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DEPARTMENT OF JUSTICE

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FEDERAL TRADE COMMISSION

I N D E X

P R O C E E D I N G S

MS. OVERTON: I'm Leslie Overton from the Department of Justice. Welcome to the final session in the DOJ/FTC joint hearings on healthcare in competition, law and policy.

My colleague, Cecile Kohrs, from the Federal Trade Commission, and I will be moderating this session. We have a very full and very distinguished panel. And so I don't want -- and we're already starting a little bit late, so I don't want to get into long introductions. But everyone's bios are in your bio booklet.

We are going to be starting this morning with Gail Kursh from the Antitrust Division, followed by Mel Orlans from the Federal Trade Commission.

MS. KOHRS: And if I could ask people to turn their cell phones off during the hearing, please.

MS. KURSH: Good morning. It's a pleasure to be part of this panel. Thank you for including me. I just want to start with the caveat that these will be my own thoughts today and do not necessarily reflect those of the Antitrust Division.

My objective this morning is to highlight some of the important considerations that come into play in structuring appropriate and effective relief for federal antitrust violations.

During the past year, the Division has been closely reviewing our policies and practices and securing remedies in merger enforcement, whether through litigation or in consent decrees.

This is incredibly important because failure to achieve adequate relief results in higher prices, decreased quality, and reduced output in innovation. On the other hand, excessive relief could hinder legitimate pro-competitive conduct that the antitrust laws are designed to promote and encourage.

Although the Division's efforts have largely focused on merger remedies this past year, many of the principles guiding the development of effective merger relief apply equally to civil non-merger remedies. They also apply just as equally to the healthcare industry as to other industries in our economy.

So let me start off this morning with some of these important guiding principles for civil remedies for federal antitrust violations.

First and foremost, the remedy must resolve the competitive problem. The only legitimate goal of a civil antitrust remedy, whether in a merger or a civil non-merger context, is to restore competition to the marketplace.

Thus, the remedy must not be punitive. That's the job for criminal enforcement. Nor should the remedy be

overreaching. Our ultimate and only goal is to protect competitive markets for the benefit of consumers.

In the course of reaching that goal, we know that remedies can have unintended effects in the marketplace. So it's our job to try to predict such effects or consequences to the extent we can, and avoid them if that's possible.

A second guiding principle, and this is particularly important in civil conduct cases or civil non-merger cases: There must be a close, logical nexus between the remedy and the alleged violation. The Division will carefully tailor the remedy to the theory of the violation. And we think this is the best way to ensure that the remedy will cure the competitive harm.

The third guiding principle is the well-known adage that the remedy should promote competition and not competitors. Although this may seem pretty obvious to all of us, it is particularly important in crafting appropriate relief. The Division’s goal is to promote and protect competition, not to pick winners and losers in the marketplace.

And finally, but very importantly, the remedy must be enforceable. A remedy is just not effective if it can't be enforced. Therefore, the decree has to be drafted as clearly and specifically as possible so that the defendants know their duties and obligations under the decree.

We also have to give careful attention to identifying those persons who must be bound by the decree to make the remedy effective, and also to insure that they are giving effective notice of the decree's provisions.

Now, not only must the decree be enforceable, it must, of course, in fact be enforced. And to that end, the Division is committed to devoting the resources and effort and time that's necessary to insure compliance with our judgments.

With respect to healthcare judgments, responsibility for enforcing them rests with our new litigation section. And if there's any issue about criminal contempt, then the National Criminal Enforcement Section would also be involved.

Okay. Now let me turn a little specifically to merger remedies. The threshold issue in remedying a merger violation is to determine the appropriate form of relief. Merger remedies can take two basic forms. One is to change the structure of the market through the divestiture of assets of the merged firm, and the other controls the conduct of the merged firm through injunctive provisions.

As a general rule, the Division strongly prefers structural remedies in merger cases over conduct relief. And there are a number of reasons for this.

First, a divestiture is relatively quick and

certain.

Second, a divestiture generally avoids costly and time-consuming government entanglement in the marketplace. Conduct relief, on the other hand, generally requires more government oversight of the decree.

Third, there is always the risk that the merged firm will attempt to circumvent the injunctions, either directly or indirectly.

And finally, conduct remedies may inadvertently restrain pro-competitive behavior or prevent the merged firm from responding to unforeseen changes in the marketplace.

There are limited circumstances, however, when conduct remedies may be appropriate in a merger case. The first is when a short-term conduct remedy is needed to ensure an ultimately effective divestiture. So, for example, it may be the case that a short-term supply agreement between the merged firm and the purchaser of the divested assets is necessary for the divestiture to be effective.

The other circumstance -- and this is a lot more rare -- is when a divestiture is simply infeasible or it would sacrifice significant efficiencies. In those very limited circumstances, the Division may consider stand-alone conduct relief without any sort of divestiture.

In the past ten years, the Division filed about 113 merger cases. Less than ten of those had stand-alone conduct

relief without any sort of divestiture, and most of those were in the defense and telecommunications industries where there's a long tradition of regulatory or quasi-regulatory oversight.

The only case of stand-alone conduct relief from the Division in the healthcare industry was the Morton Plant/Mease hospital merger in 1994. And for those of you who followed the Morton Plant/Mease judgment, you know that it ultimately presented many problems down the road.

In June 2000, the Division filed a civil contempt action against the hospitals, which among other things permitted managed care companies to terminate their contracts with the hospitals. It also required the hospitals to pay about $500,000 in fines and costs.

Now a few thoughts about civil non-merger remedies where most of our healthcare cases fall, as well as, I think, for the FTC as well.

Unlike mergers, civil non-merger antitrust violations appear in an infinite variety. Civil non-merger remedies, therefore, must be carefully tailored to the facts of the particular violation and the context in which the violation arises.

Also unlike mergers, civil non-merger remedies typically focus on conduct or very small structural change rather than large-scale divestiture or dissolution.

The appropriate goals of a civil non-merger remedy are to end the unlawful violation or the unlawful conduct, the violation, prevent its recurrence, and eliminate the anti-competitive consequences that came from the specific violation.

Now, in some cases simply enjoining the specific illegal acts that were challenged in the complaint may be sufficient to accomplish these legitimate goals. And if that's the case, that's where the remedy should end.

However, in the vast majority of civil non-merger cases, including those in healthcare, more is generally needed. In circumstances where there is a likelihood of a continued or recurring violation, what we call fencing-in provisions may also be appropriate.

Fencing-in provisions may prohibit lawful or unlawful conduct, including conduct either not alleged in the complaint or conduct that's completely different from that alleged in the complaint.

Although the Division will avoid unnecessarily restraining legitimate behavior, such constraints on legitimate conduct are often needed to prevent recurrence of the violation.

It may also be necessary to impose affirmative obligations on the defendants to either prevent recurrence of the violation or to eliminate its anti-competitive

consequences.

For example, in many of the provider most-favored-nation cases and the physician price-fixing cases the decrees permitted the purchasers of services to terminate or modify their contracts with the providers which were tainted by the violation.

In other healthcare decrees, both the Division and the FTC required the defendants to obtain prior Agency approval or, at a minimum, to notify the Agencies in writing before engaging in certain conduct or transactions.

Now, although, as I said earlier, large-scale divestiture or dissolution are relatively rare in civil non-merger cases, there may be limited circumstances where no combination of injunctive or affirmative conduct relief will achieve the appropriate goals of an antitrust remedy, and some form of structural relief is also needed.

For example, in the Division’s older St. Joseph and Danbury physician cases, we recognized that the physician organizations had to reduce their size, and they were required to reduce their size and modify their structure, if they wanted to jointly negotiate with health plans.

Also, in our recent Asheville physician price-fixing case, we required Mountain Healthcare, which is a physician or was a physician network joint venture comprised of almost all the private physicians in the Asheville area,

to dissolve.

Under the circumstances of that case, the Division believed that dissolution of Mountain Healthcare was needed to reestablish competition among physicians in the marketplace.

Now, it's important to keep in mind that permissible civil remedies do not have unlimited reach. And the Division is very cognizant of that. Federal civil antitrust remedies are limited to preventing and restraining violations. They are not an opportunity to fix all competitive problems in the marketplace, nor, as I mentioned at the outset, are they an opportunity to punish the defendants.

Finally, and very importantly, the remedy must always be related to the violation charge and the competitive consequences of that violation.

Now, my overview of Division remedies would not be complete, of course, without at least a brief discussion of criminal penalties. The Division brought a number of criminal cases in the past ten years in the healthcare field involving optometric services, dental services, and generic drugs. All of these cases were per se price-fixing cases.

Although the vast majority of cases in healthcare, as in other sectors of our economy, are civil, and with many of them even under the rule of reason, the Division is

prepared to bring criminal prosecutions in healthcare where there is a blatant violation of the antitrust laws and clear harm to consumers.

Now, a criminal conviction brings up to three years in prison and a $350,000 -- did I say that? -- $350,000 fine for an individual, and a $10 million fine or twice the gain or loss for a corporation. These are serious penalties, and should cause any person in the healthcare industry to think long and hard before engaging in per se price-fixing, bid-rigging, or market allocation schemes.

So just in wrapping up, let me emphasize again that the Division remains committed to appropriate, effective, and principled relief in all of its antitrust cases. We try to focus specifically on the facts of the cast at hand and craft a remedy that is tailored to the competitive harm.

We also try to achieve the appropriate remedy in the least burdensome way possible, doing as little damage as possible to legitimate pro-competitive behavior.

MS. OVERTON: Next we'll have Mel.

MR. ORLANS: Good morning. What I'd like to discuss today is the Federal Trade Commission's use of and experience with monetary equitable relief as an enforcement tool.

Before I do that, let me echo my colleague Gail's comments that my remarks are my own and do not necessarily

reflect those of the Commission or of any individual Commissioner.

Now, in antitrust cases, the Commission typically seeks monetary relief when it feels monetary relief is appropriate. It seeks monetary relief in the form of disgorgement. And disgorgement, of course, is an effort to eliminate the ill-gotten gain. That is, disgorgement has a deterrent effect because it takes the profit out of the wrongdoing.

These types of cases can involve -- and typically do involve -- overlap with private class actions and also with cases brought by the states.

By way of background, let me briefly describe for you the legal authority that the Commission uses in these sorts of cases. Basically, the Commission seeks injunctive relief under Section 13(b) of the Federal Trade Commission Act.

And in an injunction case, the court has -- the district court has inherent equitable authority to utilize all of the equitable relief and remedies available to it. And that, of course, includes the authority to issue monetary equitable relief. And again, in antitrust cases, that's typically taken the form of disgorgement.

Let me emphasize at the outset that the Commission seeks monetary relief, that is, disgorgement, quite sparingly

in antitrust cases. Recently, in July of this year, the Commission set out a policy statement in which it outlined the circumstances under which it would consider monetary equitable relief in antitrust cases. And the Commission set out essentially three criteria that it would consider in the exercise of its prosecutorial discretion.

The first of those is whether the violation was a clear violation. And the Commission defines a clear violation as one that a reasonable person would recognize would likely be a law violation in light of existing precedent.

The second -- and let me emphasize in that regard that a clear violation does not mean a per se violation, that we have sought monetary relief, disgorgement, in cases involving rule of reason. And I'll discuss some of those more specifically in a moment.

Secondly, there has to be a reasonable basis for the calculation of the amount of the monetary award.

Thirdly, the Commission's involvement has to yield some value added. And by this criterion, what we mean is, is there really a need for the Commission's action? We want to insure that there is a disgorgement of all ill-gotten gain and thus prevent wrongdoers from benefitting from their conduct. On the other hand, if that result seems to be achieved without Commission involvement, then that would be a

reason for the Commission not to bring a case seeking disgorgement.

The disgorgement approach is not a punitive approach. The maximum amount of disgorgement is the amount of the ill-gotten gain. So again, and this is my personal view, but it's my view that if it was clear in a particular case that the amount of the ill-gotten gain had already been disgorged through private class actions or other mechanisms, that under those circumstances there would be no basis for the Commission to seek disgorgement.

Now, I'd like to describe the FTC's experience in two recent cases that involve disgorgement, the Mylan Laboratories case and also the First Data Bank or Hearst Trust case, and then draw some conclusions from those experiences.

Let me start with Mylan, which is the older of the two. In Mylan, the Commission alleged that a generic drug manufacturer had cornered the market on supply of an essential pharmaceutical ingredient. And as a result of those actions, which it achieved through the use of an exclusive supply contract, the drug manufacturer was able to increase prices in the range of 2000 to 3000 percent.

Now, the Commission decided to seek disgorgement in Mylan. And let me outline some of the reasons why.

For one thing, we thought that the conduct was

egregious and a clear violation of law.

Secondly, at the time that the Commission considered what action to take, there were no private actions that were pending. Moreover, because of the use of royalty payments based on the excess profits that the companies had achieved, it was clear that there was an easy method available to us for calculating the amount of the remedy.

Now, we believed that without Commission action, full disgorgement would have been unlikely. And the reason for that is that the direct purchasers under Illinois Brick, who are most likely to recover, we also felt were the people least likely to bring an action.

And the reason for that was because the direct purchasers in that case were mainly the drug wholesalers. And those wholesalers for the most part had passed on the amount of the price increase to their customers. Indeed, the wholesalers had actually benefitted from the price increase because some of the wholesalers' fee was taken as a percentage of the price of the drug product.

So these factors, coupled with the fact that the wholesalers were dealing with big drug companies who were their regular customers, the sense was -- or their regular suppliers, I should say -- the sense was that for all of these reasons, it would be very unlikely for a large number of drug wholesalers to be willing to join class actions as

direct purchasers.

The real injury in Mylan was suffered by consumers and by third party payors, that is, by the indirect purchasers. The Commission and the states filed simultaneous actions against Mylan and others, and shortly thereafter class actions were brought on behalf of both direct and indirect purchasers.

And all of those actions, of course, were eventually settled. The Commission case and the state cases settled first. The indirect purchaser cases settled at the same time. And the direct purchaser class actions were the last to settle.

The Commission and the states received over $100 million in disgorgement in the Mylan case, and that money was allocated to compensate both the indirect purchasers, that is, to address the consumer injury, and it also was used by the states to address the direct injury that the states had suffered. In that case we permitted in that case the states to distribute the money to injured consumers.

Now, the total recovery in Mylan, which included the settlement of all the class actions, approximated about $180 million. And that amount, by our calculation, was roughly equal to the amount of the unjust enrichment, the unlawful gain.

Notably, the direct purchaser class action settled

quite late and I think fairly cheaply, and that was because as the Commission had originally envisioned, many of the drug wholesalers opted out of that class action.

The second case I'd like to discuss is the First Data Bank or Hearst Trust case, and that case was one in which the Commission alleged a consummated merger to monopoly.

The product market in First Data Bank was electronic databases for prescription drugs. And after the merger had been consummated, there were huge price increases to the customers of those products.

The case also involved alleged Hart-Scott-Rodino violations, and that consisted of the failure to provide certain 4(c) documents to the Commission during the course of the Commission's merger review.

Now, again, as in Mylan, the Commission sought disgorgement or decided to seek disgorgement for a number of independent reasons. For one thing, there were no private class actions that were then pending. In addition to that, we felt that absent a disgorgement action, the defendants would be likely to retain their ill-gotten gains.

And that was because had the Commission brought an action seeking only divestiture, we felt it was unlikely that that would have attracted any follow-on class actions. So again, we felt that there was a real need for the Commission

to bring a case seeking monetary relief.

Also, this was a case where the HSR violation was particularly important. The failure to provide the 4(c) documents had essentially hidden from the Commission the full impact of the merger. And, of course, the HSR violation was something that could be addressed only by the Commission or by the Department of Justice and not by a private class action.

And finally, as in Mylan, we felt that this was a clear violation. There was a knowing merger to monopoly, and the impact of that merger had been hidden from the Commission in the course of its review by virtue of the failure to produce 4(c) documents.

The Commission, in an effort to avoid duplicative recovery, agreed early on in the course of negotiations, and well before the complaint was filed, that any disgorged funds could also be used to satisfy any class actions should class actions be brought. And in that fashion, we felt that the defendants would not be subjected to multiple liability.

After the Commission filed its case in district court, class actions were filed on behalf of both direct and indirect purchasers. And those class actions settled almost immediately. The total amount of those settlements was about $26 million, including legal fees.

The Commission's settlement was somewhat delayed.

Although we had agreed in principle to a monetary award, the Commission's final settlement was delayed by the need to both negotiate a divestiture and then monitor that divestiture to ensure it's success.

Ultimately, the Commission settled for prohibitory injunctive relief to govern future conduct, divestiture to recreate a competitor in the market, and $19 million in disgorgement.

And as I said before, that $19 million overlapped with the monies that were used to settle the private class action, so the Commission didn't take money on top of the 26 million that was being paid in the private class actions. We further agreed to allow the class counsel to administer the redress fund.

The DOJ settlement for the Hart-Scott-Rodino violation was ultimately $4 million. So the total amount paid by the defendants, including the civil penalty, was roughly equal to $30 million. And again, our assessment was that that roughly approximated the injury that we calculated had occurred.

So what conclusions do we reach based on these two cases? Well, the total recovery in these cases in both instances roughly approximated single damages, not treble damages. And although many parties brought cases, it's clear from the results of these cases that the total monetary

relief that was awarded was neither punitive nor unfair.

In fact, the monetary relief was exactly what was necessary to remove the profit from the wrongful conduct. Now, whether or not that would be sufficient to deter in the future is at this point still an open question.

In closing, let me briefly address the use of set-offs or credits to address and avoid the problem of duplicative recovery. That approach, we feel, is workable where the injury is on the same level of distribution.

So, for example, in First Data Bank, where recovery sought by the Commission and that sought by the class actions was in both instances for the direct purchasers, the use of set-offs to avoid duplicative recovery would have been an appropriate and useful technique.

On the other hand, the use of set-offs is theoretically problematic in a case like Mylan, where there is recovery with Commission-sought recovery on behalf of indirect purchasers and there was also separate recovery by direct purchasers.

Nonetheless, the total recovery in Mylan, as I said before, roughly approximately single damages. So although this raises a theoretical concern, as a practical problem this has not proved to be a problem in the cases where the Commission has sought monetary relief.

So in conclusion, let me emphasize that the

Commission seeks monetary relief sparingly in antitrust cases, chooses its targets carefully and in accordance with the policy statement that it recently issued. But used as the Commission has used it, monetary equitable relief in the form of disgorgement has proved to be an effective antitrust tool.

MS. OVERTON: Kevin O'Connor.

MR. O'CONNOR: Good morning. I'm Kevin O'Connor. It's an honor to participate in the FTC/DOJ hearings on healthcare competition and policy.

Development of antitrust remedies often takes a distant second place to substantive law in the antitrust area, and consequently the federal Agencies deserve to be applauded for giving remedy development an appropriate focus.

I'm no longer with the government so I don't have to give a disclaimer, but I want to emphasize that I do not speak for Kevin Grady today.

MR. GRADY: You've never spoken for me.

MR. O'CONNOR: I am submitting a number of items with my testimony, including a speech I gave to the National Health Lawyers Association a few years back when I was chair of the NAAG -- the National Attorney General's Antitrust Task Force, and I spoke about healthcare enforcement at the state level. So I won't belabor a lot of the details there. I'm also including a number of consent decrees that were entered

into by the Wisconsin Attorney General in healthcare matters when I was an assistant Attorney General there.

I wanted to make three basic points in my opening remarks, and hopefully then leave the more interesting discussion to the panel discussion. Basically, what Gail said is correct, that at a high level structural conduct is always preferable to conduct remedies because it changes the incentives of firms in the industry and there's less regulation or oversight needed by the courts and by the enforcers.

My second point, however, is that in healthcare markets, we have a situation where the two dozen or so limiting conditions -- or limiting assumptions and boundary conditions necessary for perfect competition are often not met. In fact, in most healthcare markets, almost half of them are not met, from my back-of-the-envelope calculation.

And third, this has implications both for substantive law in the healthcare antitrust area, but also remedy formulation that is often not acknowledged.

Let me talk about structure versus conduct in civil merger and non-merger cases, for that matter. The first question in remedy development is often whether the most appropriate remedy is one which changes the structure of the industry, regulates the conduct of firms in the industry, or does some of both.

The legal criteria for remedy formulation usually does not provide clear answers to this question in the context of a particular case. The case law provides that stopping the violation, preventing a recurrence of the violation, and restoring competition are the goals of antitrust remedies, or ought to be the goals of antitrust remedies.

These somewhat contradictory criteria are often not helpful in answering the most basic questions of whether structural or conduct relief is appropriate. I was involved in the Microsoft matter, where we had intense discussions about the appropriate balance between structural and conduct relief there.

And we had vigorous discussions whether the conduct relief was necessary to stop a recurrence of the violation, but we needed structural relief to promote -- restore competition, and so forth. The standards, the general standards in the case law, are not very helpful when you get down on the ground level.

The economists, of course, tell us that structural remedies change the incentive structure of the firms, and that compliance is more likely with structural remedy than with conduct remedies that require substantially more judicial oversight.

For example, the structural component of the AT&T

decree separating the long distance from the local telecommunications business was regarded as a success because it changed the incentives of the constituent components of AT&T such that they perceived each others' turf as ready targets for increased rivalry through new entry.

The line of business restrictions, however, of course, were not generally regarded as effective in enhancing competition, and also were difficult and somewhat expensive to implement.

This high level view of remedies from the perspective of I/O economics generally is not very helpful, however, when one is on the ground trying to formulate a conduct remedy for a particular situation, especially when the likely outcome of the liability phase of the case is not clear to either side.

For example, there is general agreement that divestiture is preferred in merger cases. The issue becomes considerably murkier when one takes into account litigation risk and unclear case law in merger cases. This, of course, is the question the federal Agencies and state enforcers have had to face with respect to hospital mergers, given the unsuccessful track record of both federal and state litigation challenging hospital mergers.

So moving to my second point, the practical reality of healthcare remedies, the history of hospital merger

enforcement suggests that flexibility and humility are important virtues when dealing with remedies in healthcare markets. These markets are usually characterized by multiple lapses in the limiting assumptions and boundary conditions for perfectly competitive markets.

For example, consumers typically do not pay directly for the services they consume. Consumers often have limited information with which to evaluate healthcare choices.

Healthcare services are very heterogeneous, typically. There is typically a small number of healthcare providers and healthcare purchasers in the form of health plans in any geographic area, and a high degree of interdependence between healthcare providers often suggests that some of the conditions aren't met.

The absence of any one of these limiting assumptions or boundary conditions for perfect competition, the economists tell us, means that it is extraordinarily difficult to predict the consumer welfare effects of further relaxation of any of the other limiting assumptions and boundary conditions.

A merger that reduces the number of competitors by one, or a collusion which increases coordination among buyers or sellers, is likely to have adverse welfare effects, everything else held constant.

But the exact nature and extent of these effects is often difficult to predict in an environment where many of the other conditions for perfect competition are not met.

Remedy selection is impacted by this reality as well. A merger that reduces the number of sellers by one, especially a two-to-one or a three-to-two merger, is likely to have adverse welfare effects.

The most direct route in such a situation would be to litigate and prevent the merger. But if divestiture is unobtainable or does not appear to be obtainable or is unlikely or problematic prior to the decision whether to make a suit, it is possible that in certain cases consumer welfare can be enhanced by ameliorating the effects of the reduction in the number of sellers by fixing other aspects of the market in ways that are likely to enhance consumer welfare.

For example, requiring merging hospitals to pass on claimed efficiencies can enhance consumer welfare. Requiring hospitals to open their medical staffs and restricting tying of services may actually improve market performance beyond that in the pre-merger world.

Each of these remedy provisions may have costs associated with them that must be balanced, of course, against the possible consumer welfare benefits.

As an antitrust enforcer for the state of Wisconsin, I entered into several consent judgments that

incorporated certain conduct provisions in lieu of divestiture because they appeared to benefit the consumers of Wisconsin.

Because I have described these in detail in the material that I've submitted, I'm not going to go into each one of them in detail here. Suffice it to say we were involved in a hospital merger in the Kenosha area that tracked some of the provisions that were in the Pennsylvania consent decrees that Jim Donahue, I believe, is going to talk about in somewhat more detail.

And we also had another consent decree in a merger of two multi-specialty physician clinics in northern Wisconsin: Marshfield Clinic and the Wausau Medical Center. There, we entered into a consent decree that basically limited future acquisitions on the part of Marshfield in a particular area of the state, but allowed both of the mergers to go forward.

And then we also had substantial -- and this is in the record -- a decree in a non-merger conduct case against the Wisconsin Chiropractic Association for attempting to use their trade association, allegedly, as a focal point for price-fixing.

That's another case where we started the investigation as a criminal investigation, but then eventually treated it as a civil investigation and settled it

on those terms with significant conduct relief that's still in place.

Now, in each of these cases, the end point of the negotiations, as reflected by the consent judgments, reflected the parties' respective evaluation of their position in the litigation or prospective litigation. A negotiated solution has the added benefit of not only reducing the risk of a complete shutout on remedies, it also means that there may be a broader range of remedies available for the government enforcer to bring into play.

For example, in the Marshfield matter, the state was able to obtain relief which allowed Marshfield to enter the Wausau area, where it had had virtually no presence prior to the merger, but to craft relief which prevented Marshfield from using its dominance in areas surrounding Wausau to tip the market for primary and specialty care in that sparsely-populated north central area of Wisconsin.

This result appears to have enhanced competition in the Wausau area. At the same time, it allowed already strong healthcare entities in the Wausau area to adjust to Marshfield's entry and threatened Marshfield's dominance in the surrounding areas.

The consent judgment we entered into with the Wisconsin Chiropractic Association contains similar provisions that attempted to monitor and limit the ability of

the WCA to coordinate the pricing behavior of their members.

Although the verdict is not in on the effectiveness of this remedy since it's only a year and a half, two years old, it was clear to the Wisconsin Department of Justice that simple sin-no-more remedy provisions would not have been sufficient to deter future possible violations of the antitrust laws.

The remedy, however, did not restore competition or roll back price increases or anything like that. We simply did not have the appropriate posture in our investigation to insist on that, given the stickiness of prices in healthcare markets generally. That's a roundabout way of saying we couldn't really prove what the exact level of the price increase was that was caused by the allegedly illegal conduct.

This brings me to my third and last point, which is these market imperfections, these complexities in applying remedies to healthcare markets, suggest -- are understandable. Prior to the mid '80s -- indeed, prior to when the Arizona Attorney General brought the Maricopa case and obtained a judgment there from the Supreme Court that indicated that healthcare markets should be governed by general antitrust principles -- most healthcare markets were regulated, and some were regulated heavily in many cases, at the state level. In Wisconsin, until 1984, which I believe

is the year of the Maricopa decision, Wisconsin prohibited closed-panel plans. If you were a doctor in Wisconsin prior to that time, you had to be included as a provider in every health plan that was offered in the state of Wisconsin.

There were many regulations that essentially prevented effective competition in healthcare markets prior to that time. Over the next several years, obviously, deregulation occurred at the state level to some extent in varying degrees, depending on what state you were in.

The state Attorneys General were part of this process, for the most part. And in some cases, also their interest in healthcare markets grew dramatically as the state regulatory schemes were gradually dismantled over the past two decades.

At one time or another, most states had all or some of the following regulatory structures, familiar to anyone who has practiced in the healthcare area: certificate of need, certificate of public advantage, limitations on closed panel plans, hospital rate regulation, direct controls on hospital mergers, and varying degrees of health insurance regulation.

Even as healthcare markets were deregulated at the state level over the past two decades, the longstanding market imperfections and non-market goals inherent in our mixed public/private healthcare system remained apparent to

the state Attorneys General.

This induced a multiple focus on their part, where Attorneys General began enforcing the antitrust laws with great vigor in some cases in healthcare markets at the same time their states continued to regulate and intervene in healthcare markets, often with the Attorneys General in advisory roles.

The attorneys general were and are required to wear multiple hats even today when dealing with the healthcare industry, including representing their departments of health; actively participating in certificate of public advantage and CON processes; protecting the integrity of charitable trusts, which run most healthcare institutions, especially hospitals; prosecuting healthcare fraud and abuse; and defending state-employed healthcare providers in malpractice claims.

In conclusion, regulation at the state level and the role of the state AGs explains why they are focused on remedies that go beyond the all-or-nothing divestiture remedy that we often prefer in merger cases, or even in Section 2 non-merger cases such as Microsoft.

In the healthcare area, there often -- we need a broader range of choices and we need a considerable additional degree of humility when we're picking remedies. Thank you.

MS. OVERTON: Next we'll have Jim Donahue.

MR. DONAHUE: Thank you, Leslie and Cecile. It's an honor to be asked to talk today about our experiences with hospital mergers.

We have done some of the sort of unusual conduct remedies that have been talked about a little bit by Gail and Kevin earlier today. And I want to spend a couple minutes talking about why we got to the place we did and what our experience was.

And first, as Gail pointed out, typically in antitrust cases you're thinking about two things. You're thinking about a structural remedy or you're think about conduct remedy. And when you're thinking about a conduct remedy, you're thinking about something that is very simple and easy to enforce.

We've entered into a number of consent decrees with very complicated provisions, especially dealing with costs and efficiencies, that don't really fall into the regular mode of typical antitrust enforcement. So the question, you know, that people ask us is: Why would you do that in the first place?

There are sort of four basic reasons for that. Hospitals are nonprofit corporations, and they have a charitable mission. They oftentimes have a variety of different charitable endowments that have been given to them. And so they're viewed a little bit differently by us and by

the case law than for-profit corporations. And that's something we have to take into account.

Also, the Attorney Generals have -- you know, they are called the Attorneys General because they are the general enforcers of all the laws in their states. And in addition to the antitrust laws, all of the state Attorney Generals enforce their charitable trust laws.

So they have an obligation to see that the charitable mission of these institutions continues, as well as enforce the antitrust laws. And, you know, we're doing something different than the federal Agencies are because we're balancing two interests instead of simply looking at these from an antitrust case.

Often there's a tremendous amount of community support for controlling healthcare costs, and the phrase you hear over and over again from business people is, we've got to control the medical arms race that goes on between, you know, these competing hospitals or these competing groups of health systems in our community.

And that's a problem. That's a problem that they really mean that, and it's also a problem from a litigation standpoint because you have all these witnesses who say, we have to control the medical arms race.

Sort of the other side of that is oftentimes there are very significant efficiencies that can be achieved by

merging, you know, a couple hospitals. And you also have to look at, you know, the litigation risks. You can say, you know, we're going to be tough and block every merger that is potentially anticompetitive, but you have to look at the case law, as Kevin pointed out. The case law is problematic.

We've had three cases, three hospital mergers, with regulatory consent decrees, Williamsport/Divine Providence, Harrisburg/Polyclinic, who I had the opportunity to work with Toby on, and the UPMC/ Childrens case. And each of those consent decrees has been submitted as, you know, I guess for part of the record with this. So if you actually want to see the decrees, we have given them to the FTC and DOJ electronically.

I want to talk very briefly about Williamsport. There were two hospitals basically in a relatively small industrial city in north central Pennsylvania. We did some work on what the market was. We concluded there was a one-county market. And basically, if you merge these two hospitals, they've got a monopoly. They've got 83-1/2 percent of the admissions.

But the merger was extremely popular with the business community. Let me talk a little bit about facts that might be a little bit unique to Pennsylvania, and certainly apply in other northern industrial -- or other industrialized states.

You have a lot of business in Pennsylvania that is competing in the global market in manufacturing. And their cost structures are extremely important to them.

So to the extent that they have rising healthcare costs, that's a big problem because the solution to that for them is to go and take that manufacturing and do it in China or Mexico or some other place. So that's one of the significant factors.

Now, if we look at Lycoming County, if you see really from about 1970 on, the population stagnates. And the population really doesn't grow all that much in most of the 20th century.

I want to -- I don't have this on the chart, but I want to give you two statistics. In 1970 -- and these statistics are from the National Center for Health Statistics -- the number of patient days, hospital bed days, consumed by per 1000 of population was 1,121. In 2000, that was 580.

So what you have here is you have -- if you look at that chart in the last three or four decades there, you have a stagnant population and you have the consumption of the routine hospital service, which is an inpatient hospital day, declining by half.

And the question becomes, how long can you support two hospitals in this community, and how do you arrange or

how do you -- what should you do about what has to be the exit of some hospital capacity in this marketplace?

That's sort of the setup as to why we did what we did in Williamsport and what the key factors were. Now, as I said, we have the consent decree in the materials. But there's sort of four key provisions, greatly oversimplifying a fairly complicated consent decree.

One is no discrimination against non-employee doctors or non-owned health providers in terms of services. No additional employment of physicians; they also owned a lot of primary care doctors. And to the extent that there's a hospital market and a physician market that competes which each other, and which to some extent occurs more and more, we didn't want them getting additional market power in this other market.

These two hospitals were very close to each other physically, and that enabled them to eliminate duplicative services and other things. So they believed they could save $40 million over five years. And we required them to pass that back, 80 percent of it back, $31.5 million. And there was an obligation to negotiate in good faith.

I want to talk briefly about a couple of the key provisions. On this pass-back provision, we had this language about using the case mix adjusted net and patient revenue per admission for all inpatients treated during the

fiscal year. And what we did was we had a base year where we got that number, and then in each subsequent year we looked at that number and compared them.

In reality, actually even before we did any sort of adjustments for inflation, the net inpatient revenue went down in Williamsport. In 1999 and 2000, their net inpatient revenue was less than what it was in 1994 when the consent decree started.

Now, as I'll get to in a second, the complaint we got from the private health plans in particular was, where's my discount? You know, I see the numbers and, you know, there was a report that we gave out to everybody, and it showed that the revenue had gone down. But it didn't show up in the pockets of the health plans or in the pockets of employers. I'll get to that in a minute.

We also had a complicated -- or lengthy discussion about negotiating in good faith with health plans because you were going to have a monopolist where there were two people competing before. And so we put in this good faith negotiation requirement that basically outlined all the different types of contracts that were out there and said, you can't refuse to negotiate on any of these bases.

What are the results in Williamsport? There's really no problem with the nondiscrimination provisions. There is a doctor shortage in Williamsport, as there is in

many rural communities, and there's been, you know, a couple of requests from them to add more doctors, which we have turned down so far.

In terms of savings, they saved a ton of money. Almost 120 million instead of $40 million.

But there have been severe problems with contracting with health plans. Every health plan has had a problem contracting with them. Every health plan has -- you know, there were days where I would get dueling letters from the Williamsport hospital system to the health plan saying, you know, you guys are being unreasonable, followed the next day by a letter from the health plan saying, no, you're being unreasonable. You're an extremely high cost hospital. You're more expensive than every hospital in, you know, even the major cities.

Harrisburg/Polyclinic was the next one that we did. We did it a couple of years later. Here, you essentially had two hospitals about two miles apart in the city of Harrisburg. There you had a bigger market, or at least we alleged a bigger market, a three-county market. And you can see also from the revenues these are bigger institutions.

And the key factor in that case was that these hospitals were really two miles apart and they did a lot of the same things, and they could do things differently if they eliminated a lot of the duplication, especially of the back

office type stuff, like pharmacies and laundries and kitchens and that type of thing.

Again, we had sort of the same -- you know, a couple provisions that we had in Williamsport: no discrimination against non-employed doctors, limitation on employment of primary care doctors, the pass-through, and an obligation to negotiate in good faith with health plans.

Here things have turned out a little bit differently because while there's been some grumbling about the negotiating with the combined hospitals, it hasn't been as bad as the situation in Williamsport largely because there's been competition from two other aggressive health systems, Holy Spirit, which is just across the river from Harrisburg, and the Hershey system.

Again, they saved a ton of money, and again, we got the same complaint from the health plans: Where's my money? And, you know, I think unfortunately that the government took a lot of that money in the form of the Budget Reconciliation Act of 1996, which had a -- you know, more of an impact on places like Williamsport and Harrisburg than it did on urban hospitals where more money had to go back to -- or rates weren't reduced as much.

UPMC/Childrens is the third hospital, and we've tried to learn from our experience there. There you have a monopoly, Childrens Hospital, merging with UPMC, which is not

a monopolist but a very aggressive and very large -- and the largest system in western Pennsylvania.

And there are reasons why they wanted to merge. And there were also reasons why some type of consent decree was worked out.

But we learned from our experience in the other cases. We didn't want to have another situation where we had sort of some language about negotiating in good faith. That language is in there, but there's another step, and that other step is that if the good faith negotiations break down, they're forced into binding arbitration.

Like everything else, that's another pretty complicated provision, where we have a whole bunch of things the arbitration panel should consider in reaching a decision. It's sort of a semi-last-best-offer type arbitration provision.

What have been the results there? There have been no reported problems with access, which was a big concern in the community. And the health plans seem to be ecstatic with this arbitration provision. And we put a lot of effort into making it equally terrorizing for both the health plan and the hospital so that they -- nobody really wants to go to the arbitration provision; they hopefully will work things out, which is the whole point of this.

There are some open questions, you know. If you

take the Williamsport situation -- which we're going to have again, you know, I think, if you -- you know, unfortunately the news is terrible in terms of employment in a lot of places in Pennsylvania. Factories are closing down, and those jobs are going overseas in, you know, a lot of communities that have -- that really have a very strong industrial base.

You know, is it better to organize the exit of the hospital assets through a consent decree, or do you let these people fight it out and let the health plans and consumers get the benefit of that competition as one of the institutions is failing?

You know, that's a tough question for us. It may be an easier question for -- you know, on a theoretical standpoint. But it's a very tough question for us when we've got the dual role of protecting the charitable assets and enforcing the antitrust laws.

Do we do things like what we've done in the past, which is try to recreate the earmarks of a ,competitive market? You know, in a competitive market, costs would equal price. So if you had cost savings, that would show up in the form of reduced prices.

So do we do the savings pass-back things, or do we use these provisions where we do the binding arbitration, where we peg that or try to peg that to other efficient

markets?

And lastly, you know, if we're going to do a pass-back savings type of thing, how much savings should we pass back to outweigh the competitive effects of the merger? Do we estimate what the merger is going to cost people in terms of higher prices, and then try to get more than that passed back? Assuming you can do that. As Kevin said, pricing in healthcare is obscure at best, and it's not -- it's impossible to compare in a lot of instances.

So I've used up all my time.

MS. OVERTON: Next we'll have Toby Singer.

MS. SINGER: Thank you. I'm going to address two very different topics. I'll start out with the comments on the hospital merger cases, following up on Kevin and Jim's thoughts, and then move over to the other thing that's keeping at least me busy in healthcare cases these days, and that's the physician collective negotiation cases.

The dichotomy has been set up by all the speakers so far between the two approaches to hospital merger enforcement, structural relief on the one hand and conduct relief or, as it's otherwise called, regulatory relief on the other.

The structural relief typically is an all-or-nothing situation. Sometimes you'll have a multi-hospital acquisition, back in the days of the big for-profit chains

buying each other, and there you can have limited divestitures.

But typically in the case that comes up nowadays, like Harrisburg, like Williamsport, where you have two not-for-profit hospitals, it's really all or nothing. Either you enjoin the merger or nothing.

And from my observation, I think that there are some real down sides in some of these cases to going for the all-or-nothing approach, although it's clearly a lot cleaner, more simple, and perhaps more free-market-oriented approach.

The benefit to the parties in these cases from working out some kind of a conduct-related settlement like the Harrisburg case is, first of all, they get to do the deal. And as Jim pointed out, that's often a benefit to the community as well because if there are significant efficiencies and other good reasons for allowing the merger to go through, that happens.

And at the same time, there is some regulation of potential anti-competitive effects. And from my observation, it's really only those cases where there are significant efficiencies that these kinds of orders are entered and a merger is allowed to proceed.

The cost to the government of taking a different approach, I think you can see from what's happened in a lot of the cases that the federal government has brought. The

best example of that probably is the Grand Rapids case, where the parties offered to enter into some kind of a settlement. The FTC said, no, we think we need to enjoin this merger, lost in court, and the merger went ahead without any relief whatsoever.

Contrast that to the success in Harrisburg, where the merger was allowed to go forward. The hospitals combined, achieved not only the efficiencies they'd projected but went even further and, as census dropped even more than had been predicted at the time of the consent decree, ended up building an entire new patient tower, merging a lot more than they had thought originally, and coming up with a healthcare system in Harrisburg that probably would not have been possible if the two hospitals had remained separate.

And at the same time, the Attorney General was paying attention to what was going on in the Harrisburg market, and I think would say that the anti-competitive effects just didn't occur.

However, there are significant costs to the merging hospitals from entering into these kinds of decrees that may not be apparent at first blush. The first is that there are compliance reports. There needs to be an analysis of the financial results every year, experts have to be hired and paid, there are a lot of legal costs.

And then perhaps the less obvious cost is that

every business transaction that the hospitals want to enter into, every physician grievance, turns into a compliance issue with the Attorney General because the physicians will automatically call up Jim or his staff and want to complain about what the hospital is up to. I mean, typically that can be worked out, but it adds to the cost of doing business.

I think probably the most interesting thing that's gone on in these cases recently is the insertion of the arbitration clause, which Jim says has been a wild success in Pittsburgh. That's a very scary thing, and I know of at least one set of hospitals that called off their deal -- I'm sure that was not the only reason, but one of the big reasons for deciding not to go forward was the insistence of the Attorney General that an arbitration clause be inserted into the contract. So it's certainly a significant piece of relief.

And then, of course, there's some cost to the government in monitoring these cases. It's a fairly resource-intensive kind of thing to pay attention to every year: Have the efficiencies been achieved? What does the expert report say? Deal with the complaints that they're getting. Deal with the "where is mine" from the health plans, which I can attest to hearing myself.

But I've come -- you know, coming from sort of the purist approach when I started in my career, I've come around

to the notion that there really are some benefits to these conduct settlements in the hospital area, and especially from the enforcement perspective when the alternative is to have nothing. This way, there is some notion that the efficiencies are really going to be passed on to the community.

Moving on to a completely different topic, and that's the physician collective negotiation cases, I sat down to think about what the remedies have been in these cases and realized that it's now been 20 years since the government -- or more than 20 years since the government brought its first collective negotiation case.

And I'm not talking about Maricopa, price-fixing, or anything like that. I'm talking about a case that's now in the obscure annals of history called Preferred Physicians, Inc. out of Tulsa, Oklahoma, which was brought by the FTC in 1982, and settled at that time.

That was a case where a group of physicians formed what they called a PPO, decided they were going to collectively negotiate with the health plans in the area, and refused to deal individually with the health plans in the area. They took a fee schedule that they called the Red Book and decided that this is the fee schedule they were going to use, and they weren't going to discount more than 10 percent off of that fee schedule.

Now, does this sound familiar? Does this sound like every other physician case that's been brought for the last 20 years? Well, what's going on? Why can't either the government figure out that this is not a problem or physicians figure out that they're going to get nailed for doing this same kind of thing over and over?

Well, I think we could probably spend the next four hours trying to figure out the physician psychology and everything else that might explain it. I'm sure Jack has some thoughts on that as well. But focusing on the remedies that have come across in these consent orders maybe will help get to a point where at least these cases perhaps get less frequent.

The core remedies have been the typical cease and desist, don't do it any more remedies, with a little bit of fencing in -- no information exchanges, reporting and record-keeping, the kind of standard antitrust remedies. And the early cases, with a few exceptions, pretty much stuck to that framework. And that, of course, didn't have much impact.

So more recently, there have been other remedies that are introduced into these orders that at least in some cases may have an effect on the particular market in which the physicians have been accused of wrongdoing, even if not more broadly on physician behavior in general.

In particular, the more recent orders require the

physicians to -- the physician groups to terminate the allegedly illegal contracts when asked to do so by the payors. There have also been orders aimed at the agents who are -- the consultants who are appearing in the field to pretend to be messengers that have been in a few recent cases.

And in the particularly egregious cases like the Mountain Healthcare case that Gail mentioned and some the FTC has brought, the Agencies have required dissolution, and in at least one case, restitution.

These kinds of remedies are not without problems. From the standpoint of at least some of the health plans that I've talked to, for example, the terminate-the-contract kind of approach ends up putting the burden on the victim of the conduct to do something about it.

And the health plans are sort of in a dilemma because in markets where there has been enforcement action, it's typically where there's a large percentage of the providers who are doing things to raise prices. And those are the very providers that they depend on to form their network.

So they sometimes are reluctant to terminate the contracts, and sometimes the termination of the contracts doesn't have the desired effect, especially if other health plans in the market aren't doing the same thing.

Another problem is in some of these cases where the consultants are going around telling the physicians that they know how to be messengers when they really don't, some of these orders are permitting them to continue to act as messengers.

Perhaps they have to give notice or somehow that's being monitored, but these agents are still going to be allowed to be making their money telling physicians that they are acting as messengers when in fact they're really engaging in joint negotiations.

A couple of suggestions. The first would be perhaps for the government to consider whether they want to insert provisions automatically terminating the contracts that were entered into by these illegal organizations.

What that does is it puts everybody on an equal footing. It doesn't get the physicians -- the physicians have agreed to that, presumably, if it's a consent order, so it doesn't alter the dynamics with the health plans, and perhaps will lead to the health plans being better able to fix the problem.

On the messengers point, maybe it's time to tell some of these consultants they can't do this. They can't represent physician groups. They've got to figure out some other way to create some value added into the marketplace.

I don't know if these things are going to work

better, but these are suggestions to perhaps give these orders a little bit more teeth and perhaps have some more force.

When I was talking to various people about what their suggestions might be for maybe having -- not having another 20 years of the same kind of case, it was urged upon me that the government should consider some criminal remedies in these situations.

I'm reluctant personally to recommend that because it's not clear to me that this is criminal conduct. But I think that other people have different views, and perhaps in the appropriate case the government will consider bringing a criminal case. I think maybe other people on the panel will discuss that, too.

Thank you.

MS. OVERTON: Next we'll have Kevin Grady.

MR. GRADY: Thanks, Leslie. It's a real pleasure to be here. For a minute, I was thinking that the panel was going to outnumber the audience, but as I look around I do think that the audience is just a little bit ahead of the panel in terms of numbers. And so it's a real pleasure to at least be talking to more people than are here on the panel.

It's an honor to be here on this last day. I mean, the old adage about saving the best for last, I'm sure that will go to the last speaker on this panel. But first of all,

without being too much of a sycophant, let me congratulate the FTC and DOJ for conducting these hearings.

I have reviewed many of the materials from the past sessions. As you know, the Healthcare and the FTC Committees of the ABA Section of Antitrust Law have been publishing summaries of these, and I realize that these materials are also on the homepages and the websites of both Agencies.

But amazingly, the section has gotten a lot of favorable comments from the people out in the field about these summaries. I think Toby's the scribe for the committees today.

As I've said in the past, both publicly and privately to some of the people here, I think the key issue in terms of what's going to happen after these hearings conclude is what the FTC and DOJ are actually going to do with the information that they've gathered here. And I certainly think that one of the key issues is the whole problem of remedies, on which this current session is focused.

For those of us who've been active in the antitrust healthcare arena for many years, we can remember the surprise by many in the industry merely over the fact that the antitrust laws even applied to the healthcare industry.

We can remember even more the tremendous surprise when the Assistant AG in charge of the Antitrust Division,

Rick Rule at that time, spoke -- and I believe it was to the meeting of the American Medical Association in Dallas some time around 1988 -- and he announced, and it made the front page of the New York Times, that violations of the antitrust laws were criminal and that the Division would not hesitate to prosecute physicians and others for violating the antitrust laws in appropriate circumstances.

And we all remember even more the attention focused on the criminal grand juries who were empaneled in the late '80s and early '90s -- I think there were three -- and the subsequent indictment and trial by the Division in prosecuting the dentists in Tucson, Arizona in United States versus Allston.

Now, perhaps as a result of the mixed results from the prosecution of those dentists, the Division made the strategy decision that except for some optometrists in Lake Country, Texas, I think it was, criminal prosecutions in the healthcare industry were more pain than gain, and that prosecutorial resources could be better spent elsewhere.

As a result of the lack of any criminal bite to violations of the federal antitrust laws in the healthcare industry, and as a result of the perceived failure of the Agencies to successfully prosecute hospital mergers in the '90s, I believe that there's been a definite decline in concern for the antitrust laws, certainly compared to the

concern by providers in the healthcare industry, to violations of fraud and abuse or the anti-kickback statutes.

Indeed, I was struck in looking at the June 26 afternoon session of these hearings when there was a discussion about the business review and staff advisory letters -- and I see Jeff Brennan out in the audience, and I know he participated in that -- and comparing those advisory letters issued by the OIG concerning the federal anti-kickback statute and fraud and abuse.

Now, Claudia Dulmage and Jeff pointed out the obvious fact that for all intents and purposes, the business review letters or staff advisory letters and requests with respect to antitrust peaked in 1996 and 1997. They've gradually fallen off to a mere trickle.

And we can all debate the reasons for the decline. But there's a stark -- no pun intended, or maybe there is a pun intended -- there's a stark comparison with the number of advisory opinions issued by the OIG.

Vicki Robinson pointed out that there have been approximately 363 advisory opinion requests since February of '97, approximately 50 to 60 a year. OIG has issued approximately 101 advisory opinions over that same time period.

Now, one conclusion that you can draw is that the advisory opinions reflect the greater concern over potential

violations of the federal anti-kickback and fraud and abuse statutes than concern over potential violations of the federal antitrust laws, both of which carry criminal penalties.

Now, all of us are aware that the various U.S. Attorney's offices throughout the country have not hesitated to investigate anti-kickback and fraud and abuse violations. Indeed, I believe healthcare providers and their consultants are much more concerned about potential criminal liability under fraud and abuse and anti-kickback than they are about potential antitrust violations.

I think the reason, purely and simply, is that providers and consultants in the healthcare industry do not fear the antitrust laws as much as they fear violating fraud and abuse and anti-kickback.

When you look at the FTC's recent volume of consent orders challenging the various physician IPAs and even some PHOs for price-fixing and group boycotts, it's obvious these are all civil matters. Everyone knows the FTC doesn't have criminal jurisdiction.

But the frenetic pace of the FTC in the last year or so compared to the absence of similar activity by the antitrust Division appears to send a clear message that price-fixing is not considered criminal conduct in the healthcare industry.

What's even more striking is that in some of the actions brought by the FTC such as the recent consent order against the anesthesia groups in San Diego, California for allegedly attempting to "hold up" the hospital for payments of $1,000-a-day stipends for covering OB and uninsured ER patients.

The FTC's press release that announced the consent order, described the physicians' activities as "a naked agreement to fix prices without even a pretense of financial or clinical integration between the parties."

When the Agencies announce that they've challenged or uncovered naked agreements to fix prices, but then resolve the claims with a civil consent order that basically says “Go and sin no more,” that creates the impression within the healthcare industry that antitrust violations are a mere irritant.

Obviously, they can be expensive to defend. But in the grand scheme of things, antitrust violations are less worrisome for providers and consultants that concern over errant billing practices.

Now, I don't have any magic answer as to how to provide a greater realization as to the seriousness of antitrust violations. I certainly am not advocating that the DOJ and FTC suddenly view all physicians or hospital administrators as criminals.

However, I do think the Agencies need to explore the various potential remedies in order to send more clearly the signal that violating the antitrust laws is not simply a matter of being told to "go stand in the corner." If providers and consultants have violated the law, they should pay for it.

Certainly I believe the consultants, who have suggested business arrangements and have encouraged providers to believe that they can concertedly refuse to deal and to fix prices, should face more serious repercussions than simply being told that they can't represent provider groups for two or three years.

I view the FTC's action a few years ago against the College of Physicians and Surgeons in Puerto Rico as a potential option at least for the FTC to consider. There, the Commission challenged an eight-day boycott of the Commonwealth's insurance program, and the consent order included a $300,000 fine.

The amount of money involved at least emphasized that what the physicians did in that case was not just an antitrust violation, but also had financial consequences.

Now, certainly I believe the reluctance of the federal Agencies to seek more of a penalty from providers and others who violated the federal antitrust law sends a mixed message to the healthcare industry. Candidly, the lack of

significant consequences often makes it more difficult to counsel clients on antitrust matters because they're less willing to recognize the potential serious nature of the issues.

Obviously, the sheer volume of enforcement actions brought by the FTC within the past year has at least placed the issue of antitrust compliance on the radar screen of many providers more visibly than in past years.

However, I believe that both the FTC and DOJ need to think seriously about the consequences of proceeding solely through civil proceedings that don't involve any serious potential economic consequences except the defense costs of responding to the investigations.

If the allegations in some of the recent complaints filed by the FTC are true, the providers' collective actions in those cases raised healthcare prices significantly above the prices elsewhere in the various states.

After all these years, I am not a naive idealist, nor am I a closet prosecutor. But I do believe that if the Agencies are serious about their statements that the antitrust laws apply to the healthcare industry in the same way as they apply to any other industry such as retail automotive replacement glass stores in North Texas and Lubbock, Texas, who have recently been prosecuted criminally for price-fixing, the Agencies need to consider more

significant remedies in an effort to get their message across.

As one person said to me recently, Kevin, when will the FTC stop bringing these complaints and getting these consent orders? Now, I obviously did not have an answer, but I did have an observation.

There will likely be little need to file numerous complaints and get consent orders that appear to be almost cookie cutters if the Agencies start bringing cases with more bite, at least more economic consequences. Bringing fewer cases with serious consequences will convey a stronger message than bringing many cases with little or no real consequences.

Thank you for your attention. I look forward to the panel discussion.

MS. OVERTON: Next we're going to have Jack Bierig.

MR. BIERIG: Thank you. It's an honor to be here this morning.

I've been asked to address two remedial issues relating to application of the federal antitrust laws in healthcare. One is the propriety of criminal enforcement, and the second is the propriety of structural relief, and I want to add in non-merger cases. These are important topics, and I am honored to have the opportunity to discuss each of them.

At the outset, I should say that my views have developed over more than a quarter century of representing providers, generally physicians and associations, in antitrust proceedings. I served as counsel to the American Medical Association in the first foray of the Federal Trade Commission into healthcare back in 1975 when the Commission challenged the AMA's ethical rules on physician advertising and certain contract practices.

Subsequently, I've been involved in the defense of various FTC proceedings such as South Bank IPA, in which structural relief was an issue. I've also been involved in numerous DOJ investigations, including criminal investigations of allergists in Massachusetts and obstetricians in Georgia. And I met on several occasions with representatives of both Agencies as they were formulating both the 1994 joint statements on enforcement of the antitrust laws in healthcare and as they considered subsequent revisions.

There's no question that my thoughts have been shaped by my experience in representing physicians and other providers. But I'm not here today on behalf of any client, and I will try to speak as impartially as I can.

And in that connection, I would note that I teach Health Law and Policy at the University of Chicago Law School and at the Harris School of Public Policy at the University,

and in that capacity I've given a good deal of consideration to the matters which we will be discussing this morning.

First, criminal enforcement. Let me begin by saying that I do not believe that criminal antitrust enforcement in healthcare is never appropriate. In my judgment, however, criminal enforcement of the Sherman Act should be limited to situations in which each of two elements are present.

First, the challenged conduct should involve a clear and well-established violation of the antitrust laws. And second, there should be unambiguous proof that those who engaged in the conduct did so knowing that conduct to be unlawful. Unless both elements are present, criminal sanctions should not be sought.

And I want to emphasize that I'm not putting forward a special rule for healthcare. This rule should, in my view, govern all sectors of our economy. It is necessary, this rule, to harmonize two fundamental but competing policies: first, effective enforcement of the antitrust laws, which we've heard a lot about today; and second, something that we have heard nothing about today, the basic premise of our Anglo-American system of jurisprudence that except for certain conduct which poses risk to human health or safety, criminal punishment should be limited to conscious and calculated wrongdoing.

In advocating a very circumscribed role for criminal prosecution, I'd be the first to acknowledge that criminal proceedings are a very effective means of antitrust enforcement, as Kevin has just reminded us. I can tell you that there is nothing like a criminal conviction or even a prosecution to get the attention of those to whom the antitrust Division is trying to deliver a message.

And criminal proceedings are effective, I've found, in another sense as well. Several years ago, I served as counsel for a number of obstetricians in Savannah who were the targets of a criminal antitrust investigation. Well into the investigation, the Antitrust Division offered to drop its request for criminal sanctions if the obstetricians signed a civil consent decree. That decree is reported as United States versus Bergsteiner, who happened to have the distinction of being the first name in alphabetical order of the 22 obstetricians.

I advised my clients at the time that I thought the proffered decree was over-broad, prohibited lawful conduct, and imposed unduly burdensome procedural requirements.

But once the prospect of criminality was lifted, these physicians fell over themselves to sign lest the Division change its mind and return to the criminal approach. I would liken the obstetricians in that case to lemmings flocking to the sea, but the comparison would probably be

unfair to lemmings.

So if criminal enforcement is so effective, why should its use be very carefully circumscribed? In my view, there are two basic reasons, both of which ultimately derive from two facts.

First -- I don't know if I did a slide on this -- yes -- the Sherman Act, unlike most traditional criminal statutes, does not precisely identify the conduct which it prohibits. Rather, its broad proscription against contracts, covenations, and conspiracies in restraint of trade covers a panoply of conduct whose competitive consequences are often very difficult to predict.

And second -- well, consequently, wellmeaning individuals may engage in conduct that violates the Act without having any understanding that their conduct will later be deemed unlawful.

And second, the Sherman Act, unlike most modern statutes that impose criminal liability without intent, does not regulate conduct that threatens the health or the safety of the population.

From these two facts emerge two powerful arguments against any but the most limited criminal enforcement of the antitrust laws. I'll call the first one the fairness rationale and the second the efficiency rationale. And both of them were recognized by the Supreme Court in its seminal

decision in United States versus United States Gypsum Company from 1978.

At bottom, the fairness argument is that outside the context of regulation of health and safety, it is unfair and inconsistent with the generally accepted functions of criminal law to punish someone for engaging in conduct which he or she did not know to be wrong. As William Blackstone said in the 18th century, criminal law depends on what he called "vicious intent."

On this issue, the Supreme Court has been quite clear. I think this is a very important lesson for people who advocate criminal law as an enforcement mechanism. The criminal laws should not be used simply to regulate business practices regardless of the intent with which they were undertaken. Instead, the criminal laws should be reserved only to punish conscious and calculated wrongdoing.

And the fairness rationale is particularly strong in the physician context, where the potential defendants are not sophisticated business persons with an army of lawyers at their disposal. I can say unequivocally that in all of the criminal antitrust matters with which I have been involved, none of the physicians had a clue at the time that they were engaged in the conduct for which they were investigated, that that conduct was unlawful.

I wrote an amicus brief in the Ninth Circuit on

behalf of the American Dental Association and the American Medical Association in United States versus Alston. In the course of preparing that brief, I got to speak with the legendary A. Lanoy Alston, D.D.S., one of the evil triumvirate of Tucson dental practice. I can fairly say that Dr. Alston had no idea that it was unlawful to seek the same copayment amounts for dentists in Tucson that their colleagues in Phoenix were receiving.

Similarly, I represented an allergist who was one of the targets of the investigation in United States versus Massachusetts Allergy Society. I got to know this physician quite well, and I can say that he was an extremely decent individual who never would have knowingly acted unlawfully.

He happened to be a member of an IPA that was insufficiently integrated economically to satisfy the antitrust requirements that the Agencies had set forth that would have allowed an IPA to set and negotiate fees. But the fact was, neither he nor most of the other people who were associated with the IPAs recognized that there was anything wrong with having that IPA suggest fees to various payors and to try to negotiate those fees.

And as for the Savannah obstetricians, it just didn't dawn on them that having a meeting to discuss a proposed two-year contract proffered by a managed care company with no agreement on their part regarding specific

fees to offer to that company might be deemed to contravene the Sherman Act.

Counsel for the Department of Justice and counsel for the Federal Trade Commission have repeatedly told me over the years that everyone knows from the time you're in elementary school that price-fixing is unlawful. And of course, that's true. Everyone does know that price-fixing is unlawful.

The problem is that even sophisticated antitrust counsel, to say nothing of physicians and healthcare providers, can quite agree on precisely what price-fixing is. It comes as quite a surprise to physicians that agreeing on fees to recommend to a payor, discussing the economic implications of a proposed contract among themselves, or negotiating with an insurance company or managed care plan might constitute price-fixing, given that the ultimate decision regarding payment is made by the payor, not by the physicians.

One clear indication of a lack of criminal intent is that almost all antitrust violations by healthcare providers occur in the open. These are not covert operations performed in secrecy or in code. Rather, the conduct in cases like Alston is always carried out in the public eye. And I would submit to you that very few criminals commit their crimes overtly, with no attempt to cover up in some

way.

That the actions of healthcare providers which raise antitrust concerns are not clandestine bespeaks, in my view, a lack of criminal intent. And in this connection, to take a point that I think Toby raised, I would point out that it is a somewhat peculiar feature of Section 1 that antitrust violations are predicated on agreement rather than on market power.

Most individual physicians and small physician groups feel themselves powerless against payors which control any substantial percentage of their patients. They simply do not see it as inherently evil or wrong to band together to try to achieve countervailing bargaining power that will put them in a position to negotiate on an equal footing.

And as a matter of economics, it's not entirely clear that it is wrong, if you look to market power rather than agreement. Indeed, congressional enactments such as the federal labor laws and the Capper-Volsted Act attest that for small sellers to band together is not inherently evil.

To prosecute people for engaging in conduct that they do not see as wrongdoing is unfair. It's contrary to our Anglo-American system of justice, and it also breeds hostility to and distrust of the legal system on the part of those regulated. For these reasons, it should be avoided.

Let me turn from fairness to efficiency. It is

simply not sound policy to invoke criminal sanctions against conduct which is not a blatant violation of law. And here I agree with Mel that I don't think there should be a distinction between the per se rule and rule of reason cases.

As the decision in Arizona versus Maricopa County Medical Society points out, the competitive implications of conduct that is technically a per se violation can be quite ambiguous. I believe that the distinction should be between unambiguously clear violations and all other conduct.

The efficiency rationale for limiting criminal enforcement to well-understood and egregious violations of law is that salutory and pro-competitive conduct in the antitrust area lies close to the borderline of impermissible conduct.

And here I'm going to quote Gypsum again. The court pointed out that: "Salutory and pro-competitive conduct lying close to the borderline of impermissible conduct might be shunned by businessmen who chose to be excessively cautious in the face of uncertainty regarding possible exposure to criminal punishment for even a good faith error of judgment."

This observation, I think, holds true across the board. But it is particularly true for physicians for whom an antitrust conviction can mean not only all of the sanctions that generally apply that Gail laid out in her

presentation, but also the possibility of loss of the physician's most precious possession, which is the license to practice medicine.

There are numerous examples of pro-competitive conduct that may well be deterred if criminal sanctions are invoked too liberally. Some of these were catalogued in Alston and Felth, which is the one relatively recent criminal antitrust prosecution that has been litigated up to the Court of Appeals.

As the Ninth Circuit noted, it is lawful for individual healthcare providers to come together to level the bargaining imbalance created by managed care plans and provide meaningful input into the setting of fee schedules.

The Ninth Circuit also noted that it's lawful for healthcare providers to pool cost data in justifying a request for an increased fee schedule. And it is lawful for providers to collectively negotiate other aspects of their relationships with managed care plans.

The problem is that these activities are not all that far from what the plans might characterize as implicit threats of pass withdrawals from the plans, which would of course implicate the antitrust laws.

If we don't want to intimidate healthcare providers from engaging in lawful activities, activities which generally promote competition and do something else that we

haven't heard about today at all, which is promote patient care, the antitrust Division needs to be extremely judicious about any criminal enforcement activities that it might undertake.

And finally, I would like to return to the argument that Kevin made that criminal enforcement is needed as a deterrent because civil remedies are inadequate. You know, it's worth remembering that in addition to government actions, private treble damage actions are available.

As you know, defendants who lose such actions, of course, are subject to treble damages and to pay the plaintiff's attorney's fees even if only injunctive relief is granted. There have been many such private antitrust cases, the most recent of which that I've seen is the International Healthcare Management versus Hawaii Coalition for Health.

And I've found that managed care plans and others who feel that providers are acting anti-competitively are not shy about threatening to bring private actions. So I believe that the threat of private treble damage actions is deterrent enough for those who would ignore antitrust requirements.

In sum, on the criminal point, I submit that the Attorney General's National Committee to Study the Antitrust Laws got it right nearly 50 years ago in 1955 -- by the way, ten years after the Cubs last won a pennant -- when it concluded as follows: "Criminal process should be used only

where the law is clear and the facts reveal a flagrant offense and plain intent to restrain trade."

That was said in 1955. I think the antitrust people got it right half a century ago, and I don't think they should deviate now from that wise conclusion.

Turning to structural relief, there are a number of forms of structural relief in non-merger cases. We've heard some of them today. I'm going to briefly talk about this. I want to confine my remarks to dissolution and to breakup of large IPAs, which is something that has been considered.

But I'd like to begin by doing something that I very rarely do, which is to praise the Federal Trade Commission. And I want to cite the words of the Commission in Indiana Federation of Dentists. "Only in circumstances where there is no significant function remaining for an organization other than to repeat antitrust violations or in which a conduct order would not reasonably be expected to prevent repeating such violations or to restore competition would a dissolution order be appropriate."

In that case, the Commission rejected the recommendation of the ALJ to dissolve the Indiana Federation of Dentists because the Commission concluded that the Federation did serve some legitimate purposes and because the antitrust violation at issue could effectively be addressed by a conduct order.

I think that the approach taken to dissolution by the Commission 20 years ago was correct. Dissolution should be ordered only if either of two conditions is present: One, it's absolutely clear that a conduct order is inadequate to halt the antitrust violation, or two, the respondent has no substantial legitimate function or is a sham designed to perpetrate unlawful conduct. Where neither is present, dissolution should not be ordered.

Now, there will not be many cases in which either of these conditions is satisfied. In most cases, a well-drafted conduct order should, for the reasons that Gail stated at the outset, suffice to enjoin the violation and to prevent its repetition. And not many organizations are created as a sham or with no substantial lawful purpose.

So cases in which dissolution is ordered will be very few. But that is as it should be because dissolution is basically corporate capital punishment.

And finally, I'd like to discuss the breakup of IPAs and similar organizations. And I think it's very important for the Commission and the Division to note that there are at least two, and maybe more, very important distinctions between breakup of these organizations and dissolution.

First, unlike dissolution, which is fairly simple, breakup is a very complex remedy. It may sound easy to

divide one IPA into two or three, but it isn't. How does one decide which physician or physician group goes into the new IPA? This is a difficult -- this is a very difficult practical matter.

Indeed, one recalls the very purpose of the Hart-Scott-Rodino Act, which was enacted because it was so difficult to unscramble mergers between two previously separate companies. How much more difficult is it to break apart entities that have evolved organically and that are not the result of a merger? The practical issues in this kind of breakup are quite vexing.

And second, unlike dissolution, which by definition involves an entity with almost no substantial legitimate purpose, breakup of an IPA generally involves an organization with a lawful, pro-competitive purpose.

Antitrust Agencies need to recognize that breakup may well result in the loss of efficiencies such as economies of scale or the ability to serve a large geographic area effectively. The loss of these efficiencies has to be carefully considered before a breakup is sought.

And certainly the impact on patient care -- you know, we've talked a lot about price and reducing price, which is of course very important. But we should also not forget the impact on output, which is, in the healthcare area, the effect on patient care.

So based on these considerations and my effort to interpolate Indiana Federation of Dentists to the breakup context, I would submit that breakup should be considered only if each of three conditions is present.

First, it has to be clear that a conduct order will not suffice to remedy the violation.

Second, the breakup has to be able to be effectuated without substantial administrative costs.

And third, the breakup will not result in a loss of significant efficiencies or in a diminution of the quality of care received by patients. Unless each of these conditions exists, breakup of an IPA would in my view be inappropriate.

I appreciate the opportunity to be part of the panel, and I would be pleased to answer any questions or discuss these matters further in the discussion. Thank you.

MS. KOHRS: Thank you, Jack. I think we will save the best for last indeed, and we'll take a short break of about ten minutes before we come back to hear the economist on the panel.

(A brief recess was taken.)

MS. KOHRS: Here we go. After that big build-up, Greg.

MR. VISTNES: Well, thank you for the opportunity to come speak here.

When I was asked to come speak on the panel, I

started thinking, well, what can an economist say that will hopefully hold folks' interest? And especially what can an economist say when they'll be at the end of a speaking panel with a bunch of lawyers?

It would be okay if I was first; I could say anything and beat people to the punch. But as it was, I was trying to think what can an economist say that will be a little bit different than what the attorneys will be saying?

And after a little bit of thought, I thought, well, I can talk about some empirical issues. What have we seen empirically with regard to the success of different types of conduct relief, structural relief? What can we say? What have we learned from the past?

And that sounded really good when I was on the phone. Then I hung up the phone and started thinking, what the heck am I going to say? Because the fact of the matter is there really isn't much in the way of empirical literature.

There's a little bit of anecdotal knowledge, as we've heard some of the speakers talk about today, about what has worked, what hasn't worked, some of the pluses and minuses. But very little in the way of a broad-based coverage of what's worked.

Now, the good part of that is I very quickly realized that I was going to have absolutely no trouble

keeping to the ten-minute limitation on speaking. And I actually thought about maybe I should just finish my talk right now and sit down.

But again, in line with being the last of the speakers, not just of this panel but I take it of the entire sessions, I thought that would be ending a little bit with too much of a whimper instead of a bang. So I struggled to think what I could say.

And I think there are still some things that hopefully as an economist that we can bring to the picture as to the issue on relief. And I'm going to be talking primarily with respect to relief as directed to the physician joint ventures, the physician groups that get put together as opposed to some of the hospital mergers or some of the other conduct-type cases.

And what I want to talk about with respect to empirics is, first of all, what evidence do we have with respect to some of the determinants of appropriate relief? That is, even if we can't hit the grand slam of saying, here is the answer with respect to empirical evidence on relief, can we figure out what are the right building blocks to figure out what the right answers are, and what can we say the evidence is in regard to that?

And secondly, in order to figure out what are these right building blocks that we should be trying to get the

empirical answers to, it gets a little bit to the fundamental or more what are the determinants of the appropriate relief. So it's bringing it a little bit back more to the conceptual, a little bit back more to the theoretical, end of it.

What I came to the realization as I started working on this is that there are some very fundamental questions, I think, that should be asked, ultimately that need to be answered, things that at least for me, as I went down this path, probably with the perspective of being somewhat aggressive in the sense -- and I think I share this with a lot of the folks at the Agencies, certainly not everyone -- but it made me fundamentally question some of the preconceptions I had on some of the appropriate relief for physician joint ventures.

And so I think it's worth putting some of these questions on the table as areas where further work is really warranted in deciding what kind of relief is appropriate for these physician joint ventures.

So I'll start with what seems to be the most basic building block of the questions: Why do we even allow these physician joint ventures? Why not just bust them up, break them down to the ground, and dissolve them completely whenever we see them doing bad?

Well, the answer is pretty clear, is they're joint ventures. And we allow these joint ventures just as we allow

a joint venture in any industry because we think not that there is necessarily good associated with them, necessarily good that will overcome any anti-competitive harm associated with the joint venture, but we believe there's a real possibility of some good. And so we have to engage in a rule of reason. We have to at least allow for the possibility of these joint ventures having some net positive benefits.

And this is pretty well established in the way the Agencies act, certainly the whole rule of reason approach under which most of the physician joint ventures, at least those embodying risk-sharing or some other attribute deemed to promote efficiencies, are viewed.

The healthcare policy statements pretty explicitly recognize that these joint ventures must have some real potential value to them. Heck, the fact that the joint ventures go so far as not just to say that yes, we will treat them under a rule of reason policy, but there is this implicit recognition that these benefits must be potentially pretty darn significant because we give them a safety zone.

We say, if you're going to be non-exclusive, you can have 30 percent of the providers getting together setting price, and you've got a safety zone. That to me is a pretty significant statement. There aren't too many industries where we'll let 30 percent of the folks just get together with a safety zone and jointly set prices.

So this is, to me, at least, highlighting -- let me back up a minute. With respect to the question of why don't we always impost structural relief on these guys, we've heard some discussion today about how structural relief in general is perhaps the better approach; at least, some people think that because it gets away the risk of anti-competitive harm.

We don't need to worry about ongoing regulation. We don't need to worry about evasion of this regulation. Let's just impose the structural relief and be done with it and move on.

Well, certainly we're right that structural relief is more likely to fix the competitive problem. But at the same time, structural relief is much more likely to eliminate any of these efficiencies which we've just accepted must be potentially there.

And so we come to the fundamental question in deciding: Do we want conduct relief versus structural relief? How big do we think these efficiencies are? What is the real risk of throwing the baby out with the bath water when we impose structural relief?

Now, I think the Agencies have a pretty good sense as to what is the likely competitive harm associated with a lot of these physician joint ventures. I'm not so sure that the Agencies have as good a sense -- certainly I don't have a good sense, so I'll limit it to myself -- I don't have a good

sense what the real efficiencies are.

I know that for many years I had a strong preconception that the efficiencies associated with physician joint ventures really weren't so great. But at the same time, I've also got to admit that I, and I suspect many at the Agencies also, are potentially subject to a real bias concern.

The only physician joint ventures I ever saw at the Agencies were the ones who were doing bad. I never saw much in the way of the good ones, assuming that they're out there somewhere.

If there are these really good physician joint ventures out there somewhere, we should know more about them. We should learn about them. We should get a better sense as to what are the efficiencies, the benefits associated with them, so we can do this cost/benefit analysis of what are the risks of breaking them up.

I think we also need to know a little bit more about sort of what is the growing path of this baby we're afraid is going to be thrown out with the bath water. Is it at least possible that a physician joint venture needs a certain amount of time before it can really realize efficiencies?

How quickly can they realize these efficiencies, the ones promised with whether it's going to be risk-sharing,

whether it's going to be from some sort of a practice setting pattern? Does it take one year or five years? And again, how big are those benefits going to be?

I think it's also important to ask the question of what are we really asking when we're asking about what is appropriate relief in the context of I'll call it a bad physician joint venture.

Are we considering structural relief because we've seen these guys have done bad in the past? Or are we in fact really talking a more fundamental policy issue, that fundamental policy issue being, do the Agencies just not really like these guys at all?

Do the Agencies just not really like big physician joint ventures at all, and it doesn't matter that they've been caught in the bad act of setting prices or of not realizing real efficiencies?

But even in an ex ante sense, if the Agencies saw a physician joint venture with 70, 80, 90 percent physician market share, are they really going to be concluding this physician joint venture shouldn't be allowed to survive; it needs some sort of additional structural relief?

One way of thinking of this question is when the Agencies look at a high share physician joint venture and they make a conclusion that they want or they're considering structural relief, are they in effect saying, we don't find

that this particular physician joint venture is living up to our expectations, to the potential promise of efficiencies that could be realized, or are they instead saying, well, we didn't think you ever really were going to be achieving much efficiencies, or at least that was our ex ante view, and you kind of confirmed it here.

Because the conclusion, how you look at this, again goes back to the ramifications of what sort of relief you want. If it's the former case, where you're looking at a particular high market share physician joint venture and saying, you in particular didn't live up to our expectations, then that's still very much embracing the possibility that physician joint ventures in general can realize significant efficiencies.

If that's what you believe, then you still need to ask, well, if we break you up now, we're throwing that baby out with the bath water. Maybe conduct relief is more appropriate.

Because if we really believe there is a potential for those efficiencies to be realized -- and that's again going back to the general policy issue, do we believe there are significant efficiencies that can be realized -- then we need to be considering more carefully this issue of maybe we don't impose structural relief. Maybe we impose the conduct relief so they can still realize the promise of efficiencies

that motivates us to allow physician joint ventures at all.

Alternatively, though, if we really don't believe that these physician joint ventures are really going to do much at all, then it's more in tune with let's impose structural relief.

I think the other way, at least for me, of trying to figure out what are the Agencies' views with respect to efficiencies with physician joint ventures is I at least have a sense that to some extent, the Agencies' perspective with regard to high physician joint ventures is -- high market share physician joint ventures, sorry -- is that there's a little bit of a live-and-let-live policy.

Go ahead, fine. You can have a high market share if you want to, and we're not going to come after you. But the minute we hear complaints, then we're going to come after you, and once we hear complaints, chances are pretty good that we're not going to be swayed by these efficiencies, or at least in few cases the efficiencies are likely to sway us.

Again, if that's underlying the Agency's attitude, that's much more consistent with the notion of once we feel that there's any competitive harm, we don't think there's much in the way of efficiencies to outweigh it. So that's implicit again with this notion that physician joint ventures don't convey efficiencies at all.

All of this takes me a little bit to what do the

Agencies or what do other folks feel about the physician joint venture efficiencies? Are they big or are they small? I don't think we really know that. I think that more information on this point is necessary because again, I think the Agencies may well -- or again, at least while I was at the Agencies, I think I suffered from a biased perspective of only seeing the bad guys, not knowing what the good ones could do.

So I think a retrospective or some sort of more general survey about what are the good physicians joint ventures doing? How big are their efficiencies? How did they realize them? What was the growth path to achieve them? What are the characteristics? I think all that would be very valuable learning for the Agencies in trying to decide how to move forward.

And then finally, a little bit more in line with what we were talking about earlier, some of the speakers, is what have been the successful and the unsuccessful elements of the structural relief or the conduct relief?

Have employers really cared? Have payors cared when structural relief has been imposed? If the payor doesn't much care, that again is more suggestive of efficiencies that aren't big. But I think this is all an area where certainly more information is necessary.

Thank you.

MS. OVERTON: We're going to begin our round table discussion by allowing each panelist a chance to respond to anything that they've heard this morning or to add something that they didn't get a chance to say.

And we can begin with Gail, and just come from Gail's end down to Greg.

MS. KURSH: I'll make a couple of comments.

MS. OVERTON: Please speak into the microphones. Thank you.

MS. KURSH: Oh, I'm sorry. I'll make a couple of comments. I'll start with Jack because I just can't resist. It all came back, Jack, in a flash, our many discussions over the years.

The intent standard that you set out for what you believe is the criminal intent standard, it's funny because last night I did go back and read Gypsum again. I didn't know what you were going to say, but I had forgotten myself. I said, what did Gypsum say again about a criminal intent?

And I don't recall reading that it said there must be unambiguous proof that the defendants knew they were engaging in unlawful behavior. I mean, as I recall Gypsum, it was that they knew that they were engaging in conduct that was unlawful as opposed to specifically proving that they had that knowledge that that was unlawful, which I think is maybe perhaps what Gypsum argued but not what the Supreme Court

adopted.

Did I misread it, or is your standard stronger than what the Supreme Court came out with?

MR. BIERIG: You absolutely read Gypsum correctly. The question in Gypsum was whether some intent should be imported into the Sherman Act because there's no specific reference to intent, and the Supreme Court said you have to have some element of criminal intent.

The standard that I'm proposing did not -- the standard that I put up there, as opposed to the quotes, did not purport to quote Gypsum. It quoted me. They --

MS. KURSH: Or Gypsum, I think, made that argument.

MR. BIERIG: No, no.

MS. KURSH: Not the Court.

MR. BIERIG: I indicated that in my view, there should be unambiguously unlawful conduct, and there should be clear evidence that the individual knew that the conduct which he or she undertook was unlawful at the time that they did it. That is not what Gypsum says. I'm advocating that as a matter of prosecutorial decision-making by the Division.

MS. KURSH: And you're saying actual knowledge as opposed to should have known?

MR. BIERIG: Well, no. I mean, you know, should have known would also work. But we have to be very careful about should have known because, remember, these physicians

and others don't have the sophistication that the people around this table have.

And as I tried to -- I explained some of the reasons why physicians don't regard, you know, sort of coming together to negotiate collectively with payors as being unlawful. It comes as quite a surprise to them to find out that that is really unlawful.

And indeed, you have cases, you know, such as Judge Kozinski's opinion in Alston in which he lays out several things that the Federal Trade Commission and the Antitrust Division have viewed as unlawful, and he concluded that those were quite lawful.

So the should have known is a pretty slippery thing to get to. But I do think at bottom -- I'll go back to the 18th century since -- you know, when you read Blackstone, the basic premise of our system of criminal justice is that criminality should be reserved for people who had a conscious intent, or what he called a vicious intent, to do wrong.

And we have deviated from that in the 20th Century in the areas of environmental protection and food safety and other things. But those have to be understood to be very limited deviations for purposes of a higher good, which is maintaining the absolute purity of the food supply or maintaining an environment free of -- or, you know, relatively free of contaminants.

In purely economic situations, the tradition of our society has not been to impose criminality absent some kind of plain understanding by the perpetrator that his or her act was somehow evil. And that's the intent standard that was not required in Gypsum but I think ought to be required.

MS. KURSH: Okay. Just -- I'll make a few more comments on the regulatory decree, the whole concept of regulatory decree, which in hospital mergers, which I know a number of the states -- Jim was talking their state, and Kevin Wisconsin -- they had adopted. And, of course, I think both federal Agencies have tended over the years to stay away from regulatory decrees.

And I think -- I just would like to point out a couple of our concerns with regulatory decrees, some of which I think you've encountered in your own experiences in monitoring them.

But I think our overall sense -- and I think that's still today -- is that it's better to let competitive markets determine price and distribute efficiency savings than to inject ourselves into that role, not only because of the difficulty of doing so and determining prices and cost in healthcare markets which you noted is very complex, but it's also very difficult and costly to monitor it even if you think you've got it right.

And I think you always have to ask yourself, do the

benefits you get from these kinds of decrees warrant the very, very extensive costs and entanglement in the market?

And then I think we also just have a great deal of difficulty deciding that we're indeed getting what a competitive market would get when we inject ourselves. I mean, can -- it may be difficult to control price, but it's even more difficult to control quality and innovation.

So, you know, you may be able to control the prices that hospitals charge, but how do you account for changes in quality? And if they reduce quality but keep prices within some regulated standard, you in fact may be increasing the price because it's adjusted for the quality.

And then on the other hand, you know, you may be limiting the hospital's ability to respond competitively or efficiently to change in market circumstances where let's say prices have to increase in response to increases in costs. And there's all these dynamics that come into play that I think make a regulatory decree very, very tricky.

And then just finally, I've just always been concerned about how do we show that cost savings have indeed been passed on to consumers, and also how are we -- how can we be certain that the cost savings that we are requiring be passed off, that there might not have been even greater cost savings had we let the market remain competitive.

And I guess my sense is that if we thought a

hospital was truly failing -- someone raised this as a possibility -- then perhaps the failing firm defense applies in that case. But I think we've seen very few hospitals that have actually failed and exited the market despite their claims that they were failing.

So yes, we may have to litigate, and as history has proven, lose some of these cases. But perhaps that's better than accepting a decree that -- where we're not really confident we're making the situation any better.

So I guess I just have some concerns about the regulatory decrees even though I understand why there's the temptation to adopt them in certain local markets.

MS. OVERTON: Mel?

MR. ORLANS: Well, actually, Gail hit on the point I wanted to make. I have the same concerns from the perspective of somebody who's litigated hospital mergers about accepting anything less than structural relief in a hospital merger context.

It strikes me that the main rationale that I heard sort of underlying everything seemed to be that we can't win with structural relief, that the government has a history and the states have a history of lack of success in recent hospital merger cases, and therefore that the conduct remedy -- that a regulatory decree is sort of the best that we could possibly do.

And I guess -- I think that's a pretty slim reed on which to justify these sorts of devices. I think that they are very difficult to monitor and enforce.

Moreover, it strikes me that if the concern is, as it seems to be, that the government in recent years has had difficulty litigating -- successfully litigating hospital mergers, that there are other approaches that can be taken that still will end up in structural relief.

Right now the Commission is looking at consummated hospital mergers, and in those situations presumably where we can show, for example, price effects, the government will be in a much better position to go after the hospitals and hopefully demonstrate to a court that there have been price effects and therefore justify divestiture where maybe it would have been difficult preliminarily to enjoin the mergers.

So again, I guess I feel that if the justification for a regulatory approach is simply that we haven't won these cases, in the future that there are other things that we can do that will perhaps increase our success rate, including perhaps picking better cases, that will solve that problem without the need to resort to a regulatory decree.

Toby had mentioned that in Butterworth Blodgett, that actually what was offered -- that was the Grand Rapids case -- that what was offered initially was a regulatory

approach by the parties, and the Commission rejected that and therefore got nothing.

In fact, what happened in that case was that the judge did accept the parties' offer and incorporated it in his decree, even though the Commission didn't ask for it. He incorporated the parties' market regulatory order in his own decree.

At the Agency, our view was that we weren't involved in enforcing that. And in fact, I remember getting one call from someone who was interested in that and thought they had a complaint and wondered if the Commission would be interested in that.

And I said as far as I was concerned, it was judge's decree and they should find a way to bring the matter up to the judge, that, you know, we weren't interested in doing that. I don't think anything further came of it.

But as a practical matter, the judge did actually incorporate the parties' proposal into his consent decree.

MS. OVERTON: Kevin?

MR. GRADY: A couple of comments. Number one, I think that we ought not lose the focus in terms of what these hearings are all about, at least what I think the hearings are all about, and that is what the Agencies are going to do going forward.

And I'm not minimizing the difficulty of that

decision. And I know that -- or at least I have every confidence that you'll make thoughtful determinations, regardless of what administration is in power.

But a couple of comments. Number one, Toby touched on, you know, how many years ago, you know, the Tulsa physicians were accused of doing illegal price-fixing. And you have to say, at least I think, after 20 years of these consent orders and seeing the same types of activities, and the Agencies coming down saying these are price-fixing, these are illegal activities, it's almost like Groundhog Day. I mean, it just keeps repeating and repeating.

And with all deference, Jack, you know, I have the highest respect for doctors. We defend doctors. We defend hospitals. I'm on the defense side. But in terms of looking at the issue of these people don't understand what the law is, I must say in all candor I don't buy that argument.

Where I do think there's a real problem is I think a lot of physicians and hospital administrators have been sold a bill of goods by consultants out there. And I don't see the Agencies' actions going against the consultants at all.

You know, there had been in some of the recent FTC consent orders the approach to limiting certain consultants from not representing these physicians for three years or whatever. And maybe that's a step in the right direction.

But candidly, you know, what was it, Gail, you guys were involved with the Pershing Yoakley, you know, accountings down in Tampa, and, you know, the group of accountants from Knoxville, Tennessee going around claiming they knew how to, you know, advise physicians to get big increases in their reimbursements or something like that.

And, you know, they were precluded from representing that group for a number of years afterwards. But they weren't banned from doing it. There was no criminal action taken against them. And you have to ask yourself after a while the confusing signals that are being sent when the Agencies say something time after time after time is illegal, and how many shots across the bow do you have to take before people supposedly get the message?

And if the antitrust laws indeed have a criminal component, when do you actually impose it? And I realize that, you know, you guys were not all that successful in the Alston case. And I will also recognize the difficulty of saying that a doctor with a, you know, white coat and a stethoscope ought to be put in jail for violating the antitrust laws.

But on the other hand, the U.S. Attorneys around the country are not having problems saying that with respect to fraud and abuse and Stark. And with all deference, Jack, you talk about the Sherman Act being somewhat amorphous in

terms of what's illegal. I don't see anybody saying fraud and abuse is, you know, a clarion of clarity in terms of what's a violation.

The other thing that I'd like to point out is that to the extent that the Agencies have as a remedy disgorgement, one of the things that I haven't seen -- and there have been one or two examples, Jack -- but I haven't see a wellspring of class action litigation following on the heels of these consent orders that have been entered into.

I don't think that there is a huge number of potential class actions out there, at least from the standpoint of direct purchasers, because the payors aren't going to have the chutzpah to go in and challenge the doctors that they need to have in their networks later. That's just not going to happen.

And so who else is going to be there to try to somehow say that these people who engaged in illegal conduct should pay more than a price of, as I said in my remarks, standing in the corner? And that's something I think that needs to be seriously considered.

One of the things that we have to deal with -- I'm dealing with it right now -- I mean, with people who have been the subjects of some of these consent orders, they come to us now and ask, okay, so now what do we do?

And you look at some of the actions that they were

told that they could do by some of these consultants, and you just have to shake your head. And it's still going on out there, Jack.

And unless and until the Agencies -- unless they're willing to carve out a separate immunity for healthcare providers, unless you're willing to go your, you know, physician union route that you were articulating, unless you're willing to somehow put a market power screen and say that we're not going to prosecute anybody, you know, if they have less than 20 percent or 30 percent -- and, with all deference, the safety zone just puts them into a rule of reason analysis, not a get out of jail free card.

But there needs to be better clarity, I think, in terms of the Agencies' views about this and what the consequences are. Because when you send mixed signals, nobody knows. And then you get into the approach of, well, gee whiz, we're just doing the right thing, or, you know, we're oppressed by the payors and it's not fair.

I would say, if there's anybody on this panel that wants to defend consultants who put these things together, then, you know, speak up.

MS. OVERTON: Toby?

MR. BIERIG: What are these consultants paying?

MS. SINGER: I have some comments on sort of disparate points that were raised, some in this latest

discussion.

Picking up on Gail's comment about not really ever having seen these hospitals fail even if they're complaining about failing, I think that in part that's right. Hospitals very rarely fail. And that's because the community is not willing to let them fail. And that's because with government money, hospitals can limp along for a long time without failing.

But there are real costs to having a hospital that is not fully functioning and that has low occupancy and is scrambling around for high cost nurses and is trying to provide care.

And we've all seen the battles here in Washington about the hospital in Southeast. And it's a real -- it's a huge problem to try to figure out what to do with a hospital that's got serious financial troubles. And I'm just not sure that the failing company defense really works oftentimes.

And to connect that to something that Jim said, I think the role of the states here goes beyond just a focus on what's best for competition and competition policy.

With their other hat, with their charitable trust hat on, they are covering, I think, a broader scope of issues. And by stepping in and saying, okay, you know, we understand all the ins and outs of this, and whereas, you know, we'll allow the federal government to be more purist

about this and not bring a case in a situation where, like in Williamsport where the Justice Department didn't bring the case, where there is no real structural remedy that's going to work -- you know, we'll go in and try to do this in a way that at least preserves some of the benefits of the merger, but yet has the potential for at least the term of the consent decree to not have the real negative effects happening.

And I think while there have been mixed results, I think some of these have been actually fairly successful. And I think it's probably appropriate and a legitimate reflection of our federalist society for the federal government to take the position that no, we're not going to muck around with these regulatory decrees, but have the states take a different approach here, as much as it drives those of us who defend these things crazy.

On a completely different point, what Kevin says about the consultants is very true. You can argue about whether or not doctors in a particular situation know they are doing something wrong. I mean, I've represented a lot of doctors, and there's a lot of them that are very interested in their pocketbooks and aren't really trying to do the world good.

But setting aside that question, I guess I have a question for Jack, which is: In your view, is it more likely

that the criminal culpability will be there with some of these consultants that are going around trying -- you know, telling the doctors, I'm a messenger, but in fact are doing something beyond that?

MR. BIERIG: Well, first of all, I think as a matter of fact the criminal intent is much more likely to be present on the part of the consultants.

But to sort of follow up on Gail's question about the should have known, you certainly would expect consultants who hold themselves out as experts in antitrust law and reimbursement issues to be in a position to -- you know, they should have known what the law is, as opposed to some practicing physician. So I agree with you.

However, by the way, I don't think that the fact that the doctors are interested in lining their pockets is not equal to they have criminal intent. Everyone is interested in lining their pockets. That's, you know, called the American way. Okay?

So there's nothing wrong with wanting to line your pockets. It's only if you do so in a way that you know violates the antitrust laws.

MS. SINGER: I'll let that comment pass. I have one other thought on something that Greg said. One of Greg's recommendations was maybe the FTC should think about a retrospective in these physician cases similar to the

hospital merger retrospective.

And I just would like to caution that there are really serious difficulties in trying to study these markets and figure out what's happened. And I think that the -- what the hospital merger retrospective process has shown is that it's not really easy to go into a market and say, ah hah, prices have kind of gone up. This must have been an anti-competitive merger. There's a lot of things that go into that.

And I think that a lot of us would welcome a real, legitimate study of some of these markets and where there have been consent orders, especially where you can contrast different kinds of remedial provisions. But before that kind of thing can work, somebody has to really figure out just how you measure prices in these kinds of markets and how you figure out what the competitive result would have been had it not been for the anti-competitive conduct.

MS. OVERTON: Kevin?

MR. O'CONNOR: I'm struggling to bring together all the points that have been made here. And the thing that I keep coming back to is we're still struggling with the interplay between using a competitive regime versus a regulatory regime to deal with this industry.

And I go back to my original point, which was that until 20 years ago, this industry was basically regulated top

to bottom at the state level. And we have tried the deregulation route, and we tried to substitute competition for direct regulation, and in some cases it's worked and in a lot of cases it hasn't worked.

It hasn't worked very well. And we keep seeing the reverberations of that in the antitrust enforcement world. Four points in that regard, quick points.

First, you see it when the state AGs try to reinject a form of indirect regulation because the antitrust enforcement remedies do not provide relief. They do not give you -- give the state AG the ability to protect its citizens.

I mean, in the Kenosha Hospital case, which my office investigated with the FTC, we were left with the decision at the second request stage whether we were going to continue it after the FTC dropped it.

Well, they were litigating the Butterworth decision at the time, and we were forced to make that difficult call whether we were going to go forward with a situation where the two hospitals in Kenosha were merging, a Catholic hospital and a nonsectarian hospital, and there was significant community opposition, and it did appear that there was going to be some significant anti-competitive effects from the merger.

Would we have won the case had we litigated it? Very difficult to tell. It would have been a very difficult

case. Did we feel we had to go forward and protect the citizens of Kenosha even though, in a broader sense, it was small potatoes?

Yes, we felt we had to do that, and so we effectively issued a second request and went forward and I think achieved some welfare gains for the people in that community.

But again, was it ideal? No. I mean, in a normal merger case would we look at that kind of remedy? Probably not. But this is a different kind of industry in many respects.

On the criminal point -- this is my second point -- I hear Jack sort of suggesting that, well, you know, the docs don't quite get it. They need -- they think that because there's market power on the other side of the bargaining table, maybe they -- you know, they should be entitled to get together, that sort of thing.

I have to tell you, from having done this criminal enforcement on the -- criminal antitrust enforcement from the state perspective in other industries, I don't buy that at all.

I think at this point -- I mean, I was out giving speeches when Rick Ruhl was giving speeches in the '80s to healthcare groups in Wisconsin, telling them, there's a new ball game in town. It's called antitrust. You know, if you

get together with your competing doctors, you know, there's a potential that -- of criminal enforcement and other bad things happening to you.

And I can't believe that the medical community does not understand that at this point, at least at some level. I mean, in the securities industry, you have a willfulness standard. It's not even an intent requirement. I mean, if you sell an unregistered security, it's a five-year felony in Wisconsin. And I've prosecuted people for that.

I mean, so I don't think this is -- criminal enforcement in this industry is at all unwarranted, where you have, you know, direct collusive price-fixing, bid-rigging, market allocation. I mean, those kinds of violations are pretty clear-cut.

And I think if the medical professionals are not getting the message, then their lawyers ought to be going to more CLE courses or something on this sort of thing.

Third, my third point -- and again, it's a reflection of this divide between competition and regulation as a mechanism for dealing with the market imperfections here and the significant market imperfections here.

And you see that -- I mean, I heard that reverberating in Gail's comment when she mentioned that it was difficult to determine if conduct relief in the state remedies was really working or not. I agree, it is difficult

to determine whether it's working or not.

But I don't think it's effective to say or an appropriate response to that to say, wouldn't it be better to let competition, competitive markets, determine how resources are allocated and so forth?

I got news for you: These markets aren't competitive. I mean, let's understand this. I mean, you have a situation in many cases where there's one or two health plans buying most of the services.

And why do you think that over 85 percent of the purchasers of hospital services in Lycoming County that Jim Donahue mentioned supported the merger to monopoly in that area? It's because they probably figured they were on the boards of the hospital, they were essentially both the purchaser and the de facto seller of the services in some form, and that they could get their hands around this and could control the bad stuff that might happen in a normal market where you didn't have that situation.

And again, another market imperfection, another quirk in these markets, that suggests that letting competitive markets organize these resources is not necessarily going work all the time because the markets don't operate in that way.

Finally, to Mel's point about the perception that the reason the states and others, you know, adopt these

regulatory decrees is because of the perception that they can't win the case and that this is the next best alternative or the only alternative to get any kind of relief, I think there's some truth to that, that it's difficult to win these cases, especially when you have federal judges, like in the Butterworth case, basically making judgments about how employers on a board of a hospital can effectively control the anti-competitive effects that might result from a merger.

I mean, you have the judges at least implicitly and sometimes explicitly directing -- injecting those kinds of considerations into the case law, which makes it very difficult to win the cases. Again, they're reflecting this difficulty coming to grips with whether competition can really organize these markets or not.

Anyway, thank you very much.

MR. DONAHUE: Let me see. On the one hand, I agree with everything that Gail and Mel said. The criticisms of the regulatory consent decrees are all, you know, in theory correct.

And in fact, when I was preparing this, I was thinking, you know, doing these slides, I was thinking, you know, the one flaw in my argument about the -- or flaw in the reasoning about the firms going out of business is that necessity is the mother of invention.

So if a hospital is in the Williamsport situation

and facing its ultimate demise, maybe it does find a way, pressed by really severe economic circumstances, to come up with some way to reinvent itself, maybe as an outpatient surgical center or using some new technology or that type of thing.

And so I think all of those are, you know, legitimate criticisms of what we've done in the past. On the other hand, you know, the purist approach doesn't always work from where I sit. You know, we have an obligation to zealously represent our clients, which are the communities in the state and the state government.

And an all-or-nothing approach, where we say, okay, you know, we either make this case and block this merger or we let it go maybe isn't the best possible -- you know, or the best result.

We've looked at these cases and have tried to come up with something that we continually review. You know, as Toby has said, we had worked out something, you know, in Harrisburg in a subsequent case that we were working with Toby, a sort of unusual case where all of our correspondence between us was published in the paper.

But, you know, we took some of the faults in our earlier case, or what was the perceived faults, and adjusted that. Whether we would do this again, you know, I don't know.

The other thing that I think is important to note is that this is something we are only going to do in the nonprofit to nonprofit merger context. It's not something we're going to do in the commercial context, where there's any sort of -- where there are commercial players involved in the healthcare industry, of which there are a lot.

And I think that makes a big difference both because of the -- you know, the case law that talks about the boards of the two institutions being dominated by the business community, but also, as a practical matter, the case law might be right on that. There may be situations where you do have active boards that are going to do what's in the best interest of the community and not necessarily try to gouge everybody.

You know, these are extremely difficult cases for us from, you know, a factual standpoint and from a policy standpoint. And I think we've made -- what we're doing in these regulatory consent decrees is clearly a compromise. It's not a purist approach. It's not saying, you know, either you make an antitrust case or you don't.

And we recognize that. And I think we're going to continually evaluate both the results of what we've done in the past and what we come across in the future.

MS. OVERTON: Jack?

MR. BIERIG: First I'd like to say I'm glad that my

remarks got everyone's attention, at least, judging from the comments.

I'd like to make three points. The first is that a couple people have said, well, come on. All these guys really should know that price-fixing is unlawful, that what they're doing is unlawful.

You know, no one is going to sit here -- certainly I'm not going to sit here and defend sort of minimum price-fixing in the classic sense by physicians any more than in any other industry. Someone talked about price-fixing, big-rigging, market allocations. These kinds of very blatant traditional violations of the antitrust laws no one's going to defend.

But as I tried to say in my presentation, a number of things that are characterized as price-fixing are not inherently evil. You look at the facts of Maricopa, where these physicians got together to offer what they regarded as a competitive alternative to what we today call managed care plans, and they set up a fee schedule that they were going to offer their services to people who chose to buy healthcare services through the Maricopa Foundation for Medical Care.

You know, the Supreme Court, by a four to three decision, says that's a per se violation. But it's hardly clear that that was anticompetitive, and I can guarantee you that the people who did it regarded themselves as being pro-

competitive.

You know, similarly, negotiating with managed care plans who are, you know, generally quite powerful because they control the patients that these physicians are going to be seeing, negotiating with them and saying, here is what we would like you to pay us and here is why and here's the fee that we think is reasonable, that is really not price-fixing in the classic sense of the minimum price-fixing, where all the lore about per se arose.

So I really do think that it is a mistake to think that physicians should know that banding together to try to negotiate collectively with powerful managed care plans or to set prices for a venture that they would like to, you know, offer as a competitive alternative is understood by them to be classic price-fixing and therefore unlawful and subject to criminal violation. I think we have to distinguish among different kinds of price-fixing.

Second, I want to address Kevin's point about, you know, he thinks we need criminal enforcement because physicians don't take the antitrust laws seriously. And from that -- he deduces that from the fact that we have so many more inquiries about the fraud and abuse laws than we have about the antitrust laws in the form of, you know, business advisory letters and things like that.

The fact of the matter is that there is far more

enforcement generally about the -- over the fraud and abuse laws than there is about antitrust. And the reason is simple: Usually the fraud and abuse laws that are enforced, although there are anti-kickback statutes in the Stark law, most of them are under the False Claims Act. And the government gets back a huge amount of money for every False Claims Act that it wins.

So there's a tremendous incentive on the part of the regulators at OIG to bring these False Claims Act cases. So there are just far more of them than there are antitrust cases.

Secondly, I think that the fraud and abuse laws are generally less understood by lawyers who are advising people than the antitrust laws are understood by lawyers who are advising people, so the lawyers need guidance from OIG.

And finally, every single transaction in healthcare that involves a physician has implications under the fraud and abuse laws. So therefore, it just arises much more.

So it doesn't surprise me that there are more advisory opinion requests in the fraud and abuse area. There are more cases in the fraud and abuse area for the reasons I stated.

But I don't think that leads you to a call for more criminal action to get the attention of lawyers and physicians because I do think that most lawyers, you know,

who get asked to understand the antitrust issues, and I think most physicians tend, you know, to really believe that what they're doing generally is not unlawful.

I want to conclude by sort of raising an issue that I think the States' Attorneys General should be thinking about, and to some extent, the Federal Trade Commission in its capacity as Bureau of Consumer Protection, which I have seen very little discussion of, and maybe even the Antitrust Division, and that is there has been a tremendous review of hospital mergers. All these cases have been brought against hospital mergers.

What I have seen almost never challenged -- there are a couple exceptions -- are conversion of hospitals from nonprofit to for-profit status. A couple of the Attorneys General, notably in Kansas and Missouri, have started looking into that.

But very little is known about the effect on patients when a hospital that was traditionally nonprofit is acquired by a for-profit entity. You know, one of my favorite sayings in the antitrust law is the quote from Reiter versus Sonotone, that the antitrust laws are a consumer welfare prescription.

It's by no means clear that consumer welfare is enhanced when hospitals that have been nonprofit are acquired by for-profits. The theory is that the nonprofits can

operate these hospitals "more efficiently."

But what does that mean? I think there is a fair amount of evidence that suggests that "more efficiently" means not providing as much care to the uninsured and to the poor, cutting out things that the nonprofits have provided as a matter of community obligation.

And I think that one area that the Commission ought to be looking at and the Attorney Generals ought to be looking at is the effect on consumer welfare when hospitals that have been traditionally operated either by communities or by religious denominations get acquired by for-profits, and see what happens to those hospitals. I think that's a very fertile area for exploration, one which has sadly, in my view, not been taken up either by the federal Agencies or the states.

MR. VISTNES: Just a very quick follow-up to what Toby said. I couldn't agree more that trying to do a comprehensive retrospective on physician pricing and what happened in some of these relief cases would be a tremendous chore, probably better said that if you think that doing the hospital merger has been a lot of work and tough to do, you ain't see nothing yet.

What I was suggesting was much, much less comprehensive, much less exhaustive and exhausting, is really probably categorize it more as just let's do some more

learning. Let's do some self-education. Let's talk to some people. Let's try to find out some joint ventures where people think that they really have been doing good, where they've been doing a good job, of practice protocols, whatever some of these efficiencies that we think may ultimately be justifying, especially some of the large physician joint ventures, and try to get a better sense.

Do we think these efficiencies really are big or not? And then I think once we have that feel, we can go back and reevaluate where we stand on the balance between structural relief and giving up the promise of efficiencies in the future versus allowing for that continued promise through the form of conduct relief.

MS. KOHRS: I'm just going to say with regard to that, Greg, we actually had two days of hearings last week, and September 25th was specifically on IPAs: Patterns and benefits. And as reflective of these hearings, we were trying to get people to come in and talk about some of these issues. So that's a place where we're starting.

MR. VISTNES: I'd like to say I was prescient, but obviously I just wasn't paying attention.

MS. OVERTON: Okay. Let's see. The first question that I have touches on the deterrence issue that's come up. And I'm just wondering, do dissolution and disgorgement, do the panelists think that those might have more of a deterrent

effect than some of the conduct decrees in the physician cases, and why or why not?

MR. GRADY: I'll be glad to -- two things, Leslie. Number one, if you've got a monetary component to the relief, if it's significant, that gets peoples' attention. I mean, the headlines in the AMA news or whatever are going to focus more on dollars being disgorged than whether a consent order is entered. And I think the word is going to get out much more clearly if that happens.

Number two, dissolution, yes. I think that sounds important. A lot of times, though, when you're dealing with the dissolution of an IPA that was nothing more than a price-fixing mechanism, I'm not sure that that's all that significant.

I think if you were to preclude someone from participating in an industry for an extended period of time, that would get a lot of people's attention. And I think the ones -- again, I don't want to sound like Johnny One-Note here.

But I do think that if you focus on some of these people who are advising the physicians and the hospitals in terms of how they go about structuring their arrangements, contracting arrangements and so forth, if you go to attack those people, I think you will be getting the message across where it can do a heck of a lot of good.

I don't know whether, you know, Pershing Yoakley is still out there advising people on how to, you know, set up networks or not. Maybe they are, I mean, because the time period has passed. But, you know, certainly that got a lot of attention when it happened. I think it was probably the first time that it did happen, I think, when you guys went after them.

But anything that you can do that puts some dollars on it and that puts some meat to the remedy I think is going to be important. And with all due deference to Jeff Brennan and the incredible job that -- I can't imagine that Jeff even sleeps at night with all these consent orders coming down -- but, I mean, the fact is that you reach a point where it is like Groundhog Day. It's the same thing time after time after time.

And why is that? I think it's because the people haven't gotten the message. And I think that the reason they haven't gotten the message is I don't think they're frankly scared enough.

MR. ORLANS: Let me just add to that from the disgorgement/monetary relief perspective, I would agree with Kevin. I think that the use of monetary relief in this area does have a greater potential for deterrent than a simple conduct prohibition going forward.

That said, there is the issue that I raised in my

initial talk about what the standards are that the Commission would look to. And as Jack indicated, we are looking to more than simply was there a violation. There needs to be a clear violation such that essentially knowing or knowledge could be imputed.

And so typically in our disgorgement cases, we've required a situation where there's been ample legal precedent such that we could reasonably believe that the participants had some reason to believe that their conduct was likely to be unlawful.

And in these physicians cases, that may or may not be true, depending on how the organization has been set up. I know that, you know, we have a couple of those cases in trial now, and certainly they believe there are factual issues that justify the legality of the way they set up those particular organizations.

So subject to that caveat, if we could establish that it really was a cookie cutter situation that really was on all fours with existing precedent and therefore a clear violation, it may well be that monetary relief would be appropriate in these kinds of cases, or at least something the Commission would seriously consider.

MS. OVERTON: Jack?

MR. BIERIG: Yes. I don't think there's any question -- no one would stand here and say that disgorgement

was not more of a deterrent. So when Kevin says, yes, of course disgorgement is a greater deterrent than what he calls, I think wrongly, cookie cutter consent decrees, obviously that's true.

But I think that, you know, what Mel says needs to be emphasized, what he said in his opening remarks. First of all, it's often very hard to measure the amount of what he called ill-gotten gain as a result of the antitrust violation. The Mylan case had particularly good facts to measure that. But in a lot of these cases, it's very, very difficult after the fact to really come up with a fair measure of what the respondent received as a result of the alleged antitrust violation.

And second, again as Mel suggested, you know, there are private plaintiffs, and there is a very active plaintiffs' antitrust bar and plaintiffs' class action bar who are very happy to be out there if they spot an antitrust violation.

And I think we ought to recognize that the Antitrust Agencies are not operating in a vacuum. Mel talked about the situation in which they seek disgorgement where there are no class actions pending.

But it's pretty clear that any kind of Commission proceeding that makes an antitrust violation more visible is likely to bring in the plaintiffs, who are going to seek, you

know, more than disgorgement. They're going to seek treble damages and attorneys' fees.

And so I think that these consent decrees, which tend to be pooh-poohed by some on this panel -- Kevin, you most notably -- you know, I think are very important because even though the respondent, you know, does not admit wrongdoing, there are a lot of lawyers out there who are looking for cases like that and are very able to bring plaintiffs' actions.

And I think what Mel said about, you know, the fact that in Mylan there was not likely to be direct purchasers who would bring cases, and that disgorgement was relatively easy to calculate, need to be kept in mind as to those unique circumstances.

And in a lot of cases, for the reasons he stated, disgorgement, although a deterrent, is not necessarily the proper remedy.

MR. GRADY: Leslie, just let me comment if I could. I mean, two points. And I think we talked about this before, and if we have, I apologize for repeating it.

But number one, I don't think that there is a wellspring of plaintiffs' class actions that follow on these consent orders. I just don't think it's there, Jack. So to the extent that disgorgement is aimed at trying to treat those situations where you're not going to have that, I think

that's another reason to consider it seriously.

You know, the other point is that in terms of a lot of the activities, you know, that are involved in deciding whether or not cases should be brought and so forth, I think it's really important -- and I'm not saying that you criminalize everything, and I don't want to be, you know, accused of saying that I believe that, you know, they should abandon or the Agency should abandon civil approaches and go only criminally.

I do think that it's important, though, that if the Division were to focus in a case that in their minds there was clear criminal intent, that you had a situation where you had people who knew what they were doing was wrong, there wasn't any doubt about it, and you brought that kind of a case, that would get one heck of a lot of attention even if you lost it. Okay? It would make people understand that there are serious consequences.

The other thing, the third point I'd make here, is that again to the extent that you believe the allegations in the complaint that the FTC has filed recently in several of these cases, there appears to be a very clear allegation that you can show the difference in the prices being charged by the physicians in certain communities versus communities in the rest of the state where the allegations didn't take place.

Again, I think for disgorgement purposes, you've got -- again, if it's true, you've got a clear idea as to exactly what the amount of the relief could be in those situations. I'm not saying it's perfect. But I do think it will get a heck of a lot more attention than that.

And I say that as a defense attorney. Okay? I mean, I'm not saying this -- I don't have any dog in this fight in terms of, you know, plaintiffs' class actions. I'm not trying to bring that.

I think if you look at everybody up here, we're all defense oriented except for the government people, and maybe Greg, who's, you know, sitting there as the angel of the economists.

But the fact is if we're really serious, Jack, about telling -- or asking the Agencies or helping them understand what needs to come out of these hearings, what they ought to be doing in the future in terms of more rational antitrust enforcement and how you get peoples' attention, I don't think that you can ignore options such as disgorgement and the appropriate criminal action.

And particularly I don't think that you should ignore the fact that so far, I think that the dadgum consultants have gotten off like bandits.

MS. KURSH: Could I just add one quick point? I just want to -- just to sort of pick up, I think there's no

doubt that an appropriate criminal case and a disgorgement is going to get peoples' attention a lot more than a civil injunctive decree.

We've just also got to go back to the basic premise is, at least from the Division in seeking equitable relief, we have a limitation, and the purpose of our relief is to stop the violation, prevent its recurrence, and eliminate anti-competitive consequences.

Even though we may want to punish or we think a little bit more would deter someone else there, we have to circumscribe our relief for the legitimate purpose, and we have to be careful, if we seek dissolution, it's the appropriate remedy for that conduct and that violation, like in a recent IPA case in Asheville.

But not every case warrants that. And even though it might have a bigger bang and get more attention, it may not be the appropriate relief, given the legitimate goal of an equitable remedy.

MS. KOHRS: Jeff Brennan is in the audience and can't defend himself. So I think I'd be remiss if I didn't point out that actually the consultants have not been getting off scot-free.

In the Maine Health Alliance case that the FTC filed about a month ago, they specifically listed the consultant as one of the parties, and they brought the case

against the consultant as well. So there's an effort on the part of the FTC, at least, to look at that issue.

MR. GRADY: They've been mentioned in a couple of consent orders. But the fact is, the relief that was imposed on them, in my view, was a little more than a slap on the wrist. Candidly, I mean, I don't think that that's going to deter many other consultants from going out and doing what they've been doing. It's a personal opinion.

MS. KOHRS: And that's why we invited you.

I wanted to ask another question. We're talking about the difference between structural relief and conduct relief in a lot of cases. But I wanted to ask a question probably directed mostly at Gail and the people with state experience.

But there's an opportunity for structural relief such as outpatient services, stand-alone clinics, et cetera, in mergers of hospitals and things like that. It would be a little bit novel. Has that been considered, the opportunity of spinning off some services as an outpatient clinic or something like that?

MS. KURSH: I guess I can't think of a situation where those set of facts presented themselves, where a divestiture of less than the whole hospital, as Toby says sort of an all-or-nothing thing, has presented itself as a way to solve the competitive problem.

I guess there could be a situation where the concern you would have would be with a specific area of care that could be set up as a separate unit and compete independently. I just don't know that many hospitals that are set up that way, that you can spin off like the children's wing and let them continue to be a children's hospital, and the other, too.

It may have come up or considered possible in some hospital mergers where psych care was involved. That may be a situation. But I just -- I myself haven't -- I don't recall any situation where it was really considered.

MS. SINGER: If I could just make one comment on that. In a way, Morton Plant was sort of a reverse divestiture. It was a let's let some things merge and keep other things separate. And that didn't work too well.

MR. DONAHUE: You know, we certainly have thought about it. And I think the problem is -- or the problem so far has been, where has been the competitive problem? If you divide the industry, say, by cardiology, obstetrics, and that sort of thing -- let's take cardiology as a example.

Maybe you've got two hospitals and they both have cardiac cath labs. And you say, okay, let's divest one cardiac cath lab and have it go somewhere. The problem is you can't do that. I mean, under the health law and regulations in Pennsylvania, any hospital that has a cardiac

cath lab has to be able to do open heart surgery.

So you've got a lot of technical problems that exist so far. Now, that doesn't mean -- I mean, technology is changing things all the time, and one reason for the big drop in hospital days is technology moreso than managed care and that sort of stuff.

So, you know, it may be possible. And certainly things -- we have thought about that. We have thought about it. Is there a way to divest the outpatient operation? Is there a way to divest the -- although you usually don't get it that way.

You usually get it as, you know, these guys have -- are dominant in cardiology. These guys are also dominant in cardiology, and they're merging. On the orthopedic side and on the gastro side and all those other sides, there's not much of a competitive problem. But there is a competitive problem in cardiology.

But that's hard to fix because, you know, there's no model right now for -- in fact, the model is kind of the reverse. It used to be there were heart institutes all over the place that just focused on cardiology. And the model is for the single specialty hospitals to kind of disappear.

So it's in theory something that we have kicked around, and --

MS. KURSH: Actually, all the hospital mergers, or

at least the vast majority of them, have focused on inpatient services, not outpatient things. Those are usually where there's less, actually, competitive concern.

MR. DONAHUE: You just have to create a new market definition because the case law is all about inpatient acute care hospital services. And you need to make the market definition inpatient cardiology care or inpatient gastointestinal care or inpatient, you know, whatever care to create a sub-market to do that type of thing.

MS. OVERTON: I just want to ask about -- I want to turn our attention to how well the Agencies are doing at advancing the goals of the remedies that Gail and Mel have talked about in terms of restoring competition in particular cases. We've talked a lot about the deterrent value.

But one question I have in that regard is in matters involving physician groups setting prices, when if at all should the Agencies take into account the joint venture's market power in determining the appropriate remedy? And so if market power has been established, will integration of the joint venture remedy a competitive problem? Anybody have any thoughts on that?

MS. SINGER: I think there are a couple of examples out there where market power was part of the remedial process. Those PHO consent decrees, for example, where some of the provisions in the early decrees say, well, it's okay

for these physicians who engaged in price-fixing because they were unintegrated. It's okay for them to integrate and start doing things that are allowed under the guidelines.

But if they're going to do that, it can only be a subset of this big group of physicians because if it's too big then it's going to have a negative impact on the market. Is that an accurate description of those?

MS. KURSH: Yes. I think it's a very important issue, and in crafting appropriate relief in a physician network situation, I think it's very important for the Agencies to focus not on just were they were a legitimate joint venture, but even if they legitimize by integrating in some way of reducing some efficiencies, does that still justify the size of the network?

And I think we need to look at that because if they have been achieving -- exercising market power over the years, which many of them have, and they've not been integrated, and we challenge them as per se price-fixing and all we do is say, well, now just, you know, integrate a little and you can keep on getting those high prices even though you've got 95 percent of the market, I'm not sure we're really achieving effective relief.

And we need to at that point think about some form of structural relief. And I do understand -- I think it was Jack's point that it is very, very difficult, and we've heard

this many times, for physician organizations to restructure and figure who's in and who's out.

And maybe in some ways the answer is dissolution and reforming of a more appropriate joint venture. Because just because you're a joint venture and legitimate under the rule of reason doesn't mean that you still can't be -- I mean, just because you fall under the rule of reason doesn't mean you're legitimate under the rule of reason. You still may have too much market power.

MS. OVERTON: I think that is -- I don't think we have any time for any more comments here. And so I think I'd just like to thank all of our panelists for their very thoughtful presentations and for the lively discussion here.

MS. KOHRS: And in addition to thanking the panelists who participated today, I want to say that this is in fact, the last session. I want to thank all the participants who have soldiered on with us through this whole series of hearings.

And I want to say thanks to David Hyman, who is the Special Counsel at the Federal Trade Commission who put these together with the folks over at the Department of Justice.

I'd like to encourage people to submit written comments. We are accepting those through November 28th. I'd encourage people also to check our website, which is www.ftc.gov. And DOJ has their website also, which also has

comprehensive information on these hearings.

And we will be writing the report, which is due in 2004. And did I leave anything else out? Thank you very much for coming.

(Whereupon, at 12:30 p.m., the hearing was concluded.)

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C E R T I F I C A T I O N O F R E P O R T E R

DOCKET/FILE NUMBER: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW AND POLICY

DATE: OCTOBER 1, 2003

I HEREBY CERTIFY that the transcript contained herein is a full and accurate transcript of the tapes transcribed by me on the above cause before the FEDERAL TRADE COMMISSION to the best of my knowledge and belief.

DATED: OCTOBER 16, 2003

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LISA SIRARD

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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SARA J. VANCE