to talk from that perspective. I serve as the Executive Director of the Committee of Interns and Residents, generally known as CIR. It's a national union of interns and residents. CIR does chapter-based collective bargaining for 12,000 private and public sector interns and residents.

There are about 3,000 additional interns and residents who are members of other unions. Some of those are in independent local unions. Few are in discrete AFL-CIO resident-only units. Several groups are included

in large, multi-title, generally public sector units. That would mean that about 15,000 out of 100,000 interns and residents are currently covered by collective bargaining contracts.

Just in case anyone is not familiar with these terms, let me just give a few definitions. Interns and residents have finished medical school, have completed their MD or DO degrees. They are addressed as doctor. They give critical care. Hospitals are reimbursed for their services. They are in apprenticeship-like training for specialty and subspecialty certification.

I use the term attending to describe those licensed doctors who practice outside of residency generally in hospitals but in a range of clinical situations. For the most part, attending physicians are board eligible or board certified in a specialty.

CIR has been a national affiliate of SEIU for probably six years now. We work closely with Doctor's Council, our sister, doctors, local and SEIU. Doctor's Council represents post-residency salaried attendings, where CIR represents the residents.

CIR and Doctor's Council were both originally founded back in the 1950s. Doctor unionism didn't start in the 70s. It actually didn't start in the 50s. If you look closely, there are other events before. But CIR and

Doctor's Council have been around since the 50s.

Each of us has been growing the past number of years. Both of us regularly receive phone calls from frustrated and upset doctors who want to join a union. I've been at CIR for over 20 years. I've seen many health care changes dramatically and generally adversely impact on both residents and attendings.

A number of things that I'm going to say have already been said, but let me say them fairly quickly so that more of the discussion can be had later.

Let me start by saying the world is full of doomsayers. Every time I've been involved in an organizing campaign, I've heard the employers say, oh, my, if the doctors unionize, it will shut the hospital. When the NLRB said a few years ago that residents had rights as employees, hospitals opposed that decision and said that it would end medicine as we knew it.

When residents and medical students went to OSHA, then Congress last year to seek legislation for rational work hour limits, we said that regularly working 80, 100, 120 hours was bad medicine. The doomsayers again predicted catastrophe if hours limits with governmental enforcement would become law.

None of those predictions came true. I know of nowhere that collective bargaining, either by residents

or attendings, closed the hospital. Residency programs did not collapse when residents achieved collective bargaining rights under the NLRB. State hours regulations have existed in New York State for a number of years and did not lead to any of the predicted catastrophes.

But the doomsayers who opposed those changes that we sought, in fact, went right ahead and instituted all sorts of their own kinds of changes. Managed care and other industry changes have led to a dramatic speed up, to borrow a term from industry. There are more admissions and discharges for each doctor to handle as the length of stay in hospitals decrease. There's dramatically more paperwork to fill out as insurance forms and regulations proliferate.

Acuity is greater and treatment is more complicated as the growing number of uninsured delay their coming for care. Work is more intense for doctors every second a patient is in a hospital these days, as new technology and new treatment options expand.

Salaried attendings worked under productivity schemes that force them to cut corners. They shorten their time with each patient. Surveys of CIR members also indicate that attendings are spending less and less time with residents. Residents are made to work much

more on their own time. As nurses, transporters, translators and other staff are laid off, or otherwise in short supply, like nurses and pharmacists, somebody has to do their work. It gets passed, then, to the already harassed and overworked interns and residents.

Compassion and creativity are often squeezed and seldom awarded in the current system. Let me use some 2000 data I found from a large teaching hospital in New York. The numbers are three years old, but they still paint a vivid picture. The CEO proudly said, we have driven our outpatient activity from 875,000 visits in 1993 to 1.7 in 2,000. That's an increase of 100 percent or a doubling of outpatient visits.

He goes on. Our hospital admissions have gone from just under 40,000 in 1990 to more than 50,000 in the year 2000. That's an increase of 25 percent. This enormous growth, he says, in inpatient activity was made possible by a concomitant reduction in our inpatient length of stay. During this period of time when overall clinical activity increased, he says, the work force declined by 4.5 percent. This is the trend in lots of hospitals these days. Fewer people are now having to do much more work.

On top of this industrial-like speed up, many hospitals are also lessening employee benefits and

introducing all sorts of cost cutting schemes. In a factory, you would expect workers on a sped up assembly line to react under similar conditions. They would be objecting to the wear and tear on their bodies, to the dangerous situations they work under, and to the degradation of their product.

CIR and Doctor's Councils are unions of highly skilled professional employees. We negotiate on wages, benefits, due process and all the other traditional issues generally concerning U.S. workers. We also advocate around quality concerns related to patient care, staffing and professional development.

The union provides a structured format through negotiations or through labor management meetings for dialogue and problem solving. The professional union setting is something I know and I'm comfortable with. I used to be a teacher on the secondary and college levels. I know on both of those levels, both as a member and now as a staff person for a professional union, that professionalism and union membership are synergistic.

It never ceases to shock me how the attack on doctor's rights to be union members, to have representation and to collectively bargain wherever she or he is in the health care system never ends. If you work as an intern or resident, employers want to classify

you as a student and deny you union membership and the right of collective bargaining. If you later work as a salaried attending, employers want to classify you as a supervisor or manager and deny you union membership and the right of collective bargaining. If you work fee-for-service or in some other form of group practice, you're classified as an independent contractor and denied union membership and the right to collective bargaining.

If doctors want a change of conditions they work under, the society tells them to go join your medical or professional society. But in those organizations, doctor workers, if I can use that term, and doctor CEOs are lumped together. Those organizations are thus prevented from doing collective bargaining for their members.

All these legal fictions drive me a little crazy. Somebody out there in the real world is doing doctor work, taking care of sick people. Even for collective bargaining purposes, most of them are labeled student, manager, supervisor or independent contractors. It makes me want to shout sometimes, will the real doctor please stand up.

On a parallel issue, as others have mentioned here, to use another term from industry, not only is the uneven playing field dramatically tilted to favor

employers and insurance companies, one side isn't even allowed to form a team if all those definitions are applied.

In your invitation to me today, you asked a couple questions that have been addressed by other people, but let me take a look at one thing from another point of view. I think I'll answer those questions.

Doctors no longer provide care within the old constricts of some ancient or imagined cottage industry that once was medicine. Like the craft workers after the Middle Ages, doctors have been gathered together into a building that they don't own. They use expensive tools and equipment that they don't own. They work in conditions that they have less and less control over. Times and conditions have changed. Crafts became industries. Guilds became unions.

In the real world of the 21st century, hospital systems, insurance companies, group purchasing companies, pharmaceutical corporations, government programs, and all the rest so dominate the working conditions of doctors that it's both unfair and unreasonable to not allow hard working doctors to move forward to have a better balanced playing field.

I'll skip some pieces on general ideas about care. I know two things from sitting at the table with

employers. Internists and residents and salaried attendings pay in benefits relatively small factors in the overall budget of the institution, which also includes big items like advertising, capital construction, debt interest, administration, and executive compensation.

I also know, and we have to remember this on all levels, that whatever is eventually settled is a product of discussion and compromise and must be mutually agreed upon by both sides.

Like Mark Flaherty, if you asked me: Do negotiations focus on quality or compensation or both? The answer clearly and accurately is both. Each is truly a struggle. Employers generally want to give less pay and fewer benefits. Employees want better pay and improved benefits. Nothing is new or unusual here.

When we try to negotiate about the quality of care, administration screams, management writes and wants to avoid such discussions. But then, we generally waive those aside. We push beyond that first reaction and try to find real solutions to real problems.

I have a long list of examples of patient care issues we have fought for over the years and have actually won. They include funding for safety net hospitals, more nurse and other support staff, better

equipment, better access to patient information. In a number of our hospitals, residents have allocated a piece of their pay to purchase equipment for the hospitals.

The longest and bitterest and most important resident fight to improve quality care has been a struggle for shorter hours. Every advance on that level has followed something that CIR has done. The medical errors epidemic along with hospital infections, has been cited as the leading cause of death in the U.S. Those studies don't even count the near misses, errors actually made but caught by someone else. Exhaustion is a major cause of error. Our union has been leading and often only voiced to limit resident hours.

To me it makes good sense from a health care policy perspective to have an organized and independent countervailing voice of health professionals to balance the bottom line drive of the insurance companies, hospital chains, academic medical centers and the others. I would urge these agencies to review existing policies so that the definition of employee is broadened rather than narrowed. I think doctors should have rights to join.

In closing, let me ask, what are the fears, what are the objections to doctors forming unions? Some say that doctors make too much money so they shouldn't be

allowed to have unions. Airline pilots and many professional athletes earn more than most doctors and they can form unions.

Some say that doctors provide essential services and shouldn't be allowed to have a union. Police and fire fighters provide the essential services and they are allowed to join unions. Some say that doctors are independent contractors and shouldn't be allowed to join unions. A range of others from musicians and movie stars to electricians and carpenters are independent contractors in ways and they can join unions.

Some academics say that doctors shouldn't be allowed to join unions because doctors can't prove that doctor unions would guarantee the improvement of quality. Nurses, teachers, auto workers are not held to that standard and they are still allowed to join unions.

Some worry that doctors would be too powerful if they could join unions, but you have to look at the power on the other side of the hospital system, the chains, the insurance companies, academic medical centers. The business organizations are the really powerful ones.

Working docs have families to support. They have concerns about their own health insurance, benefits, and pay. They want to work in a safe workplace. They

want due process and fair treatment. They want an effective voice and protection to speak out without fear of retaliation about quality issues. If docs want pensions or parking spaces and have to fight for them alone, they're really up against an unfair system. Unions generally fight around those issues. In my experience, that's what doctor's unions do, too.

Thank you.

(Applause).

MR. HYMAN: Thank you.

Finally, Bill is going to speak. He has a Power Point presentation. After Bill is done, we'll take about a 10-minute break and the we'll come back and have a moderated discussion.

**STATEMENT BY WILLIAM BREWBAKER**

MR. BREWBAKER: Let me say it's a pleasure to be here today, to put some faces with people whose names I know from my own work in this area, and to talk about a very interesting and complex subject. We've been sitting here a long time and I'm going to try to translate some of my talk from law professor speak into plain English.

I'll begin with the title of the presentation, you know, Will Physician Unions Improve Health System Performance. Basically, what I want to address this morning is an unusual feature of the argument over

physician unions. That feature is this, that many proponents, and I would note with some approval this wasn't entirely the case this morning, but many proponents have argued for physician unions on the basis that physician unions would be good for patients and consumers and had been reluctant to talk about physician unions as a doctor's equity sort of an issue.

What I want to do this morning is to address that argument. Is it fair to say based on what we do know that physician unions would be a good thing for the American health care system? You know, we don't expect the auto workers to give us safer cars when they're bargaining with General Motors; we expect them to bargain over safer working conditions. We don't expect communications workers to get us faster communication times with our telephone companies, but we do expect them to ask about their own pension plans, and so on. So, again, just to point out, this is a little bit of an unusual rhetorical tact in any event.

So, what I've done is to take four fairly conventional measures of health system performance, things that we look for in our health care system, economic efficiency, quality, access and cost, and just tried to evaluate insofar as we can what the likely outcomes for the health care system of widespread

physician unionization is likely to be.

Well, let's begin with efficiency, and let me define the term a little bit here. What I have in mind is economic efficiency. We count on markets in virtually all sectors of the economy to allocate resources to people who value them the most. One of the benefits of free markets is if I've got a limited amount of money to spend, I've got lots of choices out there. I've got people who are offering to fulfill my desires in those markets in various ways. As a consumer, I can go spend my money freely, according to my own judgment, about how these things work.

Now, the reason I want to begin with that is one of the main claims that's been made about physician unions is that they'd actually improve market efficiency. That we've got some problems with health care markets that relate to the fact that health plans are basically monopolists on the buyer's side of the equation in physician services markets. The fancy word for that is monopsony or monopsonist. A monopsonist is just someone who has monopoly power who happens to be a buyer of services rather than a seller.

Now, from an economic efficiency perspective, monopsony is a bad thing. Monopsony is bad because a monopsonist, that is a person who has market power, can

drive prices to below market levels, to economically unsustainable levels, at least for a period of time. Predictably, when you do that, you see a decrease in the provision of the effected services. So, I don't want to contend that monopsony is something we shouldn't worry about. I fully agree, and I think any economist will tell you, monopsony, where and when it exists, is a problem.

The way this ties into the physician union debate is that this argument rests on two supporting assumptions. The first is that health plan monopsony is a significant problem, a pervasive problem. The second, obviously, is that physician unions -- collective bargaining by independent physicians would be a good solution to that problem.

Well, let's look at the first issue; that is, do we have a problem with health plan monopsony. Now, there are two basic sources of data about this. One has to do with data related to physician fees in various markets. There have been observations that there's been reduced reimbursement in physician services market, and the claim has been made that that's indicative of monopsony pricing, monopsony activity.

One of the difficulties with this argument is that unfortunately, price data tells us very little about

what's actually going on in the market, taken by itself. There are three, at least, I suppose, potential causes for reductions in prices in any market. One is monopsony. So, it is certainly possible that when we observe a price decrease for inputs in any market, this would include physician services, that one of the things we're observing is the exercise of inappropriate market power by a buyer.

There are two other possibilities here, though. One is simply the introduction of competition into a market where no competition had existed before. To apply this directly to physician services markets, you might imagine 15 or 20 years ago a market where physicians were reimbursed on a usual, customary, reasonable fee schedule on an indemnity basis and largely they could name their own price.

Price competition enters that market and, not surprisingly, physician fees go down. That can happen without the presence of any particular market power in that market. It can just be a function of the introduction of price competition into the market through selective contracting.

Again, we could have a situation where we have excess capacity, excess physician supply in some markets where we have physicians who we might prefer working in

other geographic areas or in other specialties. The market sends a signal that there are not as many of a particular kind of provider or there are too many of a particular kind of provider in a community, and this happens in all sorts of other markets.

Inefficient providers are weeded out. That's very painful to the individual provider that has to move, very hard on the individual doctor, just as it is hard in other sectors of the economy, but we count on markets to deal with excess capacity problems. We count on markets to provide consumers low prices by price competition all over the U.S. economy.

So, we can't just assume that because prices have gone down, we've got a problem on our hands. We may find markets doing exactly what we want them to do. What we would need to observe in order to begin to suspect that monopsony is a problem is not only reduced prices but also reduced output in the market. Mark Pauley has made some suggestions about how we might measure that.

Let me just say, in the interest of time, there are going to be some things I'm not going to talk about that appear on these slides. We can get to them in the discussion if you want.

What about market share data? This is the second other source of evidence about health plan market

share, health plan market power, I should say. Here we've got a couple of issues again. Health care market share or market share in general is used as a proxy for market power. We're not measuring market power directly when we measure market share. What we're trying to do is to get an approximation of the economic strength that a particular firm enjoys in a market.

In addition, we need to know more about that market. We need to know how competitors will respond or potential competitors will respond to an attempt to raise prices in the case of a monopolist or lower them in the case of a monopsony buyer. We need to know how the people who are being exploited will respond, what their options are. So, again, market share is a beginning proxy. It doesn't answer all our questions.

Secondly, and this is probably the more important point, the relevant market -- when we get a market share figure, that number, it's just absolutely critical that that number be economically meaningful.

Again, let me give you a fairly straightforward example. I have a very high market share personally in the market for health care law teaching in Tuscaloosa, Alabama. In fact, I believe I have 100 percent of that market. When I teach antitrust law, I make that point with my students and they sort of chuckle. I suggest I

go to see my boss and demand a pay increase, and they sort of roll their eyes, appropriately, I suppose.

By the same token, the University of Alabama Law School is, as far as I know, the only employer of law professors in Tuscaloosa, Alabama. Does that make them a monopsony buyer of law professor services? No. Why not? Because academics know that the job market is sort of a nationwide enterprise. If my dean treated me bad enough, even though my folks live two hours down the road and I like Tuscaloosa a lot, and the football team is going to get better one of these years, I would consider going somewhere else if I had to.

So, this plays out in the subject at hand today in a couple of different directions. Number one, there's a tendency -- and you can see the first tick under the second box here, insurance markets versus physician services markets -- there is a tendency to equate market power in the insurance market with market power in the physician services market. Those actually are two distinct markets. While certainly there's a close connection between the two, that tends to overstate market power in the purchasing market.

Secondly, you often see statistics about market share that say X, Y, Z insurance company has a market share in a particular state of a certain amount. That is

an economically meaningless number in most cases because most physician services markets are local. They're not all entirely local, but mostly they are. Sometimes you see health care market data broken out in terms of HMO market, PPO market, and so on, as if HMO products, PPO products, POS products, employer direct contracting, etc., didn't have anything to do economically in terms of competing with each other. So, you just want to make sure as you evaluate these issues that the numbers you're dealing with are real numbers, that they're meaningful numbers.

With that said, I think it's fair to say that there's no strong evidence that health plan monopsony is a widespread problem. Am I claiming it doesn't exist anywhere, that it's not something we ought to worry about? No. But I don't think there's evidence to support the contention that we've got a pervasive problem with health plan monopsony in the United States. This is based on two sets of studies.

By the way, this is written up in an article in the Journal of Health Politics Policy and Law. It's the same issue with Carl's article if you got the cite from his presentation.

But these studies tend to neglect the output component, I mentioned before. The ones that tend to

show monopsony power, just assume that because we observe a reduction in price, that we therefore see monopsony power. The only study that I know of that's equated or measured both price and output simultaneously is a Feldman and Willey study from 2001. That study showed no evidence of monopsony power, at least in any strong sense across the board.

The AMA study of market share data is probably the one that's gotten the most attention. It was originally produced in 2001, revised last year. For the sake of argument, for the sake of argument, let's look at the data that they've generated on combined HMO/PPO markets in 70 MSAs.

Now, if we were to have a long discussion, I'd want to qualify this by saying that these figures overstate market power among the providers by suggesting that, again, traditional commercial insurance, direct employer contracting, Medicare money, and so on, has nothing to do with the power that health plans exert in markets.

But for the sake of argument, let's accept their data. In order to conclude that we've got a widespread problem with health plan monopsony, we've got to accept a 30 percent threshold, 30 percent market plower threshold, as an indicator of when a health plan

can exercise monopoly power and create these sorts of bad efficiency effects that physician unions are said to be able to remedy.

That is, by all accounts, a very, very low threshold. And probably, the leading Section 2 monopolization case, the Alcoa case, Judge Hand deals with this question about how much market power you have to have in order to demonstrate monopoly. He says 33 percent, clearly not enough; 90 percent, clearly enough; 50 percent, maybe sometimes.

Well, the courts are a little more liberal now than Judge Hand was, but suffice it to say that 30 percent is the bare minimum, and courts are going to ask a whole lot of questions before they conclude that someone that's only serving 3 out of 10 folks in a market can dictate the terms on which that takes place.

So, again, I don't mean to suggest that there may not be monopsony power exercised in some insurance markets, but I do want to suggest that the idea that our health care system would be improved by exerting widespread countervailing economic power in the name not of fairness to physicians or distributional equity pay issues or compensation issues, but in the name of this would be better for health care consumers is just not supported by the evidence that we have about market

share. We can talk about switching costs in the discussion. That might be an interesting topic for us to have.

Now, are unions a good solution to the efficiency problem? Basically, the argument here is that what we can do with the physician union is we can move from a situation where we have a monopoly purchaser in the market, a monopsonist who is dealing with a competitive market on the seller side to a situation where we have bilateral monopoly. That is, a monopoly on both sides of the equation.

What economists will tell you, and I'm not one so I just have to rely on people that are and what I read, is that bilateral monopoly is not necessarily more efficient than monopsony is. It's conceivable in some circumstances that physician unions and health plan monopsonists might have a negotiation which is output increasing. They might agree to enlarge the pie and share more of it and so on.

We'd all hope that that were the case if we were to allow that to happen. But, in fact, it's just as likely that we would see an additional economic welfare loss from the addition of the second monopoly on the seller's side.

Certainly, bilateral monopoly is less efficient

than a competitive market. That suggests that what we need to do is to attack the market power on the HMO side or the health plan side where it exists, not with more market power but with antitrust enforcement.

One of the things I would say the physician union movement has done for doctors is it has gotten the attention of the federal enforcement authorities. You see changes several years ago in the health care policy statements. You see, I think, a more nuanced approach in the MedSouth case by the FTC. You see intervention in the Aetna merger, even as the Campbell Bill is being considered.

I'd say one of the things that the physician union movement probably has accomplished for doctors is to enhance the focus on market power to actually devote some time to figuring out where it might be exercised. So, if we do have a problem, we want to deal with it.

Finally, and this was an interesting point, I believe this was Mark Levy's point, all doctors don't have the same economic interests. I suppose one of the things that comforts me is I have considered the prospect that we might let independent physicians bargain, and you can tell that I'm not in favor of that idea, but is that perhaps that they wouldn't be able to present a united front and some of the economic problems wouldn't be as

bad, maybe, as I think.

I do think that argument, though, is a problem if the point of the union is to actually serve as a countervailing economic weight. I used to represent hospitals and doctors, and anybody that spends much time doing that is sensitive to the competing incentives that different sorts of doctors have in different situations. Not to say there's nothing in common, but certainly it's not obvious that they all share the same incentives.

Okay, well, I'll move along quickly here.

The second question: "Will physician unions improve health system quality?" Again, two claims. One, market failures are basically permitting plans to provide lower quality than consumers would prefer, something that's very hard to measure. I don't think we have any data about this, but basically what's implicit in this argument is that physician unions will go in, they will assist consumers in rewriting their insurance contracts in ways that consumers will appreciate. They'll provide terms that consumers, if they were empowered, would have chosen for themselves. They're just not empowered, so what we need to do is let the doctors negotiate on behalf not only of themselves but, in essence, on behalf of consumers.

Here I think the question is, are physicians

likely to be good agents. That is, are they likely to represent consumers well in collective bargaining negotiations. Again, I want to remind you, what my presentation is designed to address this morning is the question about whether unions will make the health system better, right. I don't have any doubt that unions would be good at representing doctor's interests. Maybe as a matter again of social policy, doctors may be deserving of that.

But the question is whether we have reason to think that physicians are likely to improve things for consumers on this front. I suppose what I'd be inclined to do is to agree with some of the comments this morning about bargaining. We don't have much data on what exactly happens in bargaining between physician unions and hospitals, health plans, etc. I've tried to do some work checking things out. I think I even quoted Mark Flaherty in something I wrote on that score.

I think it's fair to say we do see things that can be identified as fee issues, can be identified as quality issues, converging in union negotiations. The question is, how do we account for that. Can we expect unions to advance consumer interests only when physician interests and consumer interests happen to converge or even when they've divergent? What can we count on? How

do we measure what counts as the sorts of quality that consumers want to have?

If we look at fee-related bargaining, I think this is the place where we see more or less a conflict of interest between consumers, probably desires. Consumers want cheap health care. Doctors want to be well paid. Nothing wrong with either of those desires. That would just be a place where we would expect a divergence in incentives.

We're talking about non-price terms. Well, again, we can think of some situations where maybe we could find an alignment of incentives. Arguably, at least at first blush, we might say consumer value provider choice. We see some evidence of that in the market. In fact, we see the market already providing consumers with a fair amount of provider choice.

I suppose one question we might want to ask is, is this necessary to have a union to get this goal. In any event, we would expect maybe if we were prepared to concede that consumers want that, this is the place where the incentives would line up well. Consumers are concerned about health care rationing. So, maybe a union could affect the medical necessity clause in a contract or could create a payment system where doctors didn't have an incentive to withhold needed care.

The difficult question, though, here has to do with not whether in the abstract consumers prefer, once they're insured, more care to less care but whether the places at which the quality cost tradeoffs would be made by doctors line up with the places where the quality cost tradeoffs would be made by consumers.

One issue, one place this comes out, and we heard again some of this this morning, in the issue of physician autonomy in the practice of medicine. In the abstract, I think many of us like the idea that doctors ought to make medical decisions.

The question, and it's a serious question, it's not a flippant question, is whether consumers have anything to gain from the restriction of position autonomy. I think we can talk about this later, but I think there's some reason to think that consumers do have some things to gain. Do they have some things to lose? Yes, also.

Again, how are we going to resolve those tensions? Is the answer simply to turn the system back over to professional control. One of the things that I appreciated about Carl Ameringer's presentation was the recognition that collective bargaining is not a new feature in the American health care system.

I think this is really one of the, one of the

burdens that is on physician union leaders, is the result of the track record of organized, medicine for the better part of the 20th century. I don't want to take anything away from the track record of committed doctors during the 20th century, the medical scientific advances. But one of the reasons this is an uphill battle, I think, for physician union proponents is if you look at economic issues in American Medicine, the 20th century, and you look at the positions the AMA took systematically to do things like limit the physicians supplied, to suppress alternatives, to make it difficult for non-physician providers to provide reasonable services, the suppression of early HMOs in any forum, the history of boycotts and so on, it becomes very difficult to believe in a benign vision of physician unions here at the beginning of the 21st century.

Fairly or unfairly, I think that track record has to be addressed. Frankly, some of the positions that organized medicine has taken in the legislative debates have not helped themselves in that front. In connection with the Campbell Bill, some opportunities, for example, and the AMA particularly was saying, this isn't about money. An amendment was offered to make the Campbell Bill not about money. What happened? One can only suppose with the lobbying approval of the medical

community, that amendment was defeated.

I should also point out that I don't think anybody thinks there's any antitrust risk in negotiating collectively about quality issues. So, why don't we see more of that already. In other words, that's perfectly permissible already. If helping consumers is the issue, do we need physician unions to do that?

Finally, will physician unions improve access to care? Affordability, of course, is an important component of access. I don't think there's much doubt that increased fees to physicians, deserved or undeserved, will increase prices to consumers. That does affect access.

Choice of physician, I think this is a place again where physician union interest, physician interest, and consumer interest may be aligned. Strikes, I don't frankly think strikes are a particularly big concern. Maybe some day we can see a big change in doctors' attitudes, but I think doctors are committed to their patients.

I should throw in that I'm married to one and I'd get shot if I didn't say that. But I don't think too many of us are seriously worried that doctors are going to strike all the time and not care whether people get the care that they need.

Choice of non-physician providers, access in this sense I think is likely to be impaired, or certainly there's a danger of its impairment by physician unions. Access to specific therapies perhaps enhanced, but again, the question is, at what cost. Do you want the person that's going to get paid for providing the therapy determining how often it gets given? That's a difficulty that we have in medical markets. There's no easy solution to that difficulty, but it's a pervasive problem.

Costs, again, if you look at the Campbell Bill, the projected increase of about two-and-a-half percent by the CBO over a five-year period. Who pays for that? Well, frankly, I think most people think that people pay for their own health care costs. It says consumers, employees or health plan shareholders. Employees should be the employers. Over the long haul, employment is affected by how much it costs the employer to pay the salary.

Policy options, I think rightly the medical community has backed off the sort of blanket federal authorization of collective bargaining that we saw in the Campbell Bill. This would, again, conceivably provide some benefit in a few markets, perhaps, but basically what it would have done is it would have established a

physician cartel in lots of competitive health care markets in the United States.

That would have been bad for consumers under any measure, so I think rightly we see an improvement between the Campbell Bill and the Conyers-Barr Bill. My congressman is a co-sponsor. I hope nobody from his office is here. We don't need funding cut at the University of Alabama.

I think the Conyers-Barr Bill purports to be some sort of targeting federal authorization with demonstration projects, the elimination, per se, of condemnation. I think the dangers to competition, frankly, are just as real here almost as they are in the Campbell legislation, in part because the reason we have a per se rule in antitrust law -- and you can get out of a per se rule.

I mean, there are certain kinds of physician negotiations that don't involve a per se condemnation. The messenger model, for example, is one where you avoid the per se rule by not having an agreement, supposedly, but there are other situations where you engage in integration and so forth.

The time the per se analysis is applied is when we see nothing but an aggregation of economic power for bargaining purposes with nothing in it for consumers.

That's when we apply the per se rule. So, it's not clear to me that if you're probably not going to get per se treatment if you're bargaining about quality and you're not going to get per se treatment if you're integrated and are doing some incentives for efficiency that might benefit consumers, why would you back off the per se rule any other time? Maybe we can talk about that during the discussion.

The demonstration projects again, one of the interesting things about the demonstration projects, and then I see my time is up so I'll be quiet, is -- one of the things the U.S. Attorney General is supposed to do under this legislation is to give a report about how the demonstration projects are going. Interestingly, if you look at the things the Attorney General is supposed to report about, it includes quality, choice of provider, and insurance enrollment.

Guess what is not included in the report? Cost, cost. Now, you know, the bill hasn't been through Committee and may be amended. But I think that's a rather striking omission, frankly, again, one that I think doesn't help the rhetorical prospects for getting anybody interested in that sort of legislation.

With State legislation, similar issues are presented. A very interesting thing on the FTC web site,

their comments on the Alaska state legislation. If you're interested in that issue, I'd suggest you have a look at that report.

Again, increased antitrust scrutiny of health plan mergers, increased attention to actually identifying real monopsony, a worthy goal, I think something that has been accomplished through the physician union movement.

Finally, two conclusions. I think, at least I want to argue, I have argued that physician unions are likely to increase health care costs without substantially improving quality, access or efficiency. There's no documented reason to believe that they would. They might, nevertheless, be justified on distributional grounds. That's left untouched. In other words, if we want to treat physicians like auto workers, or airline pilots, or nurses, we could always amend the National Labor Relations Act to do that.

I do appreciate the sort of blunt presentations today that acknowledge that that's a lot of motivation behind this movement. It's an argument that deserves to be considered and debated. So, thanks.

(Applause)

MR. HYMAN: We'll take about a 10-minute break.

**(Whereupon, a brief recess was taken.)**

MR. HYMAN: Since everybody has carefully

observed the property rights in their time, we have lots of time for discussion. So, I'm going to let Steve kick off and then we'll probably go back and forth.

I think the first thing we wanted to do, though, was to give individual panelists that spoke early the opportunity to comment on things that were said later, agreeing, disagreeing, or expanding on. I just ask that you keep your remarks of reasonable length so that we will have time for some questions. So, let me just start again in the order in which we did and run across the room.

So, Carl.

PROFESSOR AMERINGER: A couple of things, actually quite a few things, struck me so I will try to narrow this down to items that I feel were important or significant.

There are essentially two arguments that are being made for physicians unions. One is that there's a response to concentration or monopsony powers has been mentioned. The other thread, as Dr. Connair has mentioned, has to do with the contract practices pieces of it and the exclusivity or the exclusionary, rather, practices of HMOs or MCOs. I think it's worth following up on that a bit in the sense that that was something that was emphasized a great deal at the Campbell

hearings, hearings on the Campbell Bill. It does go to the access issue which Bill Brewbaker talked about at the end.

There is an argument here that can be made, it seems to me, from the access side of it that physicians unions would increase access in certain areas of the country, particularly urban areas. It's not entirely surprising that the National Medical Association, made up of minority physicians, spoke out very strongly in favor of the Campbell legislation. So, I think that that's something to consider and has a bit of an access piece to it.

I'll respond in other respects when we get the conversation going. I don't want to take up too much more time. I do have a question for Dr. Connair with regard to Philadelphia, which he focused on, in terms of physicians leaving that area. Perhaps this goes to the entire State of Pennsylvania. I'm wondering to what extent that has to do with the medical malpractice crisis.

I've certainly been reading a good bit about that. My home state of Wisconsin, it turns out, is one of the best places for physicians to go to because of the lower premiums. As a result, I think I even read in the AMA news not too long ago, physicians from Pennsylvania

are going to Wisconsin for that reason.

At any rate, I would have some question about that.

DR. CONNAIR: Two of the ER residents just came back from a Spine Fellowship in Philadelphia. The docs in that group are now up to over $400,000 per doc per year for malpractice insurance, which is a murderous overhead cost that can only be compensated for with massive volume. In orthopedics, fortunately, some of the insurers are going to pay us so that those costs can be met. In other areas, it's not possible to meet the cost.

The main reason is, in this business, you can't pass through your costs to your payer. There is no way you can force a handful of payers, much less a single payer like Independence Blue Cross, to compensate you for your increased overhead. They ratchet down reimbursement. First they get rid of fat but then they cut into muscle and bone. There's no stopping. There's no end to the ratcheting down other than financial death of the practice.

So, unless there's a coercive way to force an insurer to yearly make up overhead costs, not only malpractice premiums but the cost of personnel, the cost of supplies, the cost of pharmaceuticals have gone up drastically as well. You know, Ford passes on the

costs of increases of rubber and glass and employee benefits. We can't.

If there is a mechanism for direct pass-through, a direct pass-through surtax, if you will, to the consumer or to the payer, malpractice wouldn't even be an issue. You know, so it goes up $100,000, it doesn't matter. You know, each office visit is now going to generate another $10. But I can just hear consumer groups and insurers objecting to that. Collective bargaining would take care of the PLI, I think.

MR. FLAHERTY: Yes. I have just a few comments about the issues raised in the presentation that perhaps will set the stage for further discussion back and forth.

During Professor Ameringer's comments about Physicians for Responsible Negotiation and their current status, it's been well publicized that there have been battles back and forth between the AMA Board and the AMA House of Delegates over funding, where I want to correct the information with respect to the number of sustaining members of PRN. PRN has both individual sustaining members as well as groups of sustaining members that represent over 180,000 doctors in the United States.

With respect to Professor Brewbaker's comments, I think it's possibly worth discussion on the question of when a monopsony begins to both drive pricing down as

well as output, that if we include quality of care as a component of output. Perhaps in some markets we have seen that, both the driving down of the price as well as the quality of care.

With respect to his comment that market share of a particular health plan is irrelevant, meaningless I believe was his word, I believe that it would be fair to say that there are physicians in his home State of Alabama who would be concerned that Blue Cross Blue Shield has 90 plus percent penetration in the HMO market is something other than meaningless to them.

With respect to his comments related to what is a meaningful threshold for analysis of monopoly power in a particular market, he noted 30 percent as a bare minimum. I would note that under the FTC rules, even in those circumstances where integrated physician groups are permitted to bargain, 30 percent is the cap and not the minimum threshold.

With respect to some of the comments related to whether physicians act in the interest of patients only when those interests coincide with the interest of the physicians, I would note the major medical advances, and this is not in historical order, of the advocacy for seat belt laws, clean water, immunization, the elimination of malaria, and the encouragement to reduce smoking. These

are all areas where physicians acting as groups, not necessarily bargaining units but acting as the AMA and the Federation of Medicine, have made tremendous strides. If you look at each of those examples from the perspective of the individual physician, it's absolutely contrary to their interests. I mean, if their interest was to have more patients, then no one would wear a seat belt. If their interest was to have more patients, we wouldn't have clean water, we'd have everyone sick all the time. I can go on and on with those lists. I would ask for some consideration of those points.

My final comment would be to mention that his comment was there have been two arguments advanced for physician unions, response to monopsony power and contracting practices. I would submit, and we can get into it, that there are certainly a number of other arguments for physician unionization beyond those two.

Thank you.

MR. HYMAN: Mark.

MR. LEVY: I think the one little piece that I would like to add is that in Professor Brewbaker's presentation, I guess the fantasy or fear that I hear is that if doctor unionization were allowed 100 percent, that all the doctors would run out and join a union in one form or another and have such power that they would

screw up the whole health care system.

I mean, I'm not proud of this, but at the height of the labor movement in the United States, all workers, I think the highest number was somewhere around 30 percent. I think the general numbers of members in unions now are probably below 15 percent. I think it's just one of those fears that says you can't even start, you can't have any rights, you shouldn't be able to do it. You know, you start out arguing backwards and therefore, nobody is allowed to join the union.

I don't see it as -- if doctors unionized, you know, as somebody mentioned, there are some docs who join, some who won't, some have religious reasons, some have professional reasons, some will be scared out of their minds by their employer, which would probably be affecting most of them, but some would join. So there would be negotiations and things would move on as they do in other collective bargaining. It's a very different kind of view, I think, that I have than what he was presenting.

MR. HYMAN: Bill.

MR. BREWBAKER: Well, I hardly know where to start. I guess that's what I get for --

MR. HYMAN: It's a target rich environment.

MR. BREWBAKER: Okay, well, as the target, I

tried to take notes. Let me begin with the points that Carl made. Let me begin with the point, first of all, that I agree with the criticism that you made. It's actually a point that I make in the article that a lot of this comes from.

There is some evidence of de-selection of physicians related to service in medically underserved areas. I think everybody or most people are probably quite concerned about that. I certainly am. There are a number of ways of addressing that problem, but I think certainly that's an important issue.

The other question, I'll use the category of switching costs to address it. This is a theory that actually the Department of Justice used in the Aetna merger case. I don't think it was ever adopted by a court, but the Clinton-Justice Department argued that even in some situations where the market share statistics were low, that health insurers might be able to exploit doctors in an economic sense because it would be difficult for doctors to make up the lost capacity if, for example, they were de-selected by a provider that accounted for 20 percent or more of their patients.

They might hang on with an insurer that they didn't want to do business with because they were concerned about continuity of care, etc. You know,

obviously we're talking about serious hardship for physicians in situations like that and some things we'd all like not to see.

I think one of the questions that I think has got to be confronted, though, by union proponents is to distinguish between the economic problems physicians face as independent business people and the problems faced by other ordinary regular independent business folks.

I was chatting with Dr. Connair during the break and I told him a story. I don't think my dad will mind me passing this along. My dad is in the automobile business and has a contract with one of the GM lines. He was involved on their dealer council which is the closest thing, I guess, to a labor union those guys have. GM was squeezing the margins of the dealers and doing all sorts of things to make their life more expensive and less remunerative.

My dad called me on the phone and said, we came up with an idea to deal with these guys. We're not going to order any more cars from them until they fix some of these things. What do you think about that? You teach antitrust law. What do you think about that?

I said, well, you know, there's a nice Federal prison at Maxwell Air Force Base, which is in the same town that you live in, so I could still come see you.

But I think it would be a little inconvenient to take the grandkids over to watch you cut the grass on the golf course over there.

You know, I could draw an analogy there, I think, because my dad has got 150 employees, he's got a plant that probably represents a several million dollar capital investment. At some point, he's got to make a choice between using that capacity in a non-optimal way, that is making some money but less money than what he wants, or sending this particular brand home and hoping he can find somewhere else to fill it in a situation where it's not easy to do. You know, you don't just call up a car manufacturer and order up a franchise, particularly if there's already a competing franchise down the street.

So, I think one of the understandable difficulties doctors are having in this environment is shifting from basically a non-market environment or a market in which they've enjoyed substantial protections from ordinary market forces into one where they have to act more like other independent business folks.

You know, I think rhetorically and on the merits there needs to be some effort made to explain why the sorts of hardships that we're talking about in terms of switching, etc., are relevant for physicians and are

not relevant for other sorts of people that own businesses of all kinds.

So, that would be one response. I bet I'll get some answers to that question in a minute.

Mark Flaherty made a couple of interesting points. The first one on the relationship between price and output in connection with monopsony, wouldn't we see a diminution in quality as indication of a diminution in output. I would say yes, that's true.

Again, though, I think the question of benchmark is important and very difficult. I mean, it's not easy to answer that. I'd want to concede that objection but then say that not all quality decreases are bad. I mean, the question we have to sort out and we hope that health care markets help us sort out is when is quality worth paying for and when is it not worth paying for.

So, for example, you can imagine a market where you've had a traditional indemnity sort of physician services market and all of a sudden managed care comes in. You see immediately reduction in price and you do see, I would imagine, a reduction in output, probably both in terms of volume and in terms of quality by some measure.

Is this just the market rationalizing pricing

quality or is this the sort of output decrease we ought to worry about? Those are hard questions to sort out empirically but I do think that that's the right way to frame the issue.

The other interesting point, insightful point, relates to the 30 percent standard in the enforcement policy statements. I think there what you're dealing with, and this does tie back into the whole question, is the difference between the cartelization concerns that are reflected in Section 1 jurisprudence in the Sherman Act where the agencies are concerned not only about aggregating market power in a single negotiating unit but the facilitation of collusion within that market. In other words, it's easier for four physician groups with 25 percent of the market each to get together and set prices than it is for 10 groups of 10 percent each.

Now, let's flip that back on the insurance side of the equation, because obviously one of the concerns with insurance companies having large market share, particularly if more than one of them does, is the possibility that they could collude. There you've got a slightly different question than the monopsony question.

Of course, any sort of collusion on prices by insurance companies is also a per se violation of Section 1. If it can be discovered as actionable and there's no

doubt, no defense about that for the same reason that the per se rule applies on the other side. So, I think what you've got there is a dual concern not only about the aggregation of market power but about facilitation of price fixing.

The comment about market share being meaningless, I did say that, I think. I would say Blue Cross' 90 percent market share in the HMO market in Alabama is meaningless. Their 80 percent market share in the market for commercial insurance generally is not meaningless. So, they've got 75 or 80 percent of the commercial insurance market. I don't think that's a meaningless figure.

I do think that because someone is shopping for an HMO product, the question is if they can't get that, can they find a substitute either by engaging in direct contracting if they are an employer or can they use a POS plan or PPO plan or some other product.

I think the fact that we saw a merger between the Health Insurance Association of America and the American Association of Health Plans this past week says a lot about the way insurance markets go. What we've seen is a move toward more managed care by the traditional indemnity folks and some opening up of the tight health plans. That's an intuitive way of

explaining myself on that.

Finally, there's nothing that prohibits doctors from engaging in political advocacy. One of the things that's difficult about making judgements about how people are likely to act is it can sort of very quickly degenerate into impugning people's motives and saying that doctors are worse than other people or more venal or something like that.

One of the things I think I did say, and I want to reiterate it, is professionalism in American medicine has been a double edged sword. It's been wonderful for American patients in a lot of ways. I mean, the ethic of putting patient's interests first, which I think is dominant in the lives of hundreds of thousands of individual medical doctors, is something we all appreciate. The emphasis on medical science is something that there's not a person in this room that hasn't benefitted from. So, nobody wants to suggest that.

I think the question is, as we try to predict the likely behavior of physician unions in the future, what can we look to to get some sense of how they might act. What I see, and this is tainted probably by my status as basically an antitrust lawyer, I look at the situation and I see basically this movement as a desire to head us back to the days when local medical societies

and the AMA controlled the shape of health care delivery in the United States. Some of the features of that situation were good for consumers and some of them weren't.

I'm taking too much time, so I'll be quiet.

DR. CONNAIR: I'd like to ask just two questions with respect to what Attorney Brewbaker had to say. He referred to the prescription against price fixing, even amongst insurers who have some immunity from antitrust constraint.

If you look at what goes on within a state or across state lines, there truly is a synchronous ratcheting down of physicians, again within a state, amongst the Blues, across the nation. Yet, it's very difficult to prove that one CEO is calling up another and saying, you know, it's time for our 10 percent reduction again this year. How vigorous is the DOJ in pursuing that or interested in pursuing it?

The other matter that was brought up by Attorney Brewbaker is that he referred to physicians collective ability to -- this isn't the exact wording -- to insist upon quality issues. Yet, technically, the current enforcement prevents collective bargaining about anything, whether it's financial or purely nonfinancial, the case of drive-through deliveries.

It took nearly an act of God to have those prohibited through legislative action and lobbying by physicians. Yet, collective action in that purely quality of care issue could have been taken care of within weeks by physicians collectively threatening insurance carriers.

Would the DOJ enforce in that situation against docs who did that purely in the interest of patient care?

MR. KRAMER: I'll be happy to address those. Perhaps we can do that at the end or I can do it now. It doesn't matter to me. But there are a number of more general questions that I'd like to raise here.

Let me address them very quickly to say the DOJ is very much interested in situations involving collusion by insurers in terms of what they pay physicians or any other health care provider. That activity is emphatically not immune from antitrust challenge by the McCarrah-Ferguson Act, as we've said for a number of years despite claims to the contrary. If there is information that goes beyond parallel pricing, which occurs in every industry in the country, and obviously occurs in this industry, then we're interested in hearing about it.

In terms of quality of care, collective negotiations, it's a complicated issue. I want to ask

Professor Brewbaker a question about that in terms of his statement, as I understood when he was talking, there's no antitrust risk in negotiating on quality issues. Well, the holding of Federation of Dentist's case certainly shows what may be quality in the views of some may not be viewed as quality in the eyes of others. There are antitrust risks in specific situations.

I can't speak for the Department in terms of what the Department would do in any particular matter. There's room for a considerable give and take on issues that are not obviously related to competitive concerns that potentially can work to the clear detriment of consumers.

So, let me leave that at that for this point, if I may, because I certainly didn't come here today to try to explicate the Department's position on issues.

Although, before I depart from that, I do want to say one other point briefly. That is, I also didn't come here today to re-litigate the facts of the Federation of Physicians and Dentist's case. So, by my not taking you on on some of your characterizations, which were brief on the facts there, it shouldn't be understood that I necessarily agree with those characterizations.

Finally, I wanted to compliment David, who,

without any input from me, organized a very nice variety of perspectives here today, all of which I thought were very high quality presentations. I want to compliment both him and the panelists on what I've heard here today, which I thought, for someone who has worked in this area, provided a very nice introduction for anyone to -- basically, all are different viewpoints in the important areas involved in this issue.

So, with that, let me now proceed to ask the first question, if I may. That would be, there was an implication, I think, in both Mark Levy's presentation as well as Bill's presentation that perhaps physicians are working under different legal principles as involving unionization. The Department took the position, along with the FTC, opposing the so-called Campbell Bill, that in fact physicians were treated no differently under the law and that the bill would seek to amend that to give them special treatment.

I'd just like to get the response of any of the panelists in terms of their view on that, whether they would disagree with the view of the Agencies on that or as some of the implications here appeared to be of some of the statements. It would be the situation that currently the law treats physicians no differently. Of course, how that law is applied to specific circumstances

may be the nub of the issue.

PROFESSOR AMERINGER: My understanding of the Campbell Bill is that there were at least three aspects to it that made it somewhat different from the typical situation regarding employees under the NLRB. One is that the NLRB would not apply. There would be no government oversight.

A second feature was that the bargaining unit -- that physicians would bargain with the health plan but not with multiple firms. Then, of course, the other feature is the fact that we're talking about self-employed providers or independent contractors.

So, those three features made it stand out. I think does give some impetus to the comment that Bill recently made with regard to an attempt to reestablish a guild type system. There are certainly some aspects to that analysis which would indicate that that might be the case.

MR. BREWBAKER: If I suggested that I thought there were currently different rules for doctors than for everybody else, then I misspoke, because that's not my view.

So, on the quality issue thing, I guess, you mentioned that as well, Steven. I certainly think, just to say, perhaps I was a little exuberant, to say there's

no antitrust risk is not correct. I'm recalling, though, at one of the Campbell Bill hearings a conversation that Chairman Pitofsky was having with the committee about the enforcement posture of the FTC at that time.

Unfortunately, I don't have total recall, but I think it's safe to say that prosecutorial discretion would be used in situations like that. It wouldn't surprise me, particularly in a situation where we weren't talking about a so-called quality issue that just happens to be completely convergent with physician's economic interest.

But that's what I had in mind when I said that, and I appreciate your calling me out on it.

DR. CONNAIR: As for differential treatment goes, I don't think there is differential treatment. Unfortunately, the antitrust laws that were intended for John Rockefeller and Alcoa have been rather awkwardly tailored to deal with the professional issues of medicine. Enforcement sometimes doesn't seem entirely rational in that the laws perhaps weren't intended for use in this situation.

I do recall very well the comments of the judiciary hearings with Mr. Pitofsky and the first comments out of John Conyer's mouth after Chairman Pitofsky's recitation of the current FTC guidelines was.

It was, and I quote, "You're screwing doctors." He challenged Chairman Pitofsky to cite one situation in one state where the regulations and guidelines had adequately protected physicians.

MR. LEVY: Not directly on the Campbell Bill, but two sort of images that I would just like to mention that are related to the whole question of whether this fairness in treatment.

A couple years ago I had a hip replacement. It was successful, good orthopod, really nice. But when I would see him, he worked at Columbia Presbyterian. So I went in to the building where all the docs were and there were shared files areas, they shared secretaries, they paid rent to Columbia Presbyterian, and they sent me for tests downstairs. It didn't look like just a group of independent docs who didn't have any other interest with Columbia Presbyterian. They were forced to pay a certain amount of rent and tithes and whatever, whatever, whatever.

I mean, there's no end to the kinds of impositions, like the reference to malpractice costs go up and you can't pass that cost along. I mean, it was the same thing. When Columbia Presbyterian would want to charge more rent or charge a bigger share for all the other services, the docs technically couldn't talk to

each other on the same floor where they were sharing offices and say, this isn't right.

That's a little odd to me. It goes back to the fiction that they are independents, that the antitrust law was really built to protect the public policy and prevent the two docs from talking to each other, when I really think antitrust laws came from another area.

I think they really are differentially applied. There's a case that's floating around out there where three residents are filing an antitrust suit against the combined weight of all organized medicine. Without sort of commenting on the content of that case, basically, what they're alleging is that through the interlocking directorate -- AMA gets to appoint so many people to be on somebody else's board and the American Hospital Association gets to appoint so many people on the Match Board, and they all appoint people to each other's boards -- they're never supposed to talk to each other or collude.

But somehow, resident pay across the country and resident work hour across the country are really resistant to change, but all these people who appoint people to each other's boards never talk about those things. It's been the burden of private individuals to bring such a suit, whereas nobody else took a look to see

whether there was that kind of collusion going on.

One of the reasons that my union has not taken a position on that suit is that whatever a judge is going to decide in an antitrust suit can really shake up the industry in ways that are not expected. I think collective bargaining where employees and employers sit down and talk things out can make better decisions in that kind of forum than in an antitrust forum.

But I really think that there are many visible aspects of this kind of interconnectedness in an industry and it didn't come to the Department of Justice's attention to do that. Whereas, a couple of people in Delaware or Connecticut get together and say this is really terrible, and that comes to their attention. I really do think it's unequal in that kind of way.

MR. FLAHERTY: Steve, I want to address directly your question, how will we respond to your observation that the Campbell Bill would have conferred some special treatment for physicians. I can see that point. I do think it should be viewed in a larger context, however. I kind of viewed the Campbell Bill as almost a Hail Mary response by the federation of medicine to what was going on at the states.

So, we have two very different regulatory systems. We have the states regulating the insurance

industry. We have the Federal Government regulating the collective efforts of physicians. So, I understand your position and your cause for concern.

What I don't understand, and I would seek your insider comment, is when the physician collective bargaining bills are presented at the state level, New Jersey, Texas, Alaska, wherever, and there we have a state regulatory scheme over the insurance companies, it's largely hands off. If the states are regulating it, then largely you let them go.

What is the Department's position or how does the Department justify having a different position if the states want to regulate physician bargaining with those very same insurance companies?

MR. KRAMER: To make this very quick, I don't believe the Department is opposed to the Federal Trade Commission. As you know, we do speak with one voice at times, but I don't believe the Department has taken a position on any of those state bills. So, I feel very uncomfortable as a staff attorney at the Department postulating on that point.

MR. FLAHERTY: I appreciate that.

MR. HYMAN: Here's where I put my academic hat on and say I'm only here part time. It would be above my pay grade even when I'm here. I think the Commission

takes a position by vote of the Commission. I have neither expressed nor implied authority to expound on that.

So, now I get to ask my question, though, and that is the transition. A lot of the discussion has sort of started from or either assumed explicitly or viewed as a necessary precondition monopsony power for unionization, not all of it, by any stretch of the imagination, but certainly a lot of the recent push is in response to the perceived monopsony power of insurance companies.

Professor Brewbaker presented some data that suggests that depending upon what your threshold is, you identify other more or less markets. I think the biggest with the most liberal threshold was something like 50 markets, and with the strictest threshold it was 4 or 5.

Conyers-Barr seems to have essentially tried to finesse this issue by limiting it to markets that have a higher concentration. But that was not the approach in the earlier bills that were considered. So, I guess the question that I would have is, would you expect unionization efforts to go better in markets where there's monopsony than in markets where there isn't.

It simply is a sort of strategic response to that. If you think it's going to basically roll out the

same across multiple markets, what's the upside of cartelizing the physician market where there isn't monopsony on the insurance side.

What are the benefits and costs associated with a universal role out of physician unionization if Mark's relatively pessimistic assessment of the prospects that 30 percent in the best of times, down around 12 percent now, is inaccurate and physicians are actually keen and enthusiastic advocates of unionization?

So, I think that's basically the question. If you could target this to markets where there's monopsony, that's a rather different scenario than if it's going to be rolled out across the country.

DR. CONNAIR: Even where there's not true monopsony, like Alabama or Philadelphia, the insurers behave synchronously whether it's by parallel pricing or by some secret phone call. So, there is parallel ratcheting down because there is absolutely no counterbalance on the other side. They all take advantage of that one-sided strength that they have to ratchet down.

So, I'm not sure whether it makes a difference. I think where the prices are badly depressed, where the insurer or insurers have taken most advantage of their combined or single power, those are the markets where

physicians will be most willing to let go of their traditional unwillingness to even consider a union. It takes them a few hearings to even consider joining a union.

It's funny how it works. They finally decide that if it's good enough for some of my workers, perhaps it's good enough for me. They really have to bleed badly. Some of their colleagues have to have left town or have been forced out of business before they will even consider a union. But I think it's in the most severely forcibly depressed reimbursement areas that they'll do it, not the monopsony alone.

MR. FLAHERTY: David, I believe that in those markets where you find a greater penetration by a single payor, that you are far more likely to find a willingness and a will to respond collectively on the part of physicians. I do not see the hesitation to join a traditional union as any kind. I just personally don't see any hesitation on the part of physicians to join some kind of an organization that they believe would have the power to collectively respond.

That is, I share Mark's view that there is a natural reluctance on the part of a large number of physicians to join a union. There is almost no reluctance on the part of any self-employed physician to

join an IPA. That is a very different professional appearance.

To the extent that those IPAs can clinically or financially integrate themselves to the extent that they are permitted to then act collectively, I find no hesitation on the part of physicians to join those organizations that are permitted under the current standards to respond to a dominant payer in a particular market.

DR. CONNAIR: But when they join an IPA, they really want a union. They finally get over the U word.

MR. HYMAN: If I can just have a follow up, that was really my next immediate response to that, is well, isn't an IPA an adequate substitute. If it isn't, as Dr. Connair's observations suggest, where do you go from there? Why is the messenger model, an existing IPA, not sufficient to address the problem?

DR. CONNAIR: Well, just the market share that's allowed for a non-integrated IPA. A third of the market isn't enough to really influence reimbursement. The nice thing about the messenger model is as it's described, there's not a prohibition against 100 percent, if you can get it, of docs being educated appropriately by a messenger.

So, even though it's relatively weak through a

comparative collective bargaining, at least it includes all the docs and not just a third of the market.

MR. FLAHERTY: My response is different than Mike's. I think that if the messenger model is the alternative, then it resolves almost none of the advantages of collective action permitted under the NLRB. There's no, at least as I read, the messenger model rules on fee or fee related issues, no collective action permitted.

MR. LEVY: I'd just like to comment about docs joining organizations. I think all doctor unions now use words like committee or federation or association. Nobody uses the U word. If you went through the whole AFL-CIO, I bet you a lot of those unions don't use the U word either.

I'm always caught in an odd position because I've worked with other employees. I've worked with docs for many years now. When I try and explain docs to non-docs, I use industrial terms. When I talk to docs, I don't want to sort of embarrass them or use those other terms.

But truth tell, docs are just like other citizens. Somebody said docs are conflict adverse. So is everybody else. Somebody said docs don't like to go on strike. Look at the statistics. No other workers

want to go on strike.

When I go to meetings, whether it's with residents or attendings, the same questions that come up when I used to work in electrical manufacturing or when I worked with groups of other hospital employees come up -- what are the dues? If somebody else goes on strike, am I going to have to go on strike? Who makes the decisions? Who are the officers? They're the same questions. They're absolutely the same questions.

We know what it takes to build a union or have a union function, get people, busy people, to participate. Docs are really busy and it's hard to get them to participate, but in a hospital worker's union where there's somebody who has got three kids and a single parent, it's hard to get them to participate.

A lot of the issues are really very much the same. But then this whole other dialogue, almost all the issues that either Professor or Lawyer Brewbaker, Attorney Brewbaker, brought up, I don't understand why these are questions that even exist before you say should a doc have a right to join a union. That's just a whole area of dialogue that I think just isn't appropriate. I mean, I understand why it's there, because the laws have been told that in a certain way and they've been interpreted a certain way.

So, it's easy to justify the status quo by developing all these very sophisticated kinds of arguments. To me, they just don't make any sense. They don’t make sense. I know where they're coming from. You said it. You're opposed to docs having unions. So, then you can develop all sorts of arguments to get to that point.

But I really think you have to get through some of that and get to some of the realities of what doctor's unions are like, the issues that doctors care about. Whether auto workers do care about making safer cars, I think they do. I think the way some of this discussion goes is beyond my imagination.

MR. KRAMER: I think before we ask another question, we'll give Mr. Brewbaker an opportunity to respond to that last statement.

MR. BREWBAKER: I don't have anything to add to what I've already said.

DR. CONNAIR: Can I just jump in here? Your comments are interesting, and I want to start with the first part of what you said, and that's with respect to physicians are the same as ordinary citizens, or something to that effect.

That's one of the difficulties that perhaps a lot of folks have with thinking about physicians and

unions, just as they would with lawyers and unions or any other particular professional group. It gets also to the issue of how do you separate reimbursement from quality.

In other words, in the union context when you're negotiating a contract, you're negotiating a contract which is going to pay people or groups of people at a certain amount, certain levels. Whereas, in this particular context, physicians as individuals are different, just as lawyers as individuals are different. To some extent, what you earn or what you make reflects quality, is some indication to the consumer as to the quality of the service that is to be provided.

Isn't that one of the problems here, the fact that you really can't separate reimbursement from quality? Then, when you try to move it into the union context, you're indeed trying to do that.

MR. LEVY: I think you can. I said in my presentation that all agreements are agreements that have to be mutually negotiated and agreed to. It takes the other side to agree to it. So, if part of what you're talking about is setting certain standards, that could be, from the employer's side, all sorts of industries, whether it's productivity standards or other kinds of standards. They're on the table as part of the negotiations and something gets worked out.

How you measure quality? I don't know. I mean, I do have some ideas but how do you set that up so that it cuts across the board evenly. That's something for the parties to negotiate. I don't think it drives prices any more out of whack than what I see some of the CEOs earning. I think that drives stuff out of whack probably even more.

I'm not worried about docs negotiating and not presenting quality care issues because it's as much the obligation of the employer to put those issues on the table as it is for docs to talk about them. What I see in some hospitals is that the best teachers who spend time with residents and explain stuff to patients, who are also a little bit older, they're the ones that are getting pushed out. Just like in an assembly line, the older workers can't make the production and so they're out.

So, there's only one criteria in that situation. It's production, not teaching and definitely not quality, not creativity, not any of these other things, you know, how many people can you move out. They're getting pushed out in droves. Look anyplace.

I bet you if somebody had access to the information, as in sealed documents all over the place, you'd find a lot of age discrimination suits against

hospitals. I mean, you just see that happening all the time.

Where's the balancing effort in this situation? I think they are the same in the kinds of ways that are important. I think there are safeguards in the collective bargaining process because both sides are obligated to put on the table whatever they want to put on the table.

DR. CONNAIR: I think what physicians would really like is the balanced sort of structure that a guild used to represent, which is a professionalism piece in there which deals with the concern for our patient's care. But then there is a hard core union piece there, too, which deals with the contractual issues and the financial issues.

Docs need both. They really need a combination of hard core labor union for their contracting needs and the functions of a medical society, which they already have. They can't do what it has to do because it's prohibited and emasculated by not being able to have that piece which it needs to complete the job that docs require for their representation and for the care and safety of their patients.

MR. LEVY: One quick thing, let the record show that I'm giving Mr. Brewbaker several years of copies of

the CIO news so that he shouldn't be able to say that he can't find instances of where a doctor's union has fought around and even won on issues of patient care.

MR. BREWBAKER: Let me express my gratitude for that. Thank you.

MR. FLAHERTY: Carl, I have one response to your question. The implication behind it, I believe, is that at present there is a recognition in the current reimbursement system for quality. Let me say, and I'd welcome Mike's inputs as well, that is not my experience in representing a large number of physicians around the country. It's common that there is no distinction from provider to provider within a particular geographic area.

The quality measure that I see has to do with volume. That is, the better docs aren't getting paid more per procedure. It's that they're perceived by patients as better doctors so the have more patients. That's what I perceive as the current situation.

MR. KRAMER: In terms of assessing the monopsony issue, Professor Brewbaker, what do you make of Dr. Connair's statement that doctors don't have any choice but to sign contracts in relation to the offers they're receiving?

MR. BREWBAKER: Well, I think there's a certain amount of truth to it and a certain amount of falsehood

to it. Are doctors often put in situations they'd rather not be in in connection with transactions with health plans? Certainly, they are. How different is that from situations we find ourselves in in other aspects of the economy? Not very different.

So, I wouldn't deny that this is a serious issue from the perspective of the individual doctor. I wouldn't want to deny that for a minute. The question is a matter of policy. Do you want to displace market forces? Do you think you're going to get a better overall result by avoiding that hardship through some intervention, whether it's regulatory or for the union than just accommodating some of the dislocations that markets bring?

So, again, I refer back to the example I gave about switching costs and car dealers a minute ago. I mean, I think there's a strong analogy there. Lots of people would like to buy an automobile in Alabama without signing an arbitration agreement. Sometimes you can and sometimes you can't. Markets just don't always give us the choices that we'd like to have.

MR. HYMAN: Let me pick up on that point and push it in a different direction. Dr. Connair, particularly when you were discussing overhead issues and malpractice, you made the statement physicians need to

recover all their costs. That actually sounded a lot to me like the kind of language you'd hear when you're talking about a public utility who needs to be entitled to a guaranteed stream of income to cover their costs and provide sufficient resources to invest in new capital. But the difficulty is, obviously, public utilities are not the sort of thing we depend on competitive markets to handle.

So, do I understand you to imply, and maybe this more general an observation, is health care special in that we should just fork over whatever their costs are plus a sufficient amount or is it subject to competitive forces because car companies, to continue the metaphor, would like to cover their costs and more, but there's no guarantee. Sometimes they sell at a loss.

So, it goes back to the basic issue, is health care special. Should it have separate rules and not be subject to the market?

DR. CONNAIR: Of course, there is a public utility aspect to medicine. There are free market components to it. I wouldn't call it truly a free market. I don't know what Professor Brewbaker thinks about that.

We are not in the position to make demands of powers much greater than us when attempting as individual

physicians to negotiate a contract, if you can call it negotiate, with Blue Cross. Blue Cross threatens even one of the two large hospitals in my area with discontinuation of contract and forcing half the patients in town to switch to the other hospital if they don't do as Blue Cross demands.

So, it's not a real market in that there is no counterbalance and real market unions provide some help for the helpless individual worker, preventing him from being taken advantage of. I truly think we are, when it comes to our contracting needs, no better off than grape pickers or steel workers and at the mercy of United Fruit or Bethlehem Steel.

MR. FLAHERTY: David, I think you've raised an excellent question. I believe there are substantial aspects of regulated industries with respect to medicine as a whole. I mean, there's substantial amount of rationing of medical resources by both the state and federal governments through certificate of need programs, through anti-dumping statutes, through minimum hour requirements in emergency rooms, which then get pushed on to doctors as on call requirements.

So, I think you start to touch on a very important question and that is, how do we juggle this industry that has certain aspects that are treated like a

regulated industry and certain other aspects as a non-regulated and purely competitive industry. If I had answers, I would give them, but I think you're raising the right question.

MR. HYMAN: Anybody else?

MR. KRAMER: I wanted to follow up on a point that you made, Mark, in your presentation when you said we know a lot about which areas are over and underserved. I'm wondering what the nature of the information is that's available on those issues, as Bill spun out a bit. It's certainly an important point on monopsony assessment.

MR. FLAHERTY: The primary source of my information is a wonderful publication of the American Medical Association called Physician Distribution. That is a report that is updated at least once every two or three years and lists by geographic area the distribution of physicians by specialty, by subspecialty and primary care status throughout the United States and on an urban area by urban area basis.

In addition to that report and for any FTC analysis, typically one is forced to go to private services that have even more detailed information about a particular market.

MR. HYMAN: Dr. Connair commented, and I'm not

going to pick on you this time, I'm just using your observation, that Medicare is one of the biggest offenders with respect to dealing with physicians in onerous terms. I noticed Professor Brewbaker nicely highlighted that in the Conyers-Barr Bill, the per se treatment is eliminated across the board except for federal programs.

I wonder whether anybody wants to discuss the sauce for the goose implications?

DR. CONNAIR: There would not have been a snowball's chance of that getting through the House of Representatives, Campbell Bill, if Medicare had not been excluded. In fact, any references to abusive behavior by Medicare and Medicare being part of the problem were stricken from the testimony that I was asked to give because it would have pushed so many buttons that it would have scuttled the chances of passage on that basis alone.

Medicare is a good guy. In PR terms, HMOs are bad guys. It's easier to deal with collective bargaining against them than against a sacred cow, which lots of people on the Committee love and which most Americans love and don't understand that it's a problem in and of itself.

MR. BREWBAKER: Well, I feel constrained to add

that perhaps the federal government was also willing to impose costs on the buyers in the private sector that they weren't willing to impose when their own budgetary issues were on the line. It's hard to know what people's motivations were there, but it certainly seems like a fairly obvious observation.

MR. KRAMER: Professor Brewbaker suggested that there may be some consumer benefits that leave some restrictions on the autonomy with which physicians provide there services. Perhaps we ought to let him elaborate a bit on that and let's see if there are any comments on that from anyone else.

MR. BREWBAKER: Did I make you angry or something here, Steve?

Yeah, here's what I had in mind. I do think if you look back at this whole question of how we spend our health care resources and how much waste there is and has been in the system, there's a strong case to be made that there really were some things that needed to be managed when managed care started. I think the medical profession, to its credit, has owned up to some of that. If you think about Jack Wenburg's studies about small area variations in medical care, the practice guideline movement designed to make sure that doctors really are bringing medical knowledge to bear on individual patient

treatment and aren't just treating patients the way they've always treated them, without the information that's required, then I think those are places where some intervention could be helpful.

I would go ahead and add that one of the potential dangers of physician unions is probably a visceral impulse to preserve physician autonomy in ways that might impede advances in quality assurance. I think if you look at the quality assurance literature, most of the trend is to think that we do better working on systems than identifying individual, bad apple doctors in the bunch.

To the extent that that involves intrusion on physician autonomy, it involves the mandating of physician and non-physician teams and so on, I would be quite concerned if unions had the unintended consequence of making those sorts of improvements harder to achieve. So, that's what I had in mind by the comment.

DR. CONNAIR: As much as I hate to agree that managed care does do some good, it certainly does have the potential for doing a great deal of good. As far as imposing the standards on patient care, for instance preventive care, mammography, bone density scanning, and immunization. There should be some limitations on the autonomy of physicians when it comes to such issues.

Even the hypochondriacal patient who wants his tenth MRI scan when nothing showed on the first nine, it's actually a relief having a managed care company say no, you can't have that.

So, there should be some restrictions on the tail end of the bell shaped curve of behaviors, but the problem is, you snip the tails off and then they start snipping at the center of the curve just to try to save costs or they start prohibiting the use of routine medications which should be allowed, forcing patients to take, say, Motrin instead of the newer Celebrex or Vioxx which will save several thousand lives a year in bleeding. They start saying, well, only if you meet these criteria, and the criteria becomes stricter and stricter and stricter as they try to increase their profitability. So, it's good and bad.

MR. LEVY: I have a passionate response when I hear about fat in the system. I know there are 40 to 60 million uninsured in this country. We have a system where somebody or some bodies are absorbing all that extra work. I think the system would be dramatically changed if this country made sure that there was insurance coverage for all those millions of people.

DR. CONNAIR: Talk about homeland security, that is the most insecure thing about this homeland,

patients being uninsured and not having access to the best care when they need it.

MR. HYMAN: I see that our time has run out. I'd like to thank the panel for their excellent contributions to the work that we've been doing. I'd ask you to join me in a round of applause.

(Applause)

MR. HYMAN: For those of you who are staying for GPOs, we will start at 1:30.

(Whereupon, a luncheon recess was taken.)

**AFTERNOON SESSION**

MR. ELIASBERG: Good afternoon, and welcome to the Health Care Competition of Law and Policy Hearing Session on Group Purchasing Organizations. My name is Ed Eliasberg. I'm an attorney with the Antitrust Division of the United States Department of Justice. I'm one of the co-moderators of this session. The co-moderator of the session is Matthew Bye from the Federal Trade Commission, who is sitting to my right, to your left.

Before we go any further, now that we've had the introductory welcome, why don't we all just take a moment to be sure that our cell phones are turned off and all that. Now would be a good time just to check to be sure so we can try to avoid that sort of disruption.

While you're doing that, let me just sort of set the framework here. Today we're going to be looking at group purchasing organizations from the perspective of health care competition law and policy. I guess the next thing I want to be sure to do is to thank each of our seven panelists for taking time out of their busy schedules to come to speak to us and give us their insights, perspectives and learning upon this topic.

If you haven't had a chance yet to look at the agenda that's on the web site, I would urge you to do so when you have a chance when you go back to your office

later today or shortly thereafter. It sets out some of the questions that we were hoping to gain insight and perspective on today.

For example, when is bundling procompetitive, when is it anticompetitive? How do you determine if the duration of a sole source contract is procompetitive or anticompetitive? Indeed, are there instances when a sole source contract with no term limit is nonetheless anticompetitive? If so, when, why? How appropriate is the analysis of Statement 7 of the Health Care Policy Statements, particularly the 35 percent safety zone test in the context of group purchasing situations? Also, which is very important for us at the Agencies is, where do things now stand with respect to these practices in the competitive sector of the economy of group purchasing organizations?

The format today is going to be this. Each of the seven panelists is going to be giving approximately 15-minute presentations. They will be giving it in the order in which they are sitting, starting from my right, your left, with Merrile Sing.

Following that, we'll take a short break and then we'll have a moderated roundtable discussion with Matthew and I asking questions. Now, to get a little bit ahead of myself, you'll be hearing shortly Merrile is

from the General Accounting Office. She'll be speaking first about a study that they've recently done concerning the GPO industry.

After her will be Bob Bloch, who is an attorney in private practice in town. Bob is going to give a little bit of what are some of the leading cases in the area of things like bundling, exclusive contracts, things of that nature. So, there's something of an analytical framework from which the other speakers can or cannot, as they think it's appropriate, guide their comments and their thoughts concerning competition law and policy. Because of that, Bob may be going a little bit longer than the other speakers but, Bob, not too much longer, okay.

Now, as with all our sessions, I'm afraid there will be no questions from the floor. But on the other hand, if folks want to bring views or thoughts to our attention, you're perfectly free to do so. You can simply e-mail them to us and you have until November 8. Likewise, I should tell you that already we do have some written submissions that have been made with respect to the session.

Now, as far as the individual speakers, I'm going to give a very, very quick introduction to them. We have the superb bound volume, excellent for keeping

and handing on to future generations, of your experience here at the sessions, and which has the biographies of all the folks who were here today.

Basically, and I'm again going quickly, starting to my far right is Merrile Sing from the General Accounting Office; Bob Bloch from Mayer, Brown, Rowe and Maw; Mr. Said Hilal who is the CEO of Applied Medical Resources Corporation.

Then to my immediate left is Mr. John Strong, who is CEO of Consorta, which is a GPO. Then to his left is Mr. Lynn James Everard, who is a health care business educator and supply chain strategist. I will divert from what I was saying before and tell you something that is in his resume in that wonderful bound volume. He's also a certified purchasing manager. So, we'll have that perspective.

Elizabeth Weatherman is a managing director of Warburg Pincus. Then, Gary Heiman is CEO of Standard Textile, a company that makes reusable products for health care facilities. I think we're also going to hear that he is or has been on the board of directors for a hospital.

So, with that, let's turn to the business at hand. Merrile, if you would do us the honors.

MS. SING: Thank you.

MR. BYE: If the speakers want to move to the first row, I think it might make it a bit easier for their presentation.

**STATEMENT BY MERRILE SING**

MS. SING: Good afternoon. Can you hear me?

I will summarize the General Accounting Office's recent study on group purchasing organizations, focusing on our findings with respect to GPO's use of certain contracting strategies.

Faced with persistent pressure to cut rising costs, hospitals over the past two decades have relied on purchasing intermediaries, such as group purchasing organizations, to keep the cost of the medical surgical products in check. Group purchasing organizations may be able to negotiate lower prices with manufacturers, which can benefit hospitals and ultimately consumers and other payers of hospital care.

The General Accounting Office studied group purchasing organizations at the request of the Senate Subcommittee on Antitrust, Competition Policy, and Consumer Rights. Subcommittee staff had heard from some small manufacturers of medical surgical devices. These manufacturers told Subcommittee staff that they believed that because the GPO industry is concentrated, some business practices of GPOs reduce competition, stifle

innovation, and create barriers to entry for small- and medium-sized manufacturers of medical surgical products. These concerns were also expressed by some witnesses at hearings the Subcommittee held on GPOs in April of 2002 and, more recently, in July of 2003.

The GPO industry is concentrated. The top seven GPOs account for more than 85 percent of hospital purchases through GPO contracts. The two largest GPOs account for 70 percent of the top seven GPO's total medical surgical purchasing volume.

The General Accounting Office's study on GPOs focused on seven large national group purchasing organizations. We also focused on the contracts that these GPOs negotiated for hospital medical surgical products, which include commodities such as bandages and cotton balls and clinical preference products such as pacemakers. These are products for which clinicians may express a particular preference for a certain model or brand.

So, we excluded contracts that GPO negotiated for drugs and capital equipment and other products that hospitals purchase. Our methods included interviews and a literature review. We interviewed representatives from group purchasing organizations, manufacturing industry, people in distribution industry, and people from the

hospital and venture capital industries.

Most of the data in the report pertains to either calendar or fiscal year 2002 or the early first part of the year 2003. To protect the confidentiality of the data we received, we do not identify the seven GPOs in our study by name.

The four contracting strategies that we studied were sole source contracting, commitment, bundling and contracts of long duration. These contracting strategies are used by GPOs to gain price discounts, and they're used by manufacturers to increase market share. They can have the potential to reduce competition when they're used by GPOs or manufacturers with a large market share.

In our study, we define sole source contracting to occur when one of several manufacturers of comparable products has an exclusive right to sell a product through a GPO. Sole source contracting can be potentially anticompetitive if one or more parties to the sole source contract has market power and as a result of the sole source contract, a competing efficient manufacturer loses business and exits the market or if the sole source contract deters entry of new manufacturer.

We found that sole source contracts accounted for a substantial portion of the purchasing volume for some GPOs. For the GPOs in our study during fiscal year

2002, sole source contracting accounted for anywhere from 2 to 46 percent of their purchasing volume. For the two largest GPOs, sole source contracts accounted for 19 and 42 percent of their purchasing volume for medical surgical products. In one of the two largest GPOs, 82 percent of sole source volume was for clinical preference products.

In our study, commitment refers to a specified percentage of purchasing volume that, when met by the GPO customer, will result in a deeper price discount. For example, a GPO may offer its customers the opportunity to buy a certain group or list of products. If customers agree to commit to purchasing 80 percent, for example, of other product requirements from that GPO, they will receive more favorable pricing than if they don't make that commitment.

We found that GPOs considered customer commitment to be important, but commitment requirements varied. All seven GPOs in our study established some commitment requirements. One GPO required 80 percent of overall dollar purchases to be from that particular GPO, and that GPO reported terminating the membership of at least one hospital that did not meet the 80 percent commitment requirement.

We also found that some GPO contracts included

tiered commitment levels. These are contracts that give customers the option to purchase, for example, a group of products at 90 percent, 80 percent and, hypothetically, 70 percent commitment levels, with more favorable pricing available to those who agree to purchase 90 percent of the products in the specified group versus those who purchase 70 percent versus those who don't make any kind of commitment at all.

In our study, bundling links price discounts to purchases of a specified group of products. Bundling can occur for complimentary products such as protective hats and shoe coverings which are used in hospital operating rooms. It can also occur for groups of unrelated products that are offered by a single manufacturer. In our study, we refer to this type of bundling as a corporate agreement. By unrelated products, we mean things like IV solutions, medical film, and patient gowns bundled together.

The third type of bundling we looked at was structured commitment programs which are programs that bundle products from different manufacturers and require customers that choose the program to purchase a certain minimum percentage from the product categories specified in the bundle to obtain the discount.

For example, one structured commitment program

bundled items from 12 product categories and had a 95 percent commitment level requirement. Although we considered structured commitment programs to be a form of bundling, some GPOs do not consider it to be a form of bundling.

Bundling may be potentially anticompetitive if one or more parties to a bundled contract has market power and the contract disproportionately raises the discounts that competing manufacturers need to offer to be competitive.

One example where this was found to be the case by the Third Circuit in 1978 is in the case of Smith-Kline Corporation versus Eli Lilly. The Third Circuit found that a bundle offered by Smith-Kline violated Section 2. This case is mentioned in a paper that Mr. Bloch, the next presenter, has written.

We found that most GPOs used bundling, and the two largest GPOs used it for a notable portion of their business. Among the seven GPOs that we looked at, one reported no bundling requirements and the other six reported at least some. For example, one of the two largest GPOs reported 40 percent of its purchasing volume attributable to corporate agreements, one type of bundling, during fiscal year 2002.

Also, in fiscal year 2002, structured

commitment programs accounted for 20 percent of the purchasing volume of one of the two largest GPOs. We found some evidence that GPO's use of bundling arrangements may be declining, particularly during the past year. One of the GPOs in our study reported decline, specifically a decline in the percent of contracts that were corporate agreements of the contracts they had in effect on January 1st, 2001 versus January 1st, 2003.

In addition, one of the manufacturers we spoke with and two of the distributors we spoke with told us that they've observed a decline in bundling. The two distributors actually told us that they observed that some of the bundles that GPOs have offered have actually been torn apart.

With respect to contract duration, we found that the two largest GPOs typically award contracts with longer terms, typically five years compared with the other five GPOs which typically had contracts that were three years long. We included potential renewal periods in our definition of contract period.

As in the case with bundling with respect to contract duration, we found some evidence that contract duration may be declining. For example, in the first quarter of 2003, one of the two largest GPOs began

excluding the optional contract extension periods from its new contracts.

So, to summarize what we learned about GPO contracting strategies, such as sole source contracting, bundling, commitment and contracts that are five years or longer, from the literature review, we learned that contracting strategies have the potential to reduce competition when used by GPOs or manufacturers with a large market share.

Some GPOs, including the two largest, use sole source contracts extensively. The two largest GPOs used either contracts or programs that bundle multiple products for a notable portion of their business.

For additional information about our study, it can be downloaded at the web address indicated above. I'll also have some copies available during the break. You can also go into GAO's web site and search for the report by the report number which is the last part of that web address, GAO-03-998T.

Thank you.

(Applause)

MR. ELIASBERG: Thank you, Merrile. We will also try to have a link to the GAO report from the web site for these hearings.

Bob.

**STATEMENT BY ROBERT BLOCH**

MR. BLOCH: Thanks, Ed. I certainly agree with Merrile that over the last two decades, GPOs have become an integral part of efforts by many different types of health care providers to reign in and reduce skyrocketing costs of health care.

Let me give you some quick facts about GPOs. Today there are over 900 GPOs in the United States, 26 of which operate nationally. Novation, the largest GPO in total purchase volume, accounts for only about 15 percent of total purchases by hospitals of all supplies and equipment. Merrile and I or the GAO and I may have slightly different numbers, but I think it depends on what studies you look at at what point in time and in what years these are measured.

The number two GPO, Premier, has only about 12 percent. If one looks at purchases by hospitals only through GPOs, Novation accounts for only about 30 percent of the so-called hospital GPO market, and Premier accounts for approximately 25 percent. Ninety-six percent of all acute care hospitals use the services of GPOs.

About 72 percent of all hospital purchases are made through GPO contracts. About $200 billion, depending on which year you look at, of products and

services are purchased through these contracts. It is estimated that hospitals save between 10 and 15 percent of what they would otherwise have paid on their own by buying through a GPO.

Finally, it is estimated that it would cost hospitals on average about $155,000 per hospital annually to replicate the functions performed by a GPO. GPO is a cooperative of buyers that aggregate their purchasing power in order to bargain with manufacturers of medical products, drugs and other types of products and services.

GPOs do not buy or sell anything. Typically, they are a buyer's agent that enters into contracts with manufacturers which specify the prices, discounts, terms and conditions under which their members can choose to purchase from the manufacturers. I say choose because most GPOs are voluntary.

GPOs offer their members increased efficiency. They eliminate wasteful administrative duplication and they increase competition between rival GPOs, manufacturers and their member hospitals, all of which can translate into lower prices and higher quality for consumers.

Nevertheless, GPOs have been under attack on several fronts. Some small manufacturers claim that GPO contracting practices, like sole source contracts and

multi-product or bundled discounts, favor large, established manufacturers foreclosing smaller innovative products from the nation's hospitals.

These concerns led to two Senate hearings since April of last year. The New York Times ran a lengthy series of critical articles about the industry last year. Several private antitrust cases have been filed involving GPO contracts and programs in which plaintiffs allege that they were foreclosed from being able to sell to hospitals.

In a 2002 GAO pilot study, the one which proceeded the one that Merrile talked about, raised questions about whether GPOs always get the lowest prices for their hospital members, a study which I believe was flawed, had major flaws in it.

So, having said all this, what are the key antitrust issues related to GPO contracting? I think there are several. In my view, they are: whether the types of contracts that GPOs enter, especially sole source contracts, are expressly or de facto exclusive contracts; second, whether these contracts, when coupled with discount programs, such as bundling and high commitment levels, reinforce the exclusive character of these contracts or have any competitive effects; third, whether GPOs have helped manufacturers monopolize various

product markets to exclude their rivals; and fourth, whether it matters that these contracts and bundling programs are being sought by buyers rather than being initiated by suppliers.

This last question, I suggest, is really a crucial one, which has been obscured in this whole debate. It should not be overlooked in the analysis. It is crucial because buyer-initiated discount programs are driven by the economic interest of GPO member hospitals in obtaining lower prices and quality products, not by the more typical seller interests of resisting lower prices and discounts and increasing market share.

When viewed through the buyer's lens, the concern about whether a GPO's contracting practices are anticompetitive should be greatly diminished and are rarely likely to present a problem from an antitrust point of view.

Let me say a few words about the contract discounts and commitment levels that underlie these issues. Most GPOs negotiate contracts that try to balance pricing and discounts against member demands for quality products and choice. In some instances, a GPO may enter into a sole source contract with a supplier in order to obtain a larger discount.

Under a sole source contract, the GPO commits

to contracting with only one supplier for a particular product. A sole source contract in this context is not an exclusive contract. In an exclusive contract, the purchaser commits to purchasing only from the contracting supplier and from no one else.

In most sole source contracts that we're talking about here with GPOs, there are no commitments by a hospital, the actual party which is doing the purchasing, to buy from only one supplier, since member hospitals are almost always free to use or not to use the GPO contract.

Thus, by entering into a sole source contract, a GPO may be selecting the best low bidders as preferred vendors that are available to member hospitals through that GPO, but it is not limiting the ability of any hospital to purchase any product from whomever it wants.

GPOs also commonly enter into dual or multi-source contracts, allowing member hospitals to buy products from two or more competing manufacturers. GPO contracts often provide member hospitals with multiple levels of discounts based on purchase volume and/or some form of committed purchasing.

These two contracts can take many different forms, but the most common are a percentage of purchase and multi-product or bundled discounts. Percentage of

purchase discounts provide that the member hospital can get rebates based on the percentage of the hospital's total volume that is purchased from a particular vendor. This differs from volume discounts which are based solely on the quantity of purchased product.

Multi-product discounts provide a purchaser with additional discounts on the condition that the purchaser buy more than one product. They are a means by which a GPO can often get a larger discount from suppliers and then, in turn, offer them to their members.

In short, offering commitment programs are often important to voluntary GPOs that cannot and do not force their members to buy off their contracts. The fact that if a GPO cannot generate significant cost savings in volume of sales through contracts, it will be unable to negotiate low prices, and it will become ineffective as a cost cutting vehicle for its members.

So, when a plaintiff alleges that a GPO sole source contract is exclusive in fact or effect, it carries a heavy burden of proof to show that buyers or their agents, as distinguished from manufacturers or sellers, have harmed competition in a relevant market.

This may sound straightforward, but these cases are even harder to prove against buyers, as evidenced by the fact that there has never been a verdict for such a

claim sustained against the GPO. The reason is relatively simple; GPOs are not your typical defendants. Sellers don't typically sue their customers or their agents when they are trying to obtain quality products at lower prices.

The touchstone for such an analysis centers around, I think, two crucial inquiries, in addition to defining the correct relevant market. First, you have to determine whether a GPO has market or monopsony power in the relevant market and second, whether the GPO has exercised that power to substantially foreclose a would-be supplier that is a competitor of the incumbent preferred supplier from access to the market. So, it would not be a competitor of the GPO.

In conducting this analysis, it's important to bear in mind that the incumbent supplier may have beat out a would-be supplier in a competitive bidding process. It is also likely that while the preferred supplier may have a three-year contract, almost all GPO contracts can be terminated on 60- to 90-days notice.

In addition, very few GPO contracts today are, in fact, exclusive. Hospitals that belong to GPOs like Novation are always free to purchase off contract, and frequently do so. Many hospitals often belong to more than one GPO, so switching costs are not significant.

All of these factors are critical in assessing whether a GPO contract has anticompetitive consequences in a properly defined relevant market, not just simply to an individual competitor.

Let me say a word or two about defining the markets affected here because this, too, is very important. First, it will almost always be the case that a GPO will not have market power in the overall market for the goods and services purchased through GPO contracts. There are so many GPOs today that even Novation has only about 15 percent of such a market.

Second, if the market is defined more narrowly to consist of the market for the product which is involved or at issue, a GPO cannot be responsible for potentially foreclosing more than the total purchases that are represented by its members relative to all purchases of the product at issue.

In each of these scenarios, a GPO by itself almost never will be able to foreclose a market to a would-be supplier because its share of the relevant market is almost always below 35 percent and because most of its members do not buy exclusively off GPO contracts.

These facts, coupled with the factors I mentioned a moment ago, particularly the ability to terminate these contracts on short notice, almost

invariably lead to the conclusion that GPO contracts involving a single product, even with a substantial discount, are not anticompetitive.

That isn't the end of the story. Critics have also alleged that discounting programs are even more exclusionary when they involve multiple unrelated products which are bundled together that must be purchased by hospitals at high commitment levels, for example, 90 percent, in order to receive a particular discount.

Excluded suppliers in these situations assert that they cannot compete against the bundle of products when they are offering only one product. That is what cases like Smith-Kline, Ortho Diagnostics and the recent LePage's case in the Third Circuit were all about.

Yet, there are two big exceptions to these cases as they relate to GPOs. The first is that all of these cases involved competitors suing each other over claims that one competitor is trying to eliminate the other. By contrast, the bundles being put together by GPOs are being put together by a buyer or its agent in order to get lower prices from the manufacture where GPO's members are free to participate in the bundled discount program, they are free to buy outside the bundled discount program, or they are free to buy off

contract all together.

Under such circumstances, antitrust policy would be turned on its head if it prohibited such programs that were initiated by buyers who were simply trying to get lower prices because they were willing to commit to higher purchase levels.

The second exception is that in almost all of these cases, the manufacturer had products with a monopoly market share and was trying to leverage that market share into a product market where it did not have a monopoly market share. It faced competition from a rival, which is not the case here with GPOs.

It may be that a GPO's bundled discount program of unrelated products contain some products that have very high market shares, for example, 70 to 90 percent. But that doesn't mean that the entire market for that product is foreclosed by a GPO whose members purchases only represent a small percentage of the total purchases of that product.

The lesson from the LePage's and Ortho cases is that a seller who is a monopolist of a product that bundles a product with unrelated additional products and offers discounts conditioned on high purchase requirements better have a good business justification for this pricing scheme other than driving a rival from

the market. This is true even if the monopolist is offering its products above average variable cost.

The same warning might also apply to a GPO that is a monopsonist. But this conclusion does not translate easily to GPOs, largely because no GPO is a monopsonist. So, what is the legal standard to analyze GPO multi-product bundles with high commitment requirements when some products have very high market shares within the GPO itself and within the product market, especially where the claim is that these buyer-initiated programs are alleged to exclude would-be suppliers or where a plaintiff contends that the GPO and the preferred manufacturer are actually working together to keep the would-be supplier out of the market?

Extrapolating from the Ortho and LePage's cases in a Section 2 Sherman Act context, I believe this is the correct test where a GPO is not a monopsonist, that is, it has less than 35 percent of the GPO market and the product market at issue as well, but offers unrelated products both as a bundle and individually, some of which have monopoly market share.

By that, I'm talking about 80 percent or more of their respective markets. And they are offered through GPO contract at deeply discounted prices, conditioned on the purchase of a high volume, like 80

percent or more. And a plaintiff which offers only one product in the bundle is claiming that it must effectively absorb the differential between the bundled and unbundled prices at which the monopoly products are being offered by the GPO, and, as a result, is being unfairly excluded from the product market and an efficient channel of distribution.

That plaintiff has to prove three things. First, that the incumbent supplier has priced its monopoly product below average variable cost to the GPO, which is passing it on to its members. Second, that the GPO forces, forces its members to buy at these prices, leaving its members no other practical alternative. Thirdly, the plaintiff is at least as efficient as the incumbent supplier of the competitive product.

As a result of this pricing scheme, the GPO has made it unprofitable for the plaintiff to stay in business or, alternatively, that the plaintiff has been foreclosed from a substantial part of the market, at least 40 percent, as a result of this pricing scheme. To the extent that the plaintiff still has sufficient alternative channels of distribution, even though they may not be the most efficient ones, as a matter of law, the Section 2 claim should fail.

The bottom line point here is that any alleged

foreclosure or inability to compete must be directly tied to the bundling scheme and must affect competition in the market as a whole, not just simply an individual competitor.

If a rival is foreclosed because it is not as efficient or it is not as competitive as the incumbent supplier, which may be caused in part by the bundling, the benefit of any doubt should go to the buyer and to consumers. Any other rule would entail a substantial risk that the antitrust laws would be used to protect an inefficient competitor, not of the GPO but of the incumbent supplier against price competition that would otherwise benefit consumers.

I think I'll stop at this point because that's really the framework. I do have some thoughts on the 35 percent rule, but I'll be happy to answer that during questions.

(Applause)

MR. ELIASBERG: Thank you, Bob. Incidentally, Bob has a paper that covers his discussion today that's on the web site, or will be on our web site. For example, for those who are interested in the citations or finding or looking at the Ortho case that he mentioned or the LePage case, there are citations to it there.

MR. BLOCH: There are some outside, too.

MR. ELIASBERG: There are some outside that I've forgotten, nicely bound versions, I believe, something like this.

So, with that, Mr. Hilal.

**STATEMENT BY SAID HILAL**

MR. HILAL: Good afternoon. Just a simple question, if the GPOs have happened upon a purchasing model that is so brilliant, are we to expect that that model is going to apply to other industries and across board? Can we imagine a free market operating under that model? If it is truly a useful model, then how come it is unique to one industry? No other industry buys into this. No other industry buys like that.

First and foremost, I would like to thank Chairman Muris, the staff of the FTC, Assistant Attorney General Pate, and the staff of the Department of Justice for having singled out health care antitrust as a top priority enforcement issue. We continue to appreciate your efforts and those of Chairman DeWine and Ranking Senator Member Khol for putting the emphasis on what is going on here.

A few years ago, Statement 7 was put in place with good intent. Today, it has no application and no connection to market realities. Today the U.S. medical device market is closed. Ladies and gentlemen, I will

share with you our view of it as a young, vibrant, innovative company attempting to bring nothing more, nothing less, than better medicine at a better value. We are shut out. We are more shut out in the U.S. than we are in foreign markets.

Let me tell you a little bit about Applied now, lest we sound as if we are just a whiny little company. We are a full U.S. company with 500 people. We're fully integrated, although we operate globally, we manufacture here in the U.S. Ninety-nine percent of our products come out of southern California.

We have one of the most competitive cost structures despite the fact that we do not have the higher volumes and the larger market shares. We put a disproportionate amount of our revenues back into research and development, committing over 20 percent of our revenues to our R&D commitment and it's paid handsomely.

We own over 380 pending or issued patents, with a phenomenal utilization rate of 52 percent. In 2002, we were recognized as one of the most innovative, 50 top most innovative companies in the U.S. under $100 million. The last two years in a row the Society of Laparoendoscopic surgeons singled out Applied and three other companies, but we're the one company with two years

in a row, as I understand it, that have had the most innovative products award.

With accomplishments like this, you would think we were building the momentum like you would not believe. In a free market, such commitments and accomplishments would have favored Applied. But despite all of these accomplishments, ladies and gentlemen, the U.S. market continues to be as closed as a fortified castle.

I've said this before, and I'll say it again. Like a castle is protected by lines of defenses, the first line of defense is the GPOs. It defends market share of existing dominant suppliers. We cannot get in. We cannot get in to present better products.

Following that comes the bundling, the single sourcing, the grants, you name it. This is not a simple operation. This is not a simple proposition. It's a very complex model.

Take, for example, the contracts. In cardiac atraumatic occlusion, a market that we entered about 15 years ago, when we entered that market, we had zero market share. And against an $8 billion corporation, unassisted, we now have 70 percent market share.

Take the European market, we have five times the market share that we have in the U.S. Mind you, we spend only 10 percent of our marketing and selling

efforts there. Ninety percent is in the U.S. In the GPO markets, we are shut out from 80 percent of the market by just a handful of GPOs. You just heard the GAO report, seven GAOs control 85 percent of the business.

In May 2002, just to give you an idea about how closed this market is, we went out in a 300, approximately $300 million market, and we approached 40 large players. We offered them prices for trocars that were 60 percent below their contracted prices. Not one taker. As a matter of fact, we were amazed at how quickly GPOs responded to quash that campaign.

Nearly $300 million market would have been priced at $150. You would think there would be takers. There were none. Why? Well, many reasons. For one, at least, three percent on half markets is a lot less than three percent on fully priced, inflated priced, markets.

Teaching centers, university hospitals where our young surgeons train, where they get exposed to new modalities, new procedures, new technologies, those are the most closed, most protected. We cannot give products free in there. So, what is going on? Why can't an innovative supplier offer better medicine and better value and be received?

We've tried to answer that question in many ways. We've developed many models and looked at it, and

the answer still eludes us. I will share with you three models and I'll ask you to think about them and reflect on it.

The first model, monopoly multiple. A handful of GPOs can control 80 percent of the demand channel, and they do. One supplier can require 90 percent compliance. I'd like you to participate in simple math. Ninety percent of eighty percent, ladies and gentlemen, is 72 percent of the market share. That's monopoly. That is achievable within the life span of a contract.

Once it happens, it's not easy to dislodge. Once it happens, it's an amazing maze because for the new contract to be offered to a newcomer, the customers would have to be familiar with that product. For them to be familiar with that product, that newcomer must have access to the market and, therefore, once in, they're in. Once in, it's a monopoly.

Now, how can a supplier really reasonably mandate 90 percent compliance from 80 percent of the demand channel? Come on. Those are folks that are trying to help our patients. Well, let's take a look at an actual example, and this is especially painful for Applied because we live it day in and day out.

J&J started out with a near monopoly in sutures. Near monopolies or monopolies are absolute shoe

horn for what you're seeing here for new monopolies. J&J started out with a near monopoly in sutures, quickly bundled sutures together and then they bundled sutures with unrelated products, unrelated to sutures, unrelated to one another. So, trocars, clip appliers, staplers, and other devices were included in that bundle.

Next came bundling of rebates. So, if you're missing one product, who knows what the impact is going to be? Next came required high market share compliance. You heard about it from Mr. Bloch. Next came prohibited evaluations, evaluations of competitive products. There were financial penalties and there are financial penalties for even evaluating.

Next came bundled multiple suppliers and rebates. Next came mis-use compliance requirement. Next came bundled non-contracted with contracted products. It is not unusual for a company such as Applied to walk into our customer's office and have that customer not even know which product is on a contract. It is assumed that any J&J product is somehow a part of that contract.

Eventually, it has reduced customer ability to evaluate an offering like centralized economies. The local folks have no way of deciding what a good deal is and what a good deal is not.

But let's examine symmetrics other than the 35

percent or the 12 percent. Examine the suture market. It is now a monopoly. Then the J&J trocar market, it is now a monopoly. Examine the clip or plier market. It is now a monopoly. Examine the average selling prices for J&J. They're level, they're stable, they're held up there. The contracts that were intended to protect the customer from increased prices are now protecting the dominant supplier from deflated prices.

Examine the so-called savings, almost always compared to artificially inflated list prices. Why not compare them to that line called average selling prices? What's it doing? What kind of a scope does it have?

Here's an Ethicon Novation form. If you folks could read the words, you'll see that the first table says sutures. That's a $.9 billion chunk, sutures. Not all sutures are related but somehow here they are. But they're certainly not related to what follows. The other table contains many products that aren't related to one another, let alone sutures. You've got trocars, clip appliers, endoscopic devices.

You have ligation. Add it up, $2.1 billion. The question for us is whether that 2.1 is going to be allowed to come down to 1.5 through real competition. If it's going to be better, just like computers get better and faster, more reliable and less expensive, or is it

going to go to $3 billion because it's shoved in the faces of those who can make it cost less.

Let me give you another example, pulse-oximetry market. Here's an innovative company called Masimo. It comes up with a better technology that can save life and save children from going blind for excess oxygen. They could not get into the market.

Eventually, it gets a contract from Novation and Premier, a bit too late, though, because that monopoly is already in place. Through simple bundling and through simple inertia, Masimo now has to fight for every inch.

Not only that, but it is now discovering that the bundling that was going on at the GPO level, the bundling that we heard is now declining at the GPO level, is spreading bad things like you wouldn't believe. As we're sitting here, the bundling practices are shifting to the IHNs and the IVNs and the local hospitals. It worked in one place. Why not have it work in another and another?

Let's talk a little bit about the union model, very quickly. Like unions, GPOs were tasked with collective bargaining. Like unions, GPOs were given exempt -- unlike unions, I should say, GPOs were given exemptions from anti-kickback laws.

But two fundamental differences between GPO collective purchasing and union collective bargaining, one is the fees for unions never come from those negotiating across the table from unions. They come from members.

Second, the duties, the fiduciary duties, have not split, nor are they conflicting between maximizing owner's wealth and taking care of membership. Unions have a clear fiduciary duty. I wonder what the GPO is going to do about resolving that issue.

Let's talk about the other model, third model, franchiser model. GPOs are not really collective bargainers. From where we sit, they are rather franchisers. The franchisers are often exclusive or de facto exclusive. You heard about the 80 percent, the 90 percent, the 70 percent from GAO. It is a fact that what's left, if what is left is 10 percent, it is neither sustainable nor obtainable to go and try to get 10 percent of trocars or 10 percent of clip appliers. It just simply doesn't happen. It might as well be 100 percent. It is de facto exclusive. It is a franchise.

GPOs also upsell other services to franchisers. So you sign up with them. They want you to sign up for e-commerce. You buy from them. They want you to buy their privately-branded OEM products. So, they're not

hands off. They are buyers and sellers.

Why would hospitals allow franchisers -- come on, why would a hospital say come on in and make my life harder? Well, perhaps if they're part owners of the franchising operation, or if the income is excluded from reimbursement computation, or if they're convinced of the savings, although the GAO and others believe that that's a disputed saving.

Why would suppliers agree to a franchise license? Well, if you'd like to exclude your competition, you would. If you covered the monopoly, you would. Very simple. It comes down to protection. Absent the exclusion, absent the protection of exclusion, there are strong indications that dominant suppliers may not be interested in a franchise.

Let me cite an example here. Consorta a year ago had a noble goal to try and break the bundling and the single sourcing. In our opinion, it was ahead of its time in asking the dominant players to submit bids that were neither bundled completely, i.e., sutures and other unrelated products. In our opinion, it didn't go far enough, but it sure as heck went much farther than anybody else was willing to do in those days, and wanted a multi-source.

What was the answer of J&J? As far as we know,

J&J declined to participate. What happened next? The other dominant player got the contracts. From our standpoint from where we sit, that's how the world looks. It may look fine and dandy and happy. From our standpoint, from the patient's standpoint and the cost standpoint, it doesn't look that way.

In conclusion, this is a time for change. The nation has 42 million uninsured. Cost is going up. We, as providers of insurance, saw a 19 percent increase last year. Fourteen percent of it is in rates. The other five or six percent went to our people in the form of higher deductibles and higher co-payments.

This nation needs to address this issue for two reasons. One is health care is a noble cause and it needs to be addressed with a full heart. We're appreciative of anybody that is attempting to help out in this situation.

Secondly, this is not a free market. Health care has been conditioned to accept price increases, enough so to where we see people defining favorable outcomes as not too big a price increase. On the other hand, a lot of high technology areas are benefitting from better productivity.

Innovation is not more expensive. We're a nation proud of our productivity. Our productivity comes

from innovation. If innovation is allowed to go free to the marketplace, it's going to help with better clinical outcomes and better cost outcomes.

I thank you very much.

(Applause)

MR. ELIASBERG: Thank you very much, Mr. Hilal.

Mr. Strong.

**STATEMENT BY JOHN STRONG**

MR. STRONG: Thank you, Ed. It's nice to be here this afternoon. I have four principal objectives. I'd like to spend just a minute familiarizing you all with who Consorta is, give you a little overview and background on the company, and talk a little bit about our contract management philosophy. I think it's important for you to understand what we represent there, and really spend the balance of my time talking about the strategy itself as it relates to bundling, contract term and sole source contracting, and then give you a couple of final thoughts on what we see as the reality of the medical device marketplace today.

Consorta is wholly owned by 12 Catholic health care systems. We're a for-profit cooperative. Cooperatives are not unique to health care. I would offer up some other examples, such as Ace Hardware and True Serve Corporation, which serves independent hardware

stores; Sunkist; Farmland Industries, which serves farmer interests, they buy and market on their behalf; and also Certified Grocers of Illinois, which is actually a coop of grocers in the State of Illinois that serves small independent grocers. So, this is not something that's unique to health care.

Our purchase volume right now is about $3 billion annually, which puts us in the top seven. Our Board took a look at matters a year ago with the Senate Subcommittee hearings and we drafted our own code of conduct. The Board also felt that if we were going to be subject to a code of conduct, our suppliers should have some expectations set for them as well. So, we have a set of supplier expectations that we use as well.

Our mission is just one purpose. We want to remove supply chain cost from our owners' material management programs. We do that two ways. Not surprisingly, we purchase as a group, since we're a group purchasing organization, and we also provide supply chain management tools for our owners.

Our owners are very diverse. They represent the three largest Catholic health care systems in the country, and they also represent some of the very smallest health care systems in the country as well. All of them have more than one hospital, however. These

facilities are, as you can see from the pin-dot map there, pretty centrally located in the Great Lakes region of the United States.

Our value proposition is very straightforward. We try to take supply chain management tools, bring to bear information technology tools, and try to drive three types of value. The first, as you might suspect, is lowest acquisition price. We do that through our group purchasing contracts.

We can't always get the lowest acquisition price, though, without cash rebates. We're somewhat unique in that we manage those rebates for our shareholders. They asked us to do that. One hundred percent of those rebates are returned to them on a monthly basis. These rebates provide a cross production value on contract purchases of about 1.2 percent.

Our owners are also interested in a patronage distribution at the end of the year. Patronage is the coop term for the cash dividend that they receive back. It's a very simple formula for us. It's our revenues less our expenses. This year we estimate that 71 percent of our revenue will be returned to our owners, 98 percent of that in cash, but 100 percent of the return will go back to the owners. This also translates to an additional cost savings on their supply chain of about

1.1 percent.

I think it's important to note that contract administrative fees, or CAF, are paid by suppliers for group purchasing services that we render. Some of these services include allowing the supplier to have one contract in the market versus literally hundreds for individual health care facilities. We provide marketing and contract visibility. We also provide contract implementation support. We do an extensive amount of contract evaluation.

We are a contract administrative fee-funded model. As you can see, our revenue this year is projected at about $45.5 million. We'll deduct the $14.1 million of operating expense and the $31.4 million goes back to our owners to help them reduce their supply cost.

If you flip this around, as some would suggest that our owners should be picking up the tab, this would result in them paying out of their pockets about $14.1 million to operate the coop. Some people in previous testimony have also suggested that that $45.5 million could translate to pure discounts that would somehow lower the cost of products. We don't believe that there's any evidence to support that whatsoever. In fact, we think that most of that $45 million would disappear, would probably be retained by the suppliers,

and our owners would be left holding the $14.1 million expense, which inevitably would drive up the cost of care.

We've been very serious about returning a high margin for our owners since the inception of the company. We began in 1999 and returned about $9 million to them and a 60 percent rate of return. As you can see, this year that rate of return is going to be about 71 percent and about a $31 million return.

One of the key things that has made Consorta work is the fact that our shareholders all have a voice, every single one of them. It's committees of all shareholders in Consorta who make all of the contracting decisions and, in fact, all of the contracting awards.

They decide which suppliers get the contracts, what their compliance requirements are going to be, because they're the ones that have to do it, and also the type of contract that's going to be awarded, whether it's a sole source contract, a dual source contract, or a multi-source contract. Every shareholder has a seat on our Board of Directors. They see financial statements every month, and they help us set the budget.

They also have a seat on every single contracting body. You can see on the lower right hand corner there, we have 11 contracting bodies who make

recommendations to a contracts and programs committee. That is a group of owners, that is all of the owners, who get together on a regular basis and make the contract awards. Staff does not do that.

As I said earlier, quality products and best price are really our key initiative, and we prefer having all of the value placed on price. But that's not always available. In some cases, to get the best value, we have to request rebates.

We also don't bundle any disparate product. We have no private label program, which is something that's been an issue in the past. Our administrative fees have been capped at three percent since the inception of the company. We've never exceeded the three percent cap.

I think you have to take a look at the health care marketplace and recognize that it's made up of many sub-markets. We believe sincerely that the only way to really get at those sub-markets is to do large scale clinical evaluations and really try to prove to our owners what the best route is.

It's the willingness of members to move volume from one supplier to another who are going to drive the best price at the end of the day. If you can't do that, you have no credibility with the suppliers, and you're not going to get the best price. So, it's something

that's absolutely critical.

As I said, we don't bundle disparate products. We're not suggesting that it's wrong; we just don't do it because we don't believe in all cases it yields the lowest price for the best value. It may end up having products on the contract that aren't products that our shareholders find the best value in.

It also tends to make it difficult for us to look at all of our contracting options on an all-inclusive basis. We like to say that we include every manufacturer who has a viable product. If you bundle too many products together, it gets a little bit challenging when you try to manage that.

We do bundle similar products together sometimes, however. Our owners want the ability to have full-line product contracts because they need assurance that these products are going to work well together, that they can train their staff and their patients effectively, and that there's a product and process standardization route through the contract.

We also make no bones about the fact that occasionally we'll bundle generic pharmaceutical products with branded items. That effectively is the only way we can get discounts on some of those branded items. So, we create bundles to try to offer a better price for our

owners.

With regard to contracting term, I think if you look at our contracts, generally we award three-year contracts. However, in certain cases, it shouldn't be surprising that we want to do a longer term contract if we can lock in a lower price in a market that's characterized by relatively increasing prices.

We also have to look at the cost that we incur when we evaluate products. There's GPO cost, which you can see on the left hand side of the screen. Our members also incur significant cost when they help us evaluate products.

We've also done two other things so that long term contracts don't have to impede competition. I think Bob alluded to some of this. We've included new technology provisions in all our contracts on a go-forward basis since the inception of our Code of Conduct. It allows us to go outside a contract with a manufacturer for new technology.

In virtually all of our contracts, with perhaps one or two exceptions, we have a 90-day termination provision. That allows us to cancel a contract if we can't come to terms and move forward and contract for that new technology.

One of the things that I found interesting in

this entire debate is the fact that in many cases, it seems to be the manufacturers who are saying that they have new innovative technology. We don't believe that it's the manufacturers who should be determining whether something is new and innovative. They certainly play a role in that.

However, it's the clinicians and the other product users who at the end of the day we feel really make that final determination. They do it three ways, either through quality improvement, through improved patient outcome or through some other cost benefit scenario that's available to them.

Let's talk for a minute about what a really large clinical evaluation looks like. This happens to be the results from an evaluation we conducted last year on suture and endoscopic product. This is a product category and these numbers reflect just the work that we did to get to the contract decision point to show our shareholders what they were thinking.

The evaluation took 18 months. Our direct costs were over $150,000. That's not the opportunity cost. We looked at product utilization in over 8,500 surgical cases in 60 of our facilities with over 2,100 surgeons participating. At the end of that evaluation process, our owners said this was too much work to award

just a three-year contract to. In the end, they decided to award a five-year contract.

We also looked at the marketplace and found that there were only two full-line manufacturers, the Ethicon Division of Johnson and Johnson, which represents probably a 70 percent market share, and the United States Surgical Division of Tyco International, which probably had about a 20 or 25 percent market share.

Because of that dynamic and the fact that we did go to market for both sole and dual contracts, we decided to award a sole source contract. Here are the results. We were pretty satisfied with these results in terms of creating competition.

First of all, we found out that U.S. Surgical had a 98 percent clinical acceptability rate in our facilities. So, the two products were viewed by surgeons as being pretty comparable. If you take a look at the blue line, you'll see the proposal we received from Ethicon. Not surprising that it's going up in a market that is dominated by a single supplier.

On the other hand, U.S. Surgical offered a five-year fixed contract, and that led to the conclusion that over five years we could save $58.3 million, probably one of the single biggest cost savings that we'll ever achieve as a group purchasing organization.

We don't think that sole source contracts have to lock out suppliers at all. First of all, our shareholders decide who they want to deal with. It's not us that's out calling those shots. As other people have pointed out, having a contract with a GPO doesn't guarantee that that business is going to move anyway. There is no penalty at Consorta for noncompliance anyway.

Generally, and not surprisingly, suppliers reward for higher levels of compliance because they're offering increased dividends in exchange for volume. That's what it's all about. They're looking for that compliance to meet their volume projection.

Our shareholders also want commitment across their systems. They want product standardization because it leads to lower inventory costs, the ability to standardize patient care, leading to better quality, better staff education and improved safety. I think they would tell you that it's consistent with the way most U.S. businesses operate today. If you take a look at Wal Mart and Cosco, they certainly have made their mark in the logistics business by standardization.

Finally, a couple of thoughts on marketplace reality. First of all, health care procurement really is unique. The product requester isn't always the person who is paying the tab. If you take a look at the slide,

the sale cycle kind of begins on the right there with a supplier who tries to sell to a physician, creating demand. The physician demands a specific product. Along the way, he may influence some of his partners or peers to purchase that specific brand. The hospital buys it on their behalf.

They can do it one of three ways. They can either use a GPO contract, they can write their own contract, or they can simply pay market price. All too often, they simply pay market price because there is no contract governing the transaction at all. The hospital initially pays for the product, but it's also worth noting that ultimately those costs all get passed on to the payer.

Now, I think it's also worth noting that physicians can receive payments from suppliers for services that are rendered. We're not suggesting that this is wrong, because suppliers do need physician input for product development, educational support and for other purposes.

In considering this, about the only place that leverage is created in a high clinical preference area is with a contract back over on the left. If that leverage isn't created, it can lead to some very costly outcomes.

This is an actual example of what's going on in

one of our facilities. There's a paid supplier consultant, who is a physician, and he influences about 300 surgical cases a year. He has two partners, who he also influences. So, the sphere of influence here is about 800 surgical cases.

Back in November, we awarded contracts to a new supplier for surgical kits. The price previous to the award with the former supplier was $1,344. The new supplier came in with a price of $1,282. Things were fine until the supplier consultant was told by the administration that he needed to move along with the rest of the physicians. He's resisted doing that. As a result, the hospital is now forced to pay $1,893 more per procedure or about $1.5 million annually. That's for one hospital. So, this can have a significant impact.

I think you have to remember that each medical device market has dramatically different attributes. You look at the number of manufacturers for a product, the stage of the life cycle, a whole host of different variables. Each one requires a unique contracting strategy.

We believe that universal rules that govern all GPOs could actually limit competition and drive up supply costs for health care providers over time. As I said earlier, only the product user can really determine what

the meaningful attributes are that they want to take care of their patients.

I think you also have to recognize that every GPO is different. We have different contracting strategies, different size, different ownership models and so forth. At the same time, suppliers are not standing still.

This is a quote from an article that appeared in the September 3rd Wall Street Journal that was headlined "Orthopedic Firms Latch Together." I think there was one really good point in here. Two recent deals in the medical devices sector are a testament to how companies reckon beefing up their size will help them demand higher prices and therefore better margins. That's why we feel that health care needs strong group purchasing, because the suppliers are also gaining. We need to be able to group our purchases together just like they're grouping their sales together.

Finally, if you take a look at the Fortune 500 list of health care manufacturers in this country, about $364 billion of their overall volume was without a group purchasing contract in 2001. Only $56.8 billion of their overall revenues came from purchases that were covered by a GPO contract. So, we believe that we need to be able to stand up to that as well.

Finally, it's been alleged several times in different hearings that group purchasing is somehow having a very negative impact on investment and medical device technology today. I would just cite two examples why we don't believe that's true.

The first one is from a Frost and Sullivan report that was delivered on February 13th. It says analyst reports medical device market flourishes. There's some information here that shows that the market is indeed doing very, very well.

The second one is in this week's Business Week. It indicates that venture capitalists are valuing young health care companies almost twice as richly as technology start-ups. So, if we're having an impact on the venture capital market, we don't see how it is. We think the group purchasing in health care is a vital piece of keeping costs down and helping hospitals manage their supply chain.

Thank you.

(Applause)

MR. ELIASBERG: Thank you, John.

Ms. Everard.

**STATEMENT BY LYNN JAMES EVERARD**

MR. EVERARD: John, that was very good. It's always difficult to come up here and talk about GPOs

after the head of what I consider probably to be the shining example of the best kind of GPO delivers a presentation like that. So, for the purpose of this conversation, we're going to assume that we're not really talking about Consorta here, but there are other ones that we can talk about.

Before I begin, I would like to thank Chairman Muris and his staff at the FTC and also Assistant Attorney General Pate and his staff at the Department of Justice. I think I'd also like to thank Senator Khol and Senator DeWine for keeping this issue at the forefront.

There are some issues that we're going to need to deal with as we move forward. My concern today is that although we have many legal wranglings and many legal discussions, what we have to look at is what is really important. What I believe is what's really important is answering the question, does Health Care Policy Statement Number 7 protect patients and caregivers. I believe that the answer to that question as it stands today is no.

Now, we have a real train wreck approaching as our Congress struggles to figure out what to do about health care. We've got 4,000 different numbers about how long Medicare will last, how long social security will last. I think we know this much. We know that we have

millions of baby boomers, many of us in this room it looks like getting close to that point. We have 41 million uninsured who are all going to be requiring high volumes of health care services. We're going to have to find a way to pay for that.

In order to do that, we're going to have to live in a health care marketplace that is very, very, very competitive, much more competitive than it is today. We're also going to need innovation. We're going to need small companies, large companies, innovators who are going to create the new generations of products that, when given opportunities in the marketplace, will be able to generate not only better care but also lower cost.

Let's take a quick look at examples of some of the GPO practices that block innovation and also block lower costs. Some examples are supplier paid fees, sole source contracts, high commitment levels, bundling of both products and companies. When you add all of those things together, what you have is reduced innovation and higher costs. We'll talk more about those as we go.

In terms of the current Policy Statement, I believe it must be revised to address the economic realities of the current medical product marketplace. Safe harbor has been with us for about 16, 17 years. The Policy Statement has been with us for several years.

There's a lot happening in the health care supply marketplace, and we need to get the Policy Statement caught up.

It's not simply a matter of what is legal. I know that you're here looking at legal issues, but we also have to look at the impact on patients and caregivers and on whether or not, for example, doctors are able to choose what products they will use in terms of treating patients.

If the doctors don't get to choose the products, then who does? If it's a GPO product council choosing the products, then maybe they should consider being part of liability cases that are pursued against doctors when they use the wrong product.

We also must revise the Statement to address the anticompetitive impact of combining the safe harbor along with the most favored nation's clause. Let me explain what I mean by that. The safe harbor gives GPOs the ability to collect fees. The most favored nation's clause, which was adopted many years ago by GPOs attempting to prevent loss of members to other GPOs that were able to generate lower prices than they could, brought a situation where every GPO wanted to start doing most favored nation's clauses.

What that has done over time is it has given

suppliers with market power the ability to choose when they do and when they do not want to compete. If they don't want to lower a price, even if there's a good reason to do so, they can cite the most favored nation's clause as the reason why they do not have to offer a lower price. Also, it creates a legal burden of proof for harm that it is so high that it cannot possibly provide protection to the public.

Bundling limits competition and it is imposed at two levels. First is the primary GPO corporate level. An example of that would be Novation's opportunity program. In that particular case, the hospital has to purchase multiple products from multiple suppliers and stay within that very rigid framework or it's not going to receive the promised rebate at the end of the program.

At a secondary level, manufacturers with market power are able to exclude competitors, in some cases with the GPO support and in some cases without. For example, a multi-line supplier might be able to go to a hospital who is considering buying a product from a small company like Applied and say, you know, you might be able to buy that product and you're right, you're free to do it.

However, if you choose to buy from that supplier, you're going to lose significant discounts on all the other products that we sell to you. So, yes,

possible is free, but no, the hospital is not really as free as one might think.

Then we end up in a situation where the hospital has to choose between its own financial survival and doing what's best for patients and caregivers. I'm not sure that's a choice that hospital CEOs should be forced to make.

Next is the case of a multi-line supplier with a GPO mandate, an example of that would be that a small manufacturer might have an opportunity to sell to a particular hospital system, but the GPO may have a clause in the contract in place that would make the volume of purchases required to use that contract so high that barely a handful of hospitals would qualify to use that supplier. There are other examples as well.

Long term sole source contracts limit competition. Now, sole source is not a bad thing. If you look around the world, you will see that many companies utilize sole source contracts. That's not the issue. A single hospital IDN utilizing a sole source contract is normally going to get the best price. That's how you do it.

The problem comes when you have a large GPO or multiple GPOs with strict compliance requirements that bridge across multiple geographies. Now you're creating

a situation of scope and scale that is such that all a dominant supplier has to do is win two or three or four major GPO contractors and, for all intents and purposes, the small supplier is shut out.

So, here's what we have. The GPOs, I believe, in essence, today are selling protected market share to dominant suppliers in exchange for fees. In order to generate the kind of pricing and the kind of savings that they claim to have, they're going to have to offer manufacturers something.

The manufacturers would be fools to give away their best pricing in a situation where nobody is committed to provide actual purchases. Why would I give my best price if nobody was going to buy or if nobody was highly incentivized or forced to buy? Obviously, I wouldn't.

Now, at the same time, the GPOs claim that hospitals are free to buy from whomever they wish. In the most technical legal sense of the word, that is true. But here again, we come back to the difficult decision that CEOs have to make: Am I going to buy what I want because it's best for my patients, best for my caregivers, or am I going to hold on tight to the GPO contract because if I don't, somebody is going to clobber me with penalties or higher prices or loss of discounts?

So, in discussing whether or not the GPO can do both, I'm going to leave that up to those of you in this room to decide that.

Let's look at the long term impact of GPO bundling and sole source contracts. Now, over time, a GPO's relationship, especially a large GPO interrelationship with a supplier with market power, over time, I think what we're seeing in this industry is that we have a smaller impact of price discounts and a larger impact of fees.

So, as that market power supplier gets more powerful, they can reach a point that I'm going to call the competitive tipping point, and that's the point at which the GPO who previously had the market power on behalf of the buyer members is suddenly put in a situation where it cannot use that buying power because without realizing it, it has played a role in reducing competition and now is faced with the terrible prospect of having a contract with only one bidder that isn't going to reduce much in terms of price or it's going to have to face another supplier that really wants to take that over.

So, I think it's really important that we look at this and we understand that there are consequences. Just to give you an idea of life in procurement outside

of health care, a director of procurement's responsibility, one of their primary responsibilities is to ensure competition.

Many companies in various industries actually give a small piece of business or a reasonable size piece of business to a number of suppliers just to make sure they're still in the game because someday that primary supplier may not be able to supply or may be in a situation where they could raise the price as buying power is transferred to the sellers, becoming selling power.

So, why would this happen? The safe harbor establishes GPOs as a taxing authority over the activities of the health care supply chain. I know that's a rather strong statement and you're probably wondering how I can make that. Well, a taxing authority is someone who takes a percentage of transactions. When you go and you pay sales tax, what is sales tax? It is a percentage of the transaction. GPOs do that, too.

Now, we call it fees when they do it in terms of a contract that they negotiated, but a number of GPOs have a practice that requires suppliers to pay them fees on contracts the GPO did not negotiate. I wouldn't call that a fee. I would call that a tax.

For years we've been hearing that hospitals

don't have to pay for the cost of using GPOs. So, who really does pay for the cost of using GPOs? Well, let's look at this. Congress passed the safe harbor. GPOs are permitted to collect fees. GPOs award contracts to sellers. Sellers pay fees to the GPOs.

Now, those fees are included in the price of the product to the hospital. Why is that? Because manufacturers don't have a magic bucket of money that they can take money out of and say, okay, this is what we'll use for fees but everything else over here is okay. They would have a real problem complying with Sarbanes-Oxley if they operated that way. So, we know that they don't.

Those fees are reported by the hospital or in the product price to Medicare. Medicare establishes a payment rate to the hospital and sends the hospital a check. Guess what? Medicare is funded by an appropriation from Congress, and at the end of this what we see is that tax dollars pay GPO fees.

So, let's now ask the question, do fees provide a good return on investment for taxpayers? If GPOs really lower product prices, why are there no scientific studies to prove the cost savings claims? All we ever get is one opinion poll after another.

Why is there no cost savings reporting standard

in the industry? Is it a discount off of a list price? Is it a difference in the average selling price or net price? Is there a value added component? What is it? How can we decide that a GPO saves money? I would submit that in some cases, the GPOs don't have proof that they save money. I wish they did.

Also, why is there more talk about fee revenues and less talk about discounts? I believe that what we are seeing is a change in power in the structure in the supply chain. I believe that fees are now starting to replace discounts to hospitals.

We lived through the aggregation days. That gave way to the quest for market share. What we're seeing lately is that in many cases, net prices are leveling out as many contracts are being extended. The discounts are being replaced with commitment levels that come with financial penalties. We're not just talking discounts; we're talking financial penalties. If you don't buy this way, you'll lose all of this opportunity.

So, my question to you is, are GPOs really lowering prices or are they simply holding the line on commodity pricing and doing it for a fee? Let's go back to the beginning. Medical innovation holds the key to affordable health care. If we're ever going to solve our health care problem, we need people in this room to start

taking a look at this.

Now, the examples I cited to you, I have written documents that would show you exactly what happened. But I'm not the DOJ. I'm not the FTC. I don't have the investigative powers that these organizations do. So, what I would ask is before all of this is revised in Statement Number 7, that you take a look and really investigate the fees, where they come from, where do they go, what do they get used for.

Mr. Bloch, in his paper, cited that Novation returns 32 percent of its fees to its members and Premier returns 40 percent. Consorta returns 71 percent. Does anybody see a difference between those numbers? Why is it that an operation like Consorta that looks like it runs a terrific program can return 71 percent and these other organizations can't? Could it be that they are coming up with new uses for those fees before they ever get a chance to go back to the hospitals?

With that, I'll turn it back over.

(Applause)

MR. ELIASBERG: Thank you very much, Mr. Everard.

We've been going at it for about an hour and a half now. Though I hate to break the stream of thought, I think it might be more beneficial for all of us if we

maybe take a 10-minute break and then get back to the discussion at hand. Then we'll go immediately after the last two panelists have had a chance to make their presentations into the moderated roundtable. So, 10 minutes, please. Thank you.

**(Whereupon, a brief recess was taken.)**

MR. ELIASBERG: If you could take your seats so we could go ahead and get started.

Ms. Weatherman.

**STATEMENT OF ELIZABETH WEATHERMAN**

MS. WEATHERMAN: Good afternoon. My name is Beth Weatherman, and I'm a partner at Warburg Pincus. Warburg Pincus is a leading venture capital firm. We've been in business since 1971.

Collectively, the venture capital and private equity industry has invested more than $240 billion over the past 21 years, funding the vast majority of the most important technological breakthroughs of this period. A substantial number of venture capital firms invest heavily in the life sciences field, including biotechnology, drug delivery, medical devices and diagnostics.

In 2002, the venture capital community invested more than $4.7 billion in new and emerging medical technologies, which accounted for almost 25 percent of

all venture investing last year. While I cannot provide you with a detailed analysis of Health Care Policy Statement Number 7 and the safety zone provision, I'm here today to shed some light on the realities of growing start-up life sciences companies in the U.S. today.

I hope my insight will enlighten the Federal Trade Commission and the Department of Justice about the daunting course of new technology companies to get their products to patients and the immense risk associated with investing in these companies.

The venture capital community exists in part because of the antitrust philosophy of the United States, prevents entrenched, unmovable competitors from abusing their market power to unfairly restrain competition.

By their very nature, virtually ever company we finance is a revolutionary and a threat to the established order. The technological innovations they develop, whether in telecommunications or medicine, are inevitably threats to some existing large competitor who will use all means at its disposal to defend itself.

Venture capital plays an integral, often unsung role, in the development of medical technology. In fact, venture capital is the single most important source of early stage financing to new and emerging health-focused companies.

Over the past 30 years, the venture community has financed 1,324 innovative medical companies with more than $20 billion in start-up capital. These companies now have sales of tens of billions of dollars, employ more than two million people, and, most importantly, have revolutionized medical care for nearly all Americans.

It is fair to say that virtually every U.S. citizen born during the last 30 years has benefitted or will benefit in his or her lifetime personally and significantly from one or more of the drugs or medical devices developed by U.S. venture capital funding.

Bringing medical innovation to market is hard. It entails taking on enormous risks. These include developing and refining the technology itself, proving its safety and efficacy via well-conceived and executed human clinical trials, obtaining FDA approval to market the technology, developing the means to assure high quality manufacture of the technology, and securing an efficient means to sell and distribute it to the market.

Any one of these risks alone may lead to a company's failure, and many companies focused on medical innovation do fail. Venture capitalists accept these legitimate risks every day, while traditional financial institutions and government-supported programs cannot. It is part of our function.

But venture investors do not and will not accept unnecessary and unfair risks. We need to provide our investors with justification that substantial capital investment can result in successful product development and financial gain. Thus, we have no interest in products that can be blocked from fairly competing for a share of a market, even after a long, expensive and risky product development cycle.

Venture capitalists will increasingly stay away from many investments in long term, high risk medical breakthroughs where anticompetitive business practices are likely to artificially limit access to medical markets.

The possibility of anticompetitive practices in the medical sales and distribution sectors serves to erode venture capital confidence in fair access to medical markets and unnecessarily increases the risk that a new medical technology will fail to run what is already frequently a fatal gauntlet to market.

Simply put, any company subject to or potentially subject to anticompetitive practices will not be funded by venture capital. As a result, many of these companies and their innovations will die, even if they offer a dramatic improvement over an existing solution.

The anticompetitive practices of GPOs disrupt

the already highly entrepreneurial and risky process of bringing medical innovation to market. The reality is that GPOs as a whole are now financed and thereby controlled by large medical product companies rather than by the hospitals they're intended to represent.

So, clearly, Mr. Strong has made a case that that is not the case with his particular GPO, but we must keep our focus on the majority of the GPOs where, in fact, let me repeat, GPOs are financed and thereby controlled by large medical product companies rather than by the hospitals they are supposedly the agents for.

While the government would not tolerate such practices in any other sector of the economy, for it to tolerate the situation in medicine is very disturbing, because one of the clear effects is to impede innovation. That is certainly not the government's intent. In medicine, in contrast to any other sector, reduced innovation ultimately affects patient's lives and health. There's no doubt that patient's health have suffered as a result of GPO activities as a whole.

In light of this, the anticompetitive activities of the GPO should be viewed with even more, not less, skepticism. The usual arguments in favor of permitting hospitals to form buying associations, or GPOs, must be weighed against the reality that these

buying associations are de facto national monopsonies but are easily influenced by the very sellers they buy from.

Fees and other incentives running from large medical manufacturers to GPOs allow such manufacturers to inappropriately influence the buying policies of the GPOs, because the compensation of most GPO management is almost always based on this fee income rather than on the real savings to hospital members, which, by the way, is essentially impossible to calculate.

A large manufacturer selling numerous products may be willing to slightly discount temporarily one stream of monopoly profits to protect another key product line from ruinous competition from a small innovator. In fact, the mere possibility that this could happen might prevent the innovator from ever being funded in the first place. But the existence of GPOs makes anticompetitive contracting incredibly easy and efficient for these large manufacturers who would have to negotiate separate contracts with thousands of individual hospitals instead of with three or four large GPOs.

So, the GPOs provide a very efficient vehicle for the large manufacturers to throw their weight around in the market. We recognize that there are true economic benefits of cooperative buying arrangements and that it is difficult to weigh these benefits against the cost of

decreased competition.

However, the influence of supplier fees running directly from medical product's vendors to the manager of the GPO buyers completely confounds any such analysis and creates such an appearance of unfairness and corruption as to deter many venture capitalists from funding new innovators in these markets.

The venture capital community believes that there are enormous opportunities to continue to improve the health of the American public through the development and application of new technology. These efforts are already very time consuming, expensive and risky, particularly in light of the prevailing and endemic uncertainties inherent in the U.S. regulatory system.

Despite this, the venture capital community is committed to further investment in U.S. health care technology, as evidenced by the data that Mr. Strong related to you that was in Business Week. I would like to comment on that data.

There are two things you should know. One, it is largely a denominator effect. In other words, the percentage of venture capital that's going into medical technology as a percent of total venture capital is high, higher than it was, because high tech investing since the burst of the high tech bubble has declined very, very

significantly.

If you peel back another layer and you look at the absolute dollars that are going into medical devices and medical technology right now, it's roughly the same. It's not statistically significant that it's meaningfully higher or lower. What is statistically significant is the valuations at which the money is going in.

Small companies and entrepreneurs who are starting innovative companies are suffering because of the risks that the investors see coming before the company. As I said, while GPO contracting isn't the only barrier that can foil a young company's success, it does have an impact in a long list of items that can trip them up.

I think it's also important to notice that while valuations of established companies, i.e., public companies in the public market, are now fairly attractively priced, there's a big difference between the two. Again, there's a lot of confidence, I think, in shareholders of these larger companies that they are going to be able to maintain their market power.

So, again, there are good and legitimate ways for them to do that. I just do not think and the venture capital team does not think that the added advantage of a GPO who is being paid by them is the most efficient way

to be sure that they're doing so fairly. There's absolutely no way to be sure that the savings are true savings.

Thank you very much.

(Applause)

MR. ELIASBERG: Thank you, Ms. Weatherman.

Mr. Heiman, you get to bat clean up.

**STATEMENT BY GARY HEIMAN**

MR HEIMAN: Well, since I know that I'm the only one that separates all of you from the end of this or the panel discussion, I'll try to be very, very brief.

Well, first of all, I would like to thank the members of the Federal Trade Commission and the Department of Justice for inviting me here today to provide my perspective as a manufacturer and a vendor of hospital supplies, who has extensive experience with the hospital supply chain.

Many questions and many issues have been raised about whether GPO contracting practices adversely affect vendors that supply products to hospitals. I'm very, very pleased that I can share some of my and Standard Textile's experience over many years in this regard.

Before I start that, let me begin by giving a brief introduction and overview of the Standard Textile company. First of all, we are a family-owned company

founded in 1940. We employ approximately 1,200 people in the United States. We have 22 manufacturing facilities worldwide, and we sell in over 40 countries.

Let me just begin by saying that when we received our first significant GPO contract, we were a small company of $60 million. We actually won the contract for our textile products from a $5 billion Fortune 500 company because we were able to show that we offered value beyond price, benefits, and as well as superb pricing that they could not do. So, despite all the other things that they were offering, they were excluded from the textile contract and we were awarded it.

Let me talk about what Standard Textile is all about and what our mission is all about. We are committed to contributing to patient care excellence and staff protection in cost effective and sound environmental ways. We are also committed to developing innovative technologies and systems which better serve our customers and lower their total cost. The meaning of this is essentially finding ways to reduce the cost of health care.

We have a strong commitment and a strong budgeting which goes into research and development, to taking commodity products, generic products, and

engineering economic value and user benefits into all of our health care textile products. This results in quality, better patient care, and ultimately lower price.

If I can just take one second to give you an example here, we show here in this particular slide a sheet, whereas your traditional generic commodity sheet is 50 percent cotton, 50 percent polyester, which after about 30 processings becomes about 75 percent polyester, which is terrible for a patient's skin, skin break down, decubitus, and so forth, we developed a technology which essentially puts cotton on both surfaces of the sheet, while using another technology which we developed with micro demure polyester fiber to give the product double the durability or the longevity of the traditional products in the marketplace.

Just to give you an overview of what our products are, we provide reusable health care textile products, really from cradle to grave, everything from baby blankets, baby diapers, throughout the entire hospital, including all the staff apparel, patient apparel, decorative products, draperies, window treatments, all the way through to the surgical suite or the operating room where we provide technology-based high barrier quality reusable gowns, drapes, sterile wrapping material, back table covers, and mayo stand covers.

I do want to mention that we have what I would call strong competition in every product category that we serve, and that is both with reusable as well as disposable companies. We, today, compete with companies like Kimberly-Clark, like Johnson & Johnson, like Cardinal Health, and so forth, and we do it with our limited product area where we can show and demonstrate every day that we can bring lower overall cost, not just unit cost, but also lower overall cost to this area.

In addition to that, we pioneered and developed management systems in software which were able to improve product quality, which were able to lower cost, boost efficiency, and reduce waste. We were actually able to allow our customers, the GPO's customers, to become more competitive in the provision of their own services.

The interesting thing about this particular area, which nobody else really realized, is that if you looked at a hospital's total cost for the provision of their linen services, 75 percent of those costs have everything to do with processing, processing of the product, processing through the system distribution, use, abuse, mysterious disappearance, and everything else. Only 25 percent has anything to do with the acquisition cost.

So, we would come to hospitals and they to

their GPOs and say, hey, Standard Textile has 35 consultants that will work with us to lower our total cost and not just the cost of the acquisition cost or the unit cost of the products which we are acquiring.

Likewise, we have another system which actually goes into hospital laundries, which are generally run as something that has to be in the hospital because they have to have some way to process and to launder their products. But nobody there has -- they have a mind set of providing the best possible medical care for their patients. They don't understand that a laundry is a production facility. The way that we think about it, it's a manufacturing facility. So, we bring in our engineers.

We do for them forecasting, planning, engineering, and we have been able to take tremendous costs out of their laundering operations and literally brought down hospital costs by hundreds of thousands of dollars per year between their laundry costs and everything else which goes within their process. So, we truly bring value beyond price, and I think the GPOs have recognized that.

I'll go through this very, very quickly because I'm going to get into more detail in one second. The benefits of GPO contracts, as we see them and have seen

them, is that they reduce cost and increase efficiencies. They level the playing field for all vendors. They increase purchasing options for hospitals, and they lower the total cost to our customers.

By reducing costs and increasing efficiencies, the GPOs allow us to decrease costs across the entire supply chain, and that means from our acquisition of raw materials, fiber, chemicals, energy costs, water, and transportation services. Across the entire spectrum they have allowed us to decrease our costs in those areas.

They've also allowed us to decrease our marketing expenses and reducing our sales force by about 15 to 20 percent, as well as bringing our bidding department down to about three people because we're dealing not with thousands, hundreds and even thousands of hospitals, but we're dealing with large groups that are negotiating for the benefit of their members.

Speaking about leveling the playing field for all vendors, GPOs help us and have helped us compete with large companies. We developed a new and innovative fabric which we then turned into surgical gown and draping in surgical packs.

At the time that we did this, one of the GPOs had a sole source agreement with one of the large Fortune 500 companies, bringing value to their hospitals,

bringing value to everybody across the line. They had every reason in the world to say to us, we don't even want to evaluate it, we don't want to touch it, we're very happy with where we are. It's a reusable product. Reusables are kind of on their way out.

But they did say, you know what, it is innovative, it is a new technology. They brought in a third party player at their cost, Deloitte and Touche, to evaluate our economic value as well as their clinical staff to evaluate the clinical benefits of our product. The bottom line was that Deloitte and Touche came back and said that this system saves an average of 17.6 percent.

They did the study across the country, and the clinical evaluations have been superb in terms of the barrier protection to the hospital staff, as well as to the patients, as to the environmental effects that decrease in infectious medical waste, and the overall lowering costs are concerned.

They've also increased the purchasing options for hospitals. Many things have been said here today, but I think from our experience it's black and white. Hospitals have the option. They may purchase under the GPO contracts or they may purchase from any vendor in the marketplace.

In addition to that, they can change GPOs. We see this all the time. They're not happy with one GPO, for whatever reason it may be. They can change to another GPO or they don't have to belong to any GPO whatsoever. So, they have choice and they have utilized that choice at many, many different opportunities.

In terms of the customer efficiencies, they receive lower prices and they also receive product standardization. One of the things that GPOs brought to this picture, just to give you a real generic example, every floor in the hospital would want their own colors of scrub suits. Some of them would say, I want my pockets here and I want my pockets there.

That creates no efficiencies for the manufacturers or the vendors, but, more importantly, it creates no efficiencies for the hospitals themselves who have to launder and process this stuff and keep it separate and deliver it separately and so on and so forth.

Number two, they've created tremendous supply chain efficiencies through this for themselves. In addition to that, they've been able to gain access to value-added services such as control tests, which I spoke about before, because that really encompasses 75 percent of their cost. Their ability to have access to that as a

value-added service has had a major impact on cutting their costs.

So, in conclusion, let me just say the following things. Number one is that in our experience, GPOs have lowered costs for the vendors and manufacturers. But, in doing that, they have significantly lowered the costs for our customers and for their members.

They've leveled the playing field for small and medium-sized vendors like ourselves and have given us the opportunity to compete against the Goliaths. We did that when we were a $60 million company and as a medium-sized company today, we still do it today.

They have greatly improved supply chain efficiency. When I say they've improved supply chain efficiency, they've done it from the manufacturer or the vendor all the way through the hospital. I think it's very, very important to point out that hospitals today don't have to carry inventory on their shelves because vendors help them do their forecasting, their planning.

They get consolidated shipments. Sitting on all that capital, which was a common practice before, the GPOs together with suppliers have virtually eliminated all of that.

So, with that, I promised I would be brief.

So, again, I'd like to thank the FTC and the DOJ for inviting me here today to share my perspectives and views at this hearing. Speaking as a hospital supplier, I believe the existing GPO system brings enormous value to the health care system.

Thank you very much.

(Applause)

MR. ELIASBERG: Thank you, Mr. Heiman.

Frequently, in these hearings, at this point we've gone down the table and asked folks, starting with the first speaker, if they had any reactions or thoughts, given what they heard. On the other hand, today, Matthew and I have some questions we want to be sure that we get asked. So, we're going to start out asking some questions. Perhaps we'll circle back in.

Seeing how I've been hogging the microphone up and now, Matthew is going to be asking the first question.

MR. BYE: Thanks, Ed.

I want to focus on a few different levels, starting first on the seller's side looking at sole source contracts. What I'm interested in hearing is panelists' views on how to reconcile two competing arguments that are being made.

On the one hand, people have said that these

sole source contracts don't foreclose choices because there are opt out provisions. On the other hand, these contracts allegedly generate large supply side efficiencies, which they generate by providing certainty to suppliers.

I was wondering if anyone could give me their view on how to reconcile those competing factors.

MR. HEIMAN: Virtually, all, if not all, of our contracts have 60- to 90-day cancellation clauses. So, our GPOs constantly want to know what have you done for me lately, what have you done not for me, really, but for our members lately. So, we are constantly under the gun to improve and to bring more benefits to those suppliers.

What we have to believe is that we will continuously bring those benefits, so if it is a three-year contract, that we can bet on the volume that we will receive from that three years, and that we'll be able to sell through to the different groups if we have a sole source. If we have a dual source, we also believe that we can sell.

But we're always at risk at losing that. But we have to have the belief in our own companies that we will perform on the contracts and, therefore, the contract will be solid for the three years. But we're always at risk of losing it.

MR. STRONG: I'd like to point out, too, that I think the argument has been made in the past that sole source contracts somehow only benefit big companies. I don't think that's the case at all. I think we have examples of a number of suppliers that are small manufacturers, that we have maybe one or two million dollar contracts with that would argue that a sole source contract is very beneficial. There's a couple of reasons for it.

Probably, the single biggest reason is that if a market share leading company, a large manufacturer, has a dual source contract with us, it's oftentimes very hard to get the health care providers, the hospital, to take a look at anything else. If you have a sole source contract with a small innovative manufacturer, there's much more incentive for the hospital to take a look at that.

There's probably better value. At the end of the day, the small supplier is going to be rewarded by actually seeing the volume move from the market share leader to their sales ledger. So, I think that sole source contracts can have significant benefits for small manufacturers.

MR. EVERARD: I'm going to weigh in on that as well. I think again the key here is that it's not so

much whether or not there's a sole source contract; it's how big is the contract, how big is the GPO, how much volume are we talking about. If you're talking about a tremendous amount of volume, you do have the potential to foreclose competition.

But I believe in sole source contracts, and I think John's GPO is of the size that for him to do a sole source contract, regardless of the size of the company, it's going to provide a good result. On the other hand, if Novation and Premier decide to do sole source contracts, the outcome may be different.

So, I think it's a matter of looking at how big the power of the GPO is in terms of deciding whether or not a sole source contract is of benefit.

MR. BLOCH: I guess I would weigh in there in response to that. Simply because a GPO is large doesn't mean that there's going to be an anticompetitive effect. The word that's used is the potential. But you just can't take it at a surface analysis. You've got to get underneath that contract to find out whether or not people are free to buy on contract or off contract, how long the contract is, whether it can be broken, whether people can join other organizations and buy through those organizations.

I think there's empirical data out there that

suggests from SMG that most hospitals belong to somewhere between two and four GPOs. So, they have a lot of options. As long as those options are there and hospitals aren't forced to buy through a particular contract, whether they're with a small GPO or a large GPO, it doesn't mean there's going to be any anticompetitive consequences to it.

MR. BYE: As a purely factual question, do GPOs or suppliers ever break these contracts using opt out clauses?

MR. EVERARD: Well, don't have representatives -- well, John maybe can speak to that.

MR. STRONG: We have from time to time broken contracts. Our intent in going into a contract is not to rip it up, but I think that when we went back and took a look at our code of conduct last year, we tried to cover not only terminating the contract but also allowing for new and innovative products so that we could continue to work with the manufacturer who held the contract as well as somebody who offered a new and innovative contract.

I think the thing that gets ignored in the conversation is the fact that at the end of the day, the market, which is really made up of caregivers and hospitals, are the ones that ought to be deciding whether something is new and innovative. I think they're the

ones that ultimately make the decision as to whether a product fails or succeeds.

MR. BLOCH: I also think that these contracts, whether they end up sole source or otherwise, you can't overlook the fact that there's a competitive process involved here, usually at the front end. So, for example, if companies like Novation and Premier put out requests for bid and they get a lot of bids, the result, the sole source result is the result of a competitive process. It creates an incentive for the vendors to submit their best offers, their best prices, their best terms and conditions, because there's a lot at stake.

So, if you look at the economics literature, if you look at antitrust cases, you will see that that is a form of competition that is important, that is valued. As long as those decisions are being made by people who have a significant interest in the outcome of how those contracts are awarded, I think that's your principal safeguard from an economic point of view.

MR. HILAL: If I may, I can see how Mr. Bloch, as representative of Novation, would see it that way. Frankly, in a lot of bids, we don't even get the RFP to bid on. Our issue is still whether or not there are punitive measures when someone deviates from the existing contract.

The hospitals may be free to cross the road, but if someone is ready to run them over financially, I would submit to you that they're not as free as one would like to think.

MR. ELIASBERG: If I could ask a follow-up to that to any of the panelists who care to respond, when you read some of the materials on the web concerning hospital group participating organizations, there's a suggestion that there are what sometimes are described as penalty clauses, that is to say, provisions that if a hospital would terminate with the particular GPO or start using a product other than what the particular GPO has on its supply list, that the hospital not only will no longer receive discounts but has to pay back a discount, sometimes over a few years.

I guess the question I have, simply, is an empirical one, and I open it up to anyone on the panel, and I guess, Merrile, I'm going to pick on you first, if anyone knows of just empirically, is there data out there on how frequently that occurs or how often that's there? If not, people can just give their sense of if that's an accurate assessment or not.

MS. SING: That's not something that we covered in our most recent report.

MR. HILAL: Our understanding is that the

rebates can be recalled, simply stated. In other words, if certain requirements are not met, not only are the rebates subject to interruption, but the previous rebates made under certain conditions can actually become due.

Mr. Elhauge in his report touched on that. So, for those of you who got that report, you may want to visit that aspect of it and find out how chained some hospitals are or a lot of hospitals are in this aspect.

Thank you.

MR. EVERARD: I'd like to respond to that as well. I think again the real question we're facing right here is if the GPOs want to have it both ways. On one hand, they want to tell their members that they've got these great contracts, they're getting the best prices. You simply can't get great contracts with the best prices and not give anything in return. It doesn't work that way in the real world.

If we're to believe that a GPO can offer the best prices, then we believe that you can get -- and yet, not have a requirement for compliance and participation, then we believe that you can get something for nothing. I think most of us are old enough to realize that in this world, you can't get something for nothing.

If a manufacturer is going to go to the trouble of getting a contract, there's certain things that they

want in return. They want volume, they want sales. That's why they're doing it. That's why they're bidding in the first place.

If all of that contract is going to turn out to be is a hunting license, then why are they giving the better prices that they're supposedly giving, why are they paying the fees? If that's all it is, then the hospitals don't need GPOs because the prices are not going to be any good under those circumstances.

MR. BLOCH: Well, let me just comment on that. I'm not sure that there's something wrong with the idea that the GPOs and their members want to have it both ways. If they can get low prices by offering commitment, I think one question you have to ask in this discussion is who is it that is seeking the commitment.

I think if you do some reading about hospital members and some of these organizations, you'll discover that as a cooperative, the hospitals that own the very organizations they ask to represent them seek and ask the GPO to come up with programs that create committed levels in order to get more choice. That's point number one.

Number two, they not only get more choice, but they get lower prices.

Number three, you have to look at the structure of these so-called committed or bundled programs, and

they vary across GPOs. If members are free to participate in those or not participate, then the fact that they choose to do so makes it clear that they think there's some value or benefit to them. So, if they make that commitment knowing what the fine print says going in, it doesn't mean that there's something wrong with it.

I think one pervasive assumption that underlies a lot of the really critical comments that I've heard here this afternoon is the fact that the hospitals which own the organizations that are involved here, who sit across the table from the manufacturers and from the consultants and from the brokers, somehow don't know or understand what's in their economic interest.

The critics seem to think that they don't understand how to run their hospitals. They don't understand how to provide care in an effective and efficient way. I think there's a lot of sour grapes in this. I think a lot of these people do understand that.

That's why they belong to a lot of these organizations. That's why they have an ownership interest. That's why they form coops. That's why they direct them about what the programs they want. If they didn't, they would either not belong or go elsewhere.

MR. HILAL: It's really interesting that at this point in time we're pondering whether hospitals know

what's best for them or not. We have every respect for the customer. We believe the customers are entitled to know what they're paying for.

There was a time when buying an airline ticket was very confusing, and the customer had a chance to find out more and more about the pricing. Mr. Bloch's client, Novation, has agreements in place that actually are very, very difficult. We know it firsthand.

It is something to present a hospital with a situation that would save them, let's say, $200,000 on a $500,000 purchase and have higher ups in the hospital say, boy, this looks really interesting. That would help a lot. We have to check with our J&J sales rep and find out if we can do this. When you ask them what does that mean, the answer is, well, we need to know if we comply.

Time after time with documented example after example, the Ethicon person or the J&J person, what have you, will come in and will always start with, you won't comply. That savings of $200,000 will cost you another $300,000 in suture price increases. Then we go through the numbers. More often than not, we find the so-called mathematical errors.

But it's a back and forth situation where the customer doesn't really know. It's a shell game. Then, when we're done with the pricing of the individual

products and their bundling, then we get into the so-called rebates. There's another shell game.

Now, specifically, the largest GPOs have a tendency to play this to the fullest with the largest most dominant of suppliers. The customer deserves to know something as simple as what am I paying for this product. It doesn't have to be a four-level equation to figure that out.

MR. STRONG: I think that what's being described here can't all be laid at the feet of the largest or the smallest group purchasing organizations entirely. I think some of this needs to be owned by medical device manufacturers, both large and small, the tactics of their sales force, the tactics that they employ to try to retain business when business tries to move from one competitor to another.

I think that it's an overgeneralization to say that complicated contracts are purely the business of the group purchasing organizations. I don't think that's the case at all. We try to simplify contracts, but it's a very complicated marketplace, and it's very difficult to do that in some cases.

The suggestion has also been made that group purchasing organizations are somehow controlled by manufacturers. I have 12 board members who would take

great umbrage at that comment. I think that if you look at the facts with the large group purchasing organizations, those are also controlled by the hospitals who own them.

There is an independent board who runs them. I think the hospital executives who run those boards and are on those boards and serve as their chairman would probably take umbrage with that comment and that implication as well. These are independent boards that see value in aggregating purchases.

MR. BYE: That partially preempts my next question, which was I was interested to hear the views on incentives of the GPO vis-a-vis the hospitals. Some of the panelists have suggested that GPOs might have a different incentive to those of the hospital. That would seem to me to be only possible if the members didn't have full ownership of that entity.

I'd be interested, as a question of fact, whether all participants in a GPO also are shareholders or are there exceptions to that?

MR. STRONG: I think if you look at the structure of most GPO contracting processes, and this certainly doesn't hold true just for us, it's committees of shareholders and owners who make the decisions. There are hospital representatives on those committees who

determine whether or not they want to see a contract structured the way it is or not. So, I think they have a pretty clear idea going in what the contract is going to look like, what the value proposition is.

I can tell you that most group purchasing organizations do very extensive analysis of what the value proposition of a contract is going into the contract decision-making process, there may be some shell games that are played by sales representatives in the field. We have a pretty good idea going into the implementation of a contract exactly what kind of value is going to be delivered, as was evidenced by the slide I showed you on suture and endosurgical products.

MR. BYE: Even if a GPO is entirely owned by its members, are there circumstances in which it could have incentives to behave in a way that was contrary to their members' interests?

MR. STRONG: I think the end game is always low price and good value. The suggestion has been made that somehow group purchasing organizations are selling out for bigger administrative fees. Group purchasing organizations have to compete with one another for business.

As several people have noted here, there's change going on in the industry and health care providers

are changing from one group purchasing organization to another. If you buy the notion that group purchasing organizations don't care about value, then you also have to buy the notion that there's no competition out there as well, because the thing that we compete the most on is the value proposition we deliver at the end of the day.

MR. BYE: Switching to a different level, assume a hypothetical situation, which is there's a degree of foreclosure in the market caused by certain long term contracts, not necessarily raising antitrust concerns. But what I'd like to look at is innovation, because a number of the panelists expressed concerns that they swore companies can't make it to market due to some of these contracts.

What I'm thinking about is a different set of industries where small companies innovate but they don't actually make direct access to the market. That's the biotech industry and, to some extent, the semi-conductor industries where companies are funded to develop an idea and then they partner with a larger company and take that through to commercialization that way. It's a different model, but biotech seems to be thriving.

I guess what I'm wondering is, are there reasons why the medical device industry can't operate in that same fashion?

MR. HILAL: I'll be more than happy to comment on that.

I'm sorry, go ahead, please.

MS. WEATHERMAN: It does operate in that fashion. One of the things I was talking about, the earlier stage companies as the valuations have dropped, there's more concern about the gauntlet that has to be run to get to market, which, as I said, it's not only this issue.

The valuations have dropped and it's been much more common that they, earlier in their development, seek a corporate partner, knowing that down the road there is going to be a benefit to be a part of a larger company that has more selling power.

MR. HILAL: The life line of not only innovation but competition in this country are smaller companies growing to be medium-sized companies growing to be larger-sized companies. There's always the option of consolidation or acquisition. But it's always an option to remain independent. That's a part of what keeps the market competitive.

Should we conclude that the only way to the marketplace is to run the younger and entrepreneurial companies simply as 4-H projects, if Farmer John doesn't buy them, they don't go anywhere, then the options are

considerably limited.

Venture capital did a phenomenal job for the past 30 years absorbing the majority of risk for the large corporations in medical devices. They bet on companies when they're very risky, very young. When they develop, and usually development means development of technology, development of product market testing it, proving its safety, its efficacy, getting some clinical input, clinical papers, etc., when most of the risk is absorbed, that's when corporations step forward and claim that innovation. They include it in their channels of distribution and go forward.

But in the process, venture capital had the ability to at least get a return on its investment. The reason they were able to do that is because there was always the option of going out and getting 20 people, establishing a sales force and saying, look, if you're not going to be able to recognize this technology and its value, then I've got other options.

Right now there are no other options. There's absolutely no option to a lot of these companies. Therefore, the larger companies are at a great advantage for two reasons. Number one, with the existing contracts, the need for innovation is considerably lower. If you can't get your innovation to the market to compete

with them, why would they have to buy it? That's one.

Secondly, if venture capital has no way out, no way of liquidity other than to sell to them, why would they pay them the full price? They wouldn't. That's what's being reflected on the pricing. That's what's being reflected on the returns for these things.

MR. BLOCH: Let me make just one observation here, and I don't know if Merrile can add to this.

To the extent that these general comments relate to GPOs, the GAO report that was released in July had a very interesting statistic. In fact, to me, it was probably the most interesting conclusion in the entire report.

It was on page 10 and it said that nearly one-third of all newly negotiated contracts awarded by the seven GPOs, these that represent so-called 80 percent of the market, in 2002 were awarded to manufacturers with which the GPO had not previously contracted.

So, clearly, and there are literally hundreds of contracts with all of these GPOs because there are thousands of products, so clearly, a very, very significant percentage of manufacturers who haven't been involved with one GPO or another are getting contracts.

Now, I don't know how many of those reflect innovative products. You know, maybe Merrile can comment

on that if she knows. But it certainly suggests that there aren't significant barriers to entry here in terms of manufacturers being able to develop relationships with organizations like this that didn't exist before.

MR. EVERARD: Can I respond to that? Many of the contracts that came out were in a flurry of activity that took place in late 2002 after the first GPO hearings in the Senate Antitrust Subcommittee. What you saw happen in many cases, and this would have skewed the numbers, was that large GPOs opened their contracting to very large numbers of small suppliers.

For example, in the glove contracts for Premier and Novation, they opened up their contract to as many as a dozen suppliers. What you may not know is that those contracts, and many others, were for only 18 months. Right now, as we're sitting here, Premier is deciding which of those suppliers on the glove area it's going to get rid of. It intends to pare it down significantly.

So, yes, that's a nice statistic, but we have to look behind the numbers to see what it really means.

MR. HILAL: If I may add one comment also, I truly believe that the number of contracts is the wrong metric to observe because it's very easy to give contracts out of politeness, out of political expediency. You can give a lot of contracts out.

The simple question is this, can the new entrants be given an even grounds opportunity to penetrate the market? How much has the market share been changed by such contracts? That's an important issue. If the products are bundled together the way they are with a Novation agreement, then is the penalty still there?

The fact that I may have a trocar agreement with Novation but the penalty, the financial penalty is still there, if the customer were to buy anything but Johnson & Johnson's trocars, what advantage does this contract give me? Next to nothing.

MR. STRONG: But at the end of the day, it's up to the customer who is a member of the group purchasing organization to really decide whether they want to do that and use the new technology or continue with the incumbent supplier.

So, it's the hospital that's still making the decision. It's not the group purchasing organization that is driving that phenomenon. It is the hospitals that own the group purchasing organizations that make the decision.

I think that it's commendable that certain group purchasing organizations have put out multi-source contracts. But at the end of the day, it's up to the

hospitals to decide and the free market to determine who is going to have a contract because products were purchased off those contracts or not.

MR. HILAL: If I may, I really appreciate what John is saying and I think it's always dangerous to look at the averages. It's always dangerous to generalize, but, folks, an enlightened organization will sort through it and will figure it out in a lot of situations. The average organization may not.

You've got very bright people in very large corporations working very diligently on making the situation less than clear. Look, it's one thing to have elections; it's another thing to have elections free of intimidation. It's one thing to have multi-source contracts; it's another thing to have multi-source contracts free of financial intimidations. You want free contracts, you want free markets, it's got to be free of intimidation.

What we're seeing in the marketplace are customers who are literally intimidated of seeing their suture business end up costing two and three times or 20 or 30 percent more, or 40 percent more. They're toeing the line. They don't dare violate that. They don't understand the full ramifications of it.

Unless our folks here, the people that are

entrusted with making sure that these things don't happen, step in and say this bundling and this illegal kind of one thing with the other, if that is the case in these situations, are to be examined and ought to be stopped, then there can be confusion.

MR. ELIASBERG: Merrile?

MS. SING: Let me just briefly say that when we asked GPOs for this information, we did not ask them for additional information as to whether or not these new contracts were with innovative products or with established firms. Also, these data are for the number of contracts. It doesn't talk about purchasing volume, which perhaps maybe would tell a fuller picture.

MR. BYE: Can you suggest any other sets of data that would be worthwhile gathering to illuminate this area more?

MS. SING: Well, I think I understand your question. What we could have done is we could have asked a follow-up question, how many of these companies were established and how many were innovative. We also could have tried to get data on purchasing volume, because you could have five contracts that account for 50 percent of the purchasing volume, or you could have 50 contracts that account for 2 percent of the purchasing volume. So, it only tells a partial picture. Was that your question?

MR. BYE: Exactly.

Do any other panelists have suggestions as to data that might be worthwhile gathering?

MR. EVERARD: I want to go back to something that we talked about a few minutes earlier. The notion that one might be suggesting that the hospitals maybe don't know what they're doing when it comes to the supply chain, I don't think that's the issue. I think the real issue is the question that I keep coming back to, because I just can't understand it and maybe some of you can enlighten me.

On one hand, it's the hospitals that are telling the GPOs to come up with these complicated, convoluted contracts that will save them more money. Yet, the hospitals are hamstrung by their own desires that they want to go and use a better product but now they can't because it's going to cost them more money.

So, I just have to ask the question, why would a hospital CEO, a board member, or somebody actually agree to do it that way? What am I missing?

MR. BLOCH: I'll let John answer, too, but I'm not sure you're missing anything. I think the decision to have these programs and have these contracts are because that's what they want. If they didn't want it, they wouldn't ask for it.

So, it goes back to my point that once they have these programs, individual hospitals are free to decide whether they want to participate in them or not. They're not shoved down their throat. If they decide to participate in those programs, it's because they want the benefits of them and they're willing to accept the compliance and commitment levels. So, there's nothing wrong with that.

There are lots of people who participate in these GPOs that don't participate in the committed programs because they don't want that. They want the freedom to go off contract or go elsewhere. So, I'm not sure you're missing anything. I think that's the explanation.

MR. STRONG: I think I agree with Bob. Some people see value in bundled programs and see economic return in that. They're comfortable with the products that are contained in the bundle, and others aren't. They don't participate in those cases.

MR. HILAL: This begs the difference, then. What was the advantage, if I may ask, of breaking the bundle between endomechanical, which is bundled itself, but endomechanical separate from sutures for what your organization --

MR. STRONG: We thought that there might be an

opportunity to lower cost by looking at the two marketplaces independently. We, in fact, did that. We asked for sole and dual source pricing from both suppliers. At the end of the day, we chose United States Surgical, both on the basis of their cost, as I illustrated in the chart, as well as the clinical acceptability of their product.

So, we did look at both. We tried to include other manufacturers as well. But I have to tell you, at the end of the day, one of the decision-making points in U.S. Surgical getting the award for both suture and endo was a complete product line. Our owners saw value in having products that they perceived to work well clinically and work well together. That's why the award was made that way.

MR. HILAL: The silver lining here is there's agreement between Consorta and Applied that unbundling in a lot of situation ends up resulting in lower prices, more options for the buyer, especially in a monopoly situation.

If, for some reason, U.S. Surgical did not have a suture, would that have affected the pricing on endomechanical, on ligation, on clipper pliers, on sutures, I'm sorry, on trocars? That is the question I had of us. That is a key element of what we're asking

for here.

MR. STRONG: Well, I think that's very speculative and it's tough to say. I mean, the market determined what the cost was going to be when we went to market a year or 18 months ago. The market is already changing. I think you're seeing different competitive tactics now in the marketplace than you would have seen two years ago with regard to the pricing of those products, with the bundling or unbundling of those products. As a result, I don't think you can speculate what would happen if you had or hadn't put certain products under contract. The market is very fluid and it will react to those types of changes.

MR. ELIASBERG: I'm going to jump in here now to turn to another topic, which I can't resist asking a question about. We heard a little allusion to Statement 7. Just so that everybody is clear, Statement 7, which covers group purchasing by health care entities, has a safety zone in it that has a two-prong test, the safety zone being that it's something that automatically will not be challenged by the Agencies, and not necessarily something falling outside of it will.

The first test is that the group purchasing arrangement not account for more than 35 percent of the total volume of the product being sold in the relevant

market. The other test is a 20 percent test, basically that the items being bought do not account for more than 20 percent of what the actual final product being sold by the purchaser is charged, or costs, I should say.

Mr. Everard has indeed pressed a great deal on Statement 7. I would be particularly interested in hearing any views or thoughts about just how appropriate Statement 7, as it is currently drafted, is with respect to the hospital group purchasing organization situation?

I'll take any volunteers here.

MR. BLOCH: I guess I'll jump in here. Ed, you've outlined the two provisions that fall within the safe harbor, but let me clarify a couple of points. First of all, the first requirement that the purchases under the arrangement are less than 35 percent of total sales of the product in the relevant market, that's directed at whether the participants in the arrangement have monopsony powers. So, that's a significant issue directed at a number of the topics that have been discussed here.

Second, the second requirement, whether the product being purchased is less than 20 percent of all the revenues derived from all the products and services sold by each participant, really goes to the requirement of whether the arrangement could result in standardizing

prices of a common significant input among the participants in a way that would enable them to fix the price of their products as they compete with each other.

The question, I guess, is, is there a problem with the Statement that needs changing? My answer to that is no, for several reasons. First, I don't think there's any evidence to suggest or really demonstrate that there's anything wrong with the Policy Statement as it presently exists. The underlying rationale for this Statement is still valid with respect to the subject matters that it addresses.

Secondly, there is no evidence that I've seen in the years that it's been out there to suggest that the legal principles underlying the Policy Statement are wrong or have changed.

Third, there is no evidence that I can see to suggest that the Policy Statement is a barrier or an impediment to the enforcement agencies being able to address any legitimate antitrust issue that may be raised concerning GPOs, or the enforcement agencies are somehow incapable of pursuing legitimate issues concerning GPOs if there's evidence to support them.

Fourth, to the extent that the issues raised concern exclusive dealing or monopolization or monopsony, which has been discussed here quite a bit today, there's

no evidence to support the view, that I see, that the law is inadequate as it exists now to address them or that the courts have not been able to deal fairly with these issues, or that the enforcement agencies cannot deal with this subject or these issues, which they have done in the past in other contexts, if evidence or a legitimate problem presents itself.

You don't have to have a policy statement for every problem that exists when there's adequate law, there are adequate venues to investigate or prosecute such cases. In fact, the antitrust law has been in existence since 1890. There hasn't been a rule for every single practice or piece of conduct which has ever occurred. If that were the case, the Agencies would never have been able to enforce anything.

There are laws of general application.

There are laws dealing with exclusive dealings. There are laws in cases dealing with monopolization. It doesn't have to be located in a policy statement somewhere when these cases have been brought for decades.

In short, I don't see any evidence to suggest that there's been a failure of the law or of enforcement or of the courts to deal with these issues when they're presented. Changing the Policy Statement, for example, the safe harbor, just take that as an illustration, by

lowering it from, say, 35 percent to 25 percent or 30 percent, in my view, would not change anything significantly because these safe harbors, bear in mind, are simply that.

It doesn't mean that if you're not within the safe harbor that the practice involved is unlawful. It simply means that it gets closer scrutiny. So, I don't think it's likely to change anything that presently exists in any significant way if you lowered the safe harbor.

And the Agencies both issued Guidelines in 2000 after the Health Care Policy Statement was issued dealing with joint ventures and collaborations. It specifically dealt with the subject of safe harbors and market share. That particular set of Guidelines had a 20 percent market share.

In footnote 54 on page 26 of those Guidelines, it explicitly carved out the Health Care Policy Statements. So, to me that was an acknowledgment that the Policy Statement as it existed did not require revision at the time.

Finally, I think the fact of the matter is that there have been very, very few cases that have been brought against GPOs, and none of them have ultimately been successful.

So, in short, I think the rule as it exists today is perfectly adequate for the reasons that I mentioned. I think the law is perfectly adequate to deal with these problems. I think the Agencies are perfectly capable of dealing with issues that are presented to them if they feel they're justified.

MR. EVERARD: Could I just ask a question of Mr. Bloch? You said that none of those cases had been successful. Then, your client agreeing to a settlement out of court would not be a success for the company that brought the suit?

MR. BLOCH: Well, first of all, I'm not going to discuss litigation.

MR. BYE: This is not the forum to discuss particular cases, I'm sorry.

MR. EVERARD: He made a blanket statement, so I felt like it's important to respond.

MR. BLOCH: I made a statement that said that the cases that have been brought, the litigated cases that have been brought and been decided by the courts, there has never been a case that has ultimately been successful against a GPO.

MR. HILAL: I will stay away from the litigation issues. I am not a lawyer, Mr. Bloch is, and so I'll stay far away from that issue.

A colleague of mine always reminds me that it's absolute craziness to continue to do the same thing expecting different results. Folks, let's take a look at the results that are coming out here, increasing monopoly, decreasing interest on the part of venture capital, increasing health care costs, escalating.

The health care cost is going up much faster than anything else, not for one factor, not for two or three, but certainly also because of purchasing practices. It isn't working and it would be crazy for us to continue to do it the same way. It would be crazy for us to pretend that everything is just fine, leave it as is. It isn't.

MR. ELIASBERG: I hate to pick on a panelist, but I'm going to do so, nonetheless.

Ms. Weatherman, from your perspective, do you have any thoughts on this particular issue about Statement 7, looking at it from the venture capitalist point of view?

MS. WEATHERMAN: As I said in my opening statement, we haven't investigated this to the level -- I mean, we are much more focused on trying to understand the flow of funds, the classic follow the money. Where are the fees coming from? Where are they going? How are they calculated? I think therein lies the next layer of

information that's critical to really getting to the bottom of how this system really works and who is really benefitting from it.

MR. ELIASBERG: I'll pick on one other panelist, Mr. Heiman, from your perspective as a vendor?

MR. HEIMAN: Let me speak both as a vendor but also as chairman of a hospital in Cincinnati and member of a board of directors, which encompasses about 40 percent market share of the Cincinnati marketplace.

What I can say, as Mr. Hilal has already stated, there are many reasons for rising health care costs, but I can tell you in terms of the supplies that are being supplied to hospitals, that is absolutely not one of the reasons.

I mean, I can't tell you off the cuff, but I can provide you how much the acquisition costs, the total cost of our products, have come down in the last seven to ten years. I won't go beyond that. The GPOs, without any question, have had a major impact on bringing those costs down. So, while I agree with you, it's not one factor or two.

Where I would take issue with you is that the GPOs have absolutely had a very, very positive impact on bringing costs of Med/Surg and all other medical equipment coming into the hospitals down. One exception

might be pharmaceuticals and I really can't speak to that. But in terms of all other products, our costs, I know, at our hospital and within our system have come down dramatically.

MR. ELIASBERG: Thank you. It appears that we have run out of time. That being so, I want to thank all the panelists for their excellent presentations. I'd appreciate it if you would join me in giving a hand to this panel.

Thank you.

(Applause)

**(Whereupon, at 4:28 p.m., the hearing was concluded.)**

# C E R T I F I C A T I O N  O F  R E P O R T E R

MATTER NUMBER: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW

DATE: SEPTEMBER 25, 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: OCTOBER 17, 2003

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KAREN GUY

# C E R T I F I C A T I O N  O F  P R O O F R E A D E R

I HEREBY CERTIFY that I proofread the transcript for accuracy in spelling, hyphenation, punctuation and format.

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MARILYNN McNULTY