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HEALTH CARE AND COMPETITION LAW

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FEDERAL TRADE COMMISSION

I N D E X

P R O C E E D I N G S

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CHAIRMAN MURIS: I wanted to welcome everyone to our new conference center. This is our inaugural event, the first event in this facility, and we're quite excited to be here. When we held a health care workshop with the Antitrust Division last fall, we actually had to have two overflow rooms. And the snow has obviously kept things down a little bit today, but it's certainly nice to have a facility where we can hold conferences, workshops, roundtables.

We do a lot of this at the FTC and we moved our staff into this building toward the end of last year, and as I said, this is the inaugural event. So, I wanted to welcome you to this event, to these hearings on Health Care and Competition Law and Policy, which we're jointly hosting with the Department of Justice.

Over the next seven months, we'll devote 30 days of hearings to a variety of subjects in the health care financing and delivering markets. Consistent with the broad mandate of the Federal Trade Commission, we'll examine these issues through the lens of competition law and policy, encompassing antitrust, consumer protection and competition advocacy.

Today, we're releasing a detailed agenda for

the next month of hearings and an outline for the balance of the hearings. In brief, March will be devoted to hospitals; April to insurers -- I don't know if there's any connection with tax month -- May to quality and consumer information; and June, to physicians and non-price competition. July and September will cover a range of subjects, including pharmaceuticals, long-term care, Medicare, remedies for anti-competitive conduct, and international perspectives on competition law and policy. Each month, we'll hold three to five days of hearings.

In keeping with the basic medical insight that diagnosis must precede treatment, we'll gather the information necessary to understand how the markets for the financing and delivery of health care currently work. We will identify and characterize particular examples of market and regulatory failure and evaluate the costs and benefits of various responses.

Around the FTC, we refer to all these activities as policy research and development. Our goals are information gathering, dialogue and consensus building. When the hearings are over, we will use the information to prepare a comprehensive report. In the interim, we'll post the testimony and documentation on our website within a few weeks of each hearing.

The hearings will provide the most up-to-date

and in-depth information available on the performance of various sectors of health care. The hearings should also help us make our decisions regarding enforcement and non-enforcement more transparent, which will be of considerable benefit to the health care bar.

These hearings are not the first foray of the Federal Trade Commission into health care. In the mid-1970s, when I was an Assistant to the Director of the Planning Office, my first job at the FTC, we established a task force to investigate occupational regulation in several industries, including health care. In the intervening three decades, the antitrust and consumer protection authorities; for antitrust, the FTC and DOJ; and for consumer protection, the FTC, have been a constant presence in the health care marketplace, bringing enforcement actions against hospitals, physicians, trade associations, pharmaceutical companies, promoters of fraudulent cures, and a wide range of other individuals and entities.

These are also not our first meetings about health care and competition law and policy. Last September, we held a two-day workshop on health care in which we examined numerous issues. These hearings are certainly our most ambitious foray on the subject. Indeed, whether one judges by the number of days, the

scope of the subjects covered or the commitment of resources, these hearings are one of the most ambitious policy R&D initiatives in the Commission's history.

I'm particularly pleased that a full seven days will be devoted to consumer information issues in health care. In the past, the focus of our consumer protection initiatives in health care has been fraud and deception, including the deceptive advertising of diet supplements and miracle cancer cures. Yet, consumer information problems in health care are obviously not limited to fraud and deception. Informational asymmetries in health care are pervasive, particularly regarding quality. The hearings will accordingly address the availability of information regarding the quality of care provided by hospitals, physicians, nursing homes and other providers of professional services.

Measuring and disseminating information about health care quality raises complex issues that we will explore at length. One of these issues is the historical opposition of professional organizations to the advertising of cost and quality information regarding professional services. The Commission has long advocated using competition to deliver truthful and accurate information to consumers, and has consistently supported the voluntary disclosure of truthful, non-deceptive

information by market participants.

Our position is the same as that of Nobel Laureate George Stigler, who once observed that advertising is an immensely powerful instrument for the elimination of ignorance.

These hearings also will help provide a factual foundation to respond to the Supreme Court's challenge in California Dental. Our enforcement efforts involving advertising in the professions must be based on actual empirical evidence, not on assumptions and presumptions.

Quality is a crucial part of the competitive mix when purchasing health care. Competition law does not hinder the delivery of high quality care. We will always consider arguments that a particular transaction or certain conduct will improve quality. Competition law also does not prevent efforts to disseminate information about what providers perceive to be barriers to enhanced quality.

The favorable advisory opinion earlier this month from the staff of our Bureau of Competition responding to the request of physicians in Dayton to collect and disseminate information regarding fees and quality exemplifies our position in this area.

When the Federal Trade Commission began in 1915, it encompassed both research and enforcement.

actually need. Theory and practice confirm that such interference with competition is far more likely to hurt consumers than to help them.

We do not have a preexisting preference for any particular model for the financing and delivery of health care. Such matters are best left to the marketplace. What the Commission does have is a commitment to vigorous competition along both price and non-price parameters.

Let me close by acknowledging that hearings such as these do not take place at all, let alone include the talent we have assembled over the next three days, and are assembling over the next seven months, without an extraordinary degree of hard work and commitment at both the FTC and the Department of Justice.

As Chairman, my job is to pick the right people to make sure the work gets done and done well. Here at the FTC, these talented people include Bill Kovacic, our General Counsel; Susan DeSanti, the Deputy General Counsel for Policy Studies; David Hyman, Special Counsel, currently on loan to the Commission from the University of Maryland School of Law and he has the distinction of having both a JD and an MD; Sarah Mathias from the General Counsel's Office; Nicole Gorham, a paralegal in the General Counsel's Office; and Angela Wilson, an administrative assistant from the Policy Studies Group.

I especially wish to thank my fellow Commissioners for supporting these hearings.

I hope you will find these hearings to be both educational and enjoyable. As Bob Pitofsky, my predecessor, noted in a speech on health care he gave six years ago, in health care, as in no other area, there appears to be a recurring need to return to first principles and to talk about why competition and antitrust enforcement makes sense. These hearings mark our attempt to return to first principles and talk and listen about why competition, antitrust enforcement and consumer protection make sense in health care.

Let me now introduce Hew Pate, my counterpart at the Department of Justice, who will make some opening remarks as well. Hew is the Acting Assistant Attorney General of the Antitrust Division. Prior to his current appointment, Hew served as Deputy Assistant Attorney General in the Division. Before joining the Department, Hew had a very successful career at the law firm of Hunton and Williams as a partner in their antitrust group. He litigated cases relating to the competitive process, including antitrust, patent, trademark, trade secrets, false advertising and business torts.

Hew has also had the wonderful opportunity of clerking for several outstanding jurists, Supreme Court

Justice Kennedy, former Supreme Court Justice Powell, and Judge Harvie Wilkinson of the U.S. Court of Appeals for the Fourth Circuit.

I'm delighted to have the opportunity to work with Hew and his colleagues. One of the great pleasures of working in the government is the opportunity to meet and to work with people as outstanding as Hew, and I'm especially pleased that the FTC and the Division are working together to hold these hearings.

Please welcome my colleague, Hew Pate.

(Applause.)

MR. PATE: Thanks very much, Tim. It's a real pleasure to be able to participate in the first day of these joint hearings on the topic of health care and the role of competition law and policy in the health care arena. The great playwright, Menander, is credited with saying that health and intellect are the two blessings of life. Well, if that's right, I guess this is the place to be. And on the intellect front, we certainly are going to be blessed with a number of speakers that have been assembled through the hard work of our staffs at the FTC and the DOJ.

We have an impressive list of speakers just today, including Thomas Scully who will be joining us. So, I want to be very brief in covering three points.

The first is to underscore the Antitrust Division's past, present and future commitment to vigorous enforcement in the health care arena.

The second is to mention, from the DOJ perspective, some of the highlights among the topics that we will examine this spring during the parts of these hearings that will be hosted at the Great Hall over at Main Justice, primarily dealing with the payer side of the field. And third, I think this is a perfect occasion to mention the great public benefits that I think are produced by having collaborative efforts by two separate competition and consumer-oriented agencies working together on projects of this type.

Turning first to the Division's activity in this field, I don't want to belabor the statistics that all of you are familiar with demonstrating that health care is an extremely important part of the economy, nor that the figures showing that the rise in health care costs is really a critically important public policy issue in the United States today.

Let me simply say together with Tim, that while there are likely to be many factors that have influenced increases in health care costs and likely to be many complexities in terms of dealing with the situation, we share with Tim a faith in open competition in the market

as a very critical component to containing health care costs and to providing the best quality of services for consumers.

At the Division, for our part, we are trying to back that commitment up through vigorous enforcement of the antitrust laws. Our lawyers, at different times, have done that in different shops. We used to have a Professions and Intellectual Property Section. We have had, at various times, a health care task force. We now have, under the leadership of Mark Botti at our Litigation I shop, a strong group of health care lawyers supported by economists from our economic analysis group, and we're very active in this field, not only in terms of litigation, but in providing guidance jointly with the FTC, as was the case with the policy statements on health care adopted in 1993 and then revised in 1996.

In the past decade, the Division has brought nearly 20 cases and we've issued over 55 business review letters in this field. Just in the second half of 2002, I might mention four major health care initiatives that were brought to fruition, our Mountain Health Physicians Decree, which was a case involving a joint fee schedule adopted by a group of physicians in North Carolina, where, in an unusual decree, the Division obtained the dissolution, the disbandment, of a provider organization

that was engaged in anti-competitive activity. Recently, we issued a business review letter similar to Tim's in the Dayton case, our Washington State business review letter, trying to outline the situations in which it is legitimate for providers to share information in a way that can provide pro-competitive benefits without running afoul of the antitrust laws.

With respect to litigated cases, we completed the trial late last year in our Dentsply case, which was a case involving distribution in the artificial tooth industry, a trial that was headed up by Bill Berlin, who is one of the people here today and is working on these hearings, on our side. And then finally I would mention our Federation of Physicians and Dentists case, also from late last year, where we obtained a stringent decree prohibiting collusive activity, which would have forced health plans to pay increased fees.

On the current investigative efforts side, while, of course, I can't go into details of cases that are open, I might just point out the degree to which our efforts are focusing on the conduct of health plans. We're looking right now into two separate matters that focus on the manner in which health plans market and price their products, both to employers and to other groups. One of these focuses on punitive collective

action by the plans and another focuses on potentially questionable unilateral conduct. We have an active inquiry into a national joint venture among plans that requires us to consider the potential benefits of coordination among health plans in different markets in contracting for national and regional accounts.

We're examining, likewise, the conduct of plans vis-a-vis providers. We have open inquiries into a joint venture among plans and contracting with provider networks, open matters with respect to the imposition of most-favored nation pricing by another plan, and likewise, an allegation that groups of plans have colluded in the setting of provider fees. As to that latter matter, we're currently exploring whether a Grand Jury should be convened in connection with the facts that are uncovered there.

The competitive concern in all but one of these matters focuses on whether payer conduct has reduced the quality or raised the price of plans to their customers. The remaining matter focuses on allegations of collective monopsonization which is a topic that the Division is continuing to study in response to allegations by providers, including allegations contained in the recently released study from the American Medical Association.

By no means do I aim to suggest that our work is confined to the health plan area. We certainly will be active on any appropriate front where we see the need for enforcement. We continue to examine a number of allegations of physician collective bargaining that have exceeded appropriate bounds. We're also taking a close look at issues of integration and competitive effects in regard to a consummated hospital joint operating agreement, as well as a network of hospitals engaged in joiI wajoird make at simpainthis,orkbe actainDnvolvgaged'relber o

market power. We will encourage our diverse panelists to discuss the various competitive effects theories that might predict higher prices to consumers, or a reduction in quality following a merger, and we expect that discussion to range across issues of unilateral effects, coordinated effects and auction theories, as well as devoting substantial time to whether there is a potential for competitive entry in this area that will constrain potential injury to competition.

On the health insurance monopsony side, we're going to be looking to gain further insight regarding the conditions under which plans might obtain and exercise monopsony power against providers. Monopsony, obviously, is the term used to describe market power being exercised by buyers over sellers. And in the health insurance industry, payers are both sellers of insurance to consumers and buyers, for example, of hospital and physician services. And many providers accuse insurance companies of forcing them to accept unreasonably low rates and unattractive contract terms in ways that they say impact quality of care and other issues for consumers.

In response, payers cite substantial competition among health insurers seeking strong provider panels and they cite a consumer backlash against managed

forward, which I greatly appreciate, given the wide array of enforcement work that she's got to do right now during the transitional period we are in at the Division. Likewise, Special Counsel Leslie Overton has, along with Bill Berlin, a great deal of day-to-day organizational responsibility. I hope that those of you with an interest in these hearings and their success will make yourselves known to Bill and to Leslie and feel free to pass on to them your input for how we can make the range of sessions more productive.

From a broader perspective, I think these hearings really exemplify the benefits of having two separate agencies working on competition related issues. Perhaps the benefits are unintended. There's certainly a lot of folks who point out that nobody would have designed a system with two separate Federal agencies with so much overlapping responsibility. I think maybe this is a little simplistic and it ignores the fact that some of life's most effective arrangements really are the product less of an elegant design than of historic accident and a lot of hard work in the intervening years. That's the case with the Antitrust Division and FTC. And we hope that our overlapping and, hopefully, complementary efforts can provide real benefits to the cause of promoting competition for the benefit of

consumers.

The agencies differ, of course, in many ways. The Division is charged with criminal enforcement, for example, which is not part of the FTC's authority. Likewise, the FTC has important consumer protection functions that we don't share at DOJ. It might be fairly said that at the Division, not surprisingly since we're a component of the Justice Department, we see ourselves more primarily as law enforcement. Likewise, I think some of my colleagues at the FTC take a great deal of pride in the FTC's policy leadership and ability to do empirical research.

None of this is to say that the FTC isn't a great enforcement agency or that we're not interested in policy, but my point is that there are differences of approach at the agencies and I think the public can benefit from this. This happens in our day-to-day operations, whether it be a criminal case referral from the FTC to the Division, or to the benefits that our lawyers derive from relying on the research and policy leadership and empirical work that the FTC is so well suited to and was created to do.

It even happens in areas of overlapping interest and through initiatives that are sometimes spurred by a little bit of friendly rivalry, and that's

not a bad thing so long as we avoid inefficiency and duplication.

Obviously, I think these joint hearings are really an example of FTC/DOJ collaboration at its best, and I'm very happy to have had an opportunity to participate in opening the hearings and look forward to seeing many of you as the hearings go forward over the next months.

Thank you very much.

(Applause.)

CHAIRMAN MURIS: Thank you very much, Hew. It's now with great pleasure that I introduce my friend, Tom Scully, who will deliver our keynote address. Tom has had a very impressive career in both the public and private sectors. Currently, as you know, he's the Administrator of the Centers for Medicare and Medicaid Services at the Department of Health and Human Services.

I've only now gotten used to calling it CMS. It's responsible for the management of Medicare, Medicaid, the State Children's Health Insurance Program and other national health care initiatives. Hew was talking about monopsony. Well, Tom may be a monopsonist.

(Laughter.)

CHAIRMAN MURIS: CMS is directly responsible for one out of every three dollars spent on health care

in the United States. CMS insures over 70 million beneficiaries, including the elderly, disabled and some of the lowest income individuals in the country.

Before joining CMS, Tom served in numerous positions. He worked at the White House as Deputy Assistant to the President and Counselor to the Director of the Office of Management and Budget, and as the Associate Director of OMB for Human Resources Veterans in Labor or HRVL, as it used to be called, from 1989 through 1992. Tom and I are both OMB alums and have often discussed health care issues together. I'd like to say that all the discussions were about lofty issues about patient quality and the direction of health care, but that wouldn't be completely true.

One of the first discussions we had was in a meeting when I was out of the government, but I was brought in to chat with Tom about creep and whether there was a distinction between real creep and coding creep. This is in the reimbursement formula for hospitals. We also spent time discussing arcane issues such as the MEI and the new-then Physician Reimbursement System, which continues to this day to be a prominent part of Tom's life.

But I have seen, firsthand, his dedication to improving the health care system as well as to mastering

these arcane details. In the private sector, he was President and CEO of the Federation of American Hospitals and earlier a Partner in the D.C. firm of Patton Boggs, L.L.P. So, I'm honored that Tom has come today, and

ago, I think my mom read it. I'm not sure anybody else ever read it. It's probably been buried in those law libraries. So, I can't claim to know anywhere near as much as either of these guys, but I do really think as somebody who's a regulator and probably the biggest price fixer left outside of what's left of Eastern Europe, I really have always believed that if you're a market-oriented, conservative economic type person, the most important regulation on the market is antitrust regulation and balancing markets to make sure that no particular piece of the market gets out of hand.

I'm a big regulator, we regulate an awful lot of -- and I'll get into that in a few minutes -- we fix a lot of prices for a lot of people. I hate fixing prices, but as long as I am where I am, I try to be the best price fixer I can be. But the nature of the beast makes the market a little strange, which I'll get into. But if you really want to make sure that the economy works and you're a Republican and you're a moderate conservative and you actually believe in balancing the markets and making sure that nobody gets excessive market power is pretty critical, and I think that's why, as important as anything I do in Medicare or Medicaid, having Justice and the FTC make sure that market power doesn't get out of hand for anybody is really critical. And I'll talk about

that primarily for the next few minutes.

Before I circle back to antitrust, let me talk about health care markets. First of all, I think when you talk about health care markets and health care, it's kind of an oxymoron. The fact is, the health care market, whatever there is in health care, is extremely muted and extremely screwed up and it's largely because of my agency. For those of you who don't follow CMS, which used to be called HCFA, we changed the name because it was so well loved. I always say it's kind of like when Enron comes out of bankruptcy, they'll probably change their name. So, HCFA -- Secretary Thompson and I decided to confuse everybody. We changed the name to CMS for a couple of years so people wouldn't realize we're actually HCFA. So far, it's worked reasonably well.

(Laughter.)

MR. SCULLY: But there were a lot of reasons. Because we're so big and we are so extensively involved in the health care field, both in Medicare and Medicaid, that you obviously, when you're spending that kind of money and you're -- our budget, if you count both halves of Medicaid this year, is $570 billion is the projection for 2004 that just came out. $570 billion. It's $450 billion just directly for us and another $120 billion that the states will spend through us on Medicaid. So,

it's a lot of money and it affects every sector of the health care field.

Generally, one of the things I've found -- I've never been really good at making people happy, as Tim knows. That's your training at OMB. You train for years how to make people miserable and we both succeeded in some cases. But when you're fixing rates for hospitals and docs and other things, they're never really quite happy. And when you have large, incredibly complicated formulas, you make mistakes that don't make people happy.

But the bottom line is there really isn't much of a health care market and the reason is that when you look at a hospital, for instance, 57 percent -- Mindy is here somewhere. I was reading the AHA's comments yesterday. Fifty-seven percent of the average hospital's revenues come from Medicare and Medicaid. So, if you're sitting there as a hospital administrator and you're looking at 57 percent of your revenues coming from Medicare and Medicaid, probably 6 or 7 percent are indigent care, the market forces you have to deal with in the private sector on insurance are pretty muted. It's not much of a market. Let's kind of kick the ball and drag the government along when you're setting prices for everything else.

In the nursing home field, 82 percent of the

nursing homes in this country are now filled with either Medicare or Medicaid patients. That doesn't leave a whole lot left for the private sector to change the nursing homes. It depends on the physician, but many physicians and many physician specialties treat -- 70, 80 percent of their patients are Medicare patients. So, that doesn't leave a whole lot of flexibility to negotiate with the private sector.

So, you inherently have a pretty limited market force in the health care market as it is. And what's the reason for that? I only have 40 million seniors in the Medicare program, but obviously seniors consume the most health care. And even though they're only one out of seven Americans, seniors and with Medicaid together generally consume about half the health care in the United States. So, when the government, either Federal

Tim or, I guess, Hew are either. But you have to look at the fact that when you're talking about health care, you're looking at a market that is not structured like markets for anything else in our society and probably shouldn't be.

But there's still a place, I think, for it to work. I think health care, for me -- and for those of you -- I assume a lot of you are health care people. A lot of my friends on the Democratic side think we need single payer health care. Well, we already have single payer health care. If you're over 65 years old, we have a single payer. Medicare is a single payer, national health system and it's a wonderful system. There's nobody over the age of 65 that's uninsured. But it's an unbelievably archaic, crazy, nutty system where we do a lot of -- we essentially fix prices for everything.

Just to give you the most recent example, for the doctors -- a formula I was involved in in 1989 -- the Physician Pay Reform. We came up with a better way to fix prices than the old way to fix prices in 1989. I don't like fixing prices, but it was better than the old way. It was broken and we made a mistake. So, last year, every doctor in the country got a negative 5.4 percent reduction in their base payment in health care because we screwed up the formula. We made an accident.

affects everything, I can tell you that I was on the board of Oxford Health Plans, the biggest HMO in New York for eight years, and Oxford's rates for physicians were all piggybacked off Medicare rates. So, even in the private sector, the government price fixing kind of trickles down in everything and has a really negative impact on the market.

Under 65, we have an incredibly dynamic health care market. You can buy anything you want. High deductible, low deductibles, PPOs, HMOs, fee for service, anything you want. But we also have a cherry picking market where we have lots of people, 40 million people uninsured. So, we have a wonderful single payer broken model that covers everybody over 65 and an incredibly capitalistic dynamic market that cherry picks everybody and leaves an awful lot of people uninsured under 65.

The market under 65 works reasonably well, but it's dragged down a lot by the market over 65 and it's incredibly inequitable and it leaves an awful lot of people uncovered, which is obviously another problem that we hope we're going to work on.

But it is really the one size fits all price fixing that really, in my opinion, screws up the system and makes the market in health care so difficult to either monitor, follow or really understand what's

happening.

So, it's easy to say the system is broken, which I think everybody's been saying in health care for 25 years. I guess the question is, then, which Paul may answer -- in fact, I should note here that you have probably two of the only -- health care is not a bastion for market-oriented people. In fact, if you had a health care market conference, the only two guys I know that would probably show up are Paul Ginsburg and Mark Pauly. That's probably unfair. But there aren't a whole lot of -- it's not a place where you see a lot of big market thinkers in health care and you, obviously, have two of the best ones here today.

But what do you do to try to fix it? Congress has been struggling with the Medicare reform and we're going to struggle again for years. We've been struggling with Medicaid reform. Fundamentally, we're probably not going to fix the system overnight. I've been working on health care issues since I quit being an antitrust lawyer actually, about 20-some years. And one thing I can say is, very little has changed in health care. We talk about big legislative changes all the time and we're hoping to pass one this year. But the reality is, very little changes.

If you look at the fundamental structure of

Medicare and Medicaid, they're virtually the same today as they were in 1980. I hope we get some things fixed, but I try to be realistic, and I think the odds are not great that we're going to get overwhelming changes.

So, if you're in my position or you're in Tommy Thompson's position, my boss who runs HHS, what do you do? My view is, you try to find ways you can to instill market awareness into the system to make it more reactive and make it work better.

And one of the things we've really focused on, I've focused on, is quality. It drives me crazy that somebody flew into Washington, D.C. for this conference today. If you landed at the airport, you can find the best cab company, the best car and driver, the best hotel, and the best hot pizza, but if you had a heart attack, you'd have no clue where to go to get a bypass because nobody would know who has the best heart bypass program in Washington, nobody would know who does the

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are completely insured with first dollar coverage, once you get through Medicare and Medigap. So, their own market awareness is pretty muted, but at least you want them to know where do you go for the best hospital care, where can you find the best nursing home, where do you

important, is to get information out there.

Twenty-five years ago or 20 years ago for those of you who do follow health care, Bill Roper is an old friend of mine and was then the HCFA administrator, back when we called it HCFA. He put out mortality data, which he thought was a good idea to start comparing hospitals, and he got creamed. The myth in the health care field since then has been you can't possibly put out quality information, providers will kill you and it can't be done. And when I came into the job, that's what everybody said, you're nuts to try to do that, it can't be done.

Well, to be honest with you, I picked on the weakest people on purpose in the health care system to begin with, the nursing homes, because, number one, they had a bad public image, which they understood; they had a miserable relationship with their unions and the consumer groups; they wanted a lot more money from Washington. And so, I got the nursing homes together with Secretary Thompson's help and said, look, if you want more money from Washington, you better start talking about quality and measuring quality because the consumer groups hate you and think you're providing bad quality. You're getting no sympathy in state capitols and none in Washington. So, if you want us to work with you, start

measuring quality and put out quality outcomes.

We got all the major unions and all the major -- AARP and all the other health care groups that are consumer groups, who generally never talk to each other and didn't talk to the nursing homes, and the nursing homes in a room about a year and a half ago and we started -- people thought we were crazy. We did a six-day demo where we published outcomes -- you know, it's not perfect -- on major nursing home outcomes in major newspapers in those states and everybody said, you're crazy, you're going to get killed, and I did get beat up a little bit.

Last October, we published full page ads in every newspaper in the country in every major market comparing every nursing home in the country and I didn't hear a peep. Unbelievably popular. The nursing homes are happy, the consumer groups are happy, the unions are happy, and it's going extremely well, and they're fair, reasonable outcomes data.

Does every senior when they open the Washington Post and see that understand it? No, they don't understand it. But the families understand it. The patients understand it a little bit. I can guarantee you the nurses understand it and the boards of the nursing homes read it and they change. It has a big impact when

you start putting patient quality information out there because the boards of the nursing homes start asking their employees, how come we have the number one number of bed sores in the community.

And my view is, that may seem irrelevant to markets, but I think eventually when people start seeing this and they see we've got 43 nursing homes in Washington, D.C., why are we paying them all the same amount when one's doing a great job and one's doing a terrible job. Nobody ever asks those kind of questions

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starting next month with home health care. We have 22,000 home health agencies around the country. We have extremely thorough data on every home health patient that goes in every home health agency in this country, whether it's Medicare, Medicaid or the private sector. We have it in our computer systems. We've never given it to anybody.

In eight states, as of next month, we're going to have full page ads in those eight states talking about relative home health care. So, if your grandmother or your parent gets out of the hospital and is trying to figure out which home health agency to go to, Medicare pays every dollar, no deductibles. I think it would be nice if one of them started wondering which of those places does the best quality and which one is likely to take the best care of them. There's no source of information on that now.

As of next month, you'll have it in eight states, and as of next October, you'll have it in 50 states -- again, as soon as my budget -- somebody will eventually figure out to cut off my budget so I can't pay for anything probably -- with full-page ads in the newspaper. And eventually, and I know they're nervous about it, we have tons of data on nursing homes and we have tons of data -- in nursing homes we have something

we can use the MDS System, which we have extensive data on every nursing home patient and we have exactly the same thing in home health. We don't have that in hospitals. And, obviously, the biggest institutional provider that's the most sensitive is hospitals. In all fairness to the hospitals, we don't have a standardized measuring system for hospitals. The VHA and the Federation which I used to run and the teaching hospitals have all been very good about working with us because we have to build a base to get that information out there.

But eventually, the real final thing that consumers are going to want that's going to drive change is hospital data, and then eventually, which is even tougher because it's such a balkanized field, is physician data. But we really believe that the thing that we can do as regulators to change the system is to start putting information out there and having people start asking the same questions about the health care system that they ask about everything else in their lives.

You know, we're 13 percent of the economy. Medicare is the only part that is 100 percent government-driven, has no competition, no information, and that's bad for everybody. So, I think our view is for consumers to really look at changing the system, we have to start

make any sense and lack of consumer information doesn't make any sense.

So, let me just jump into one other thing we've been trying to do to put a little bit of market incentive and then I'll circle back. They may not actually tie together, but what the hell.

(Laughter.)

MR. SCULLY: To antitrust, why I think it's important is when I came into this job, I also thought it was astounding that the hospitals and the nursing homes would all come running to my office and say, we need more money. I used to do the same thing. I was a hospital lobbyist for seven years, and it's like Pavlov's Bell, whether you need it or not, you come in and say, we need more money.

Well, there's absolutely no substantive data from the government to figure out, outside occasionally from Paul and MedPAC, what people really -- what their margins really are. And I know for one, I used to represent the for-profit hospitals and I would run up to the Hill and say, we're doing terrible, I need a lot more money. And then I'd hop on a shuttle and go to New York and say, we're doing great, buy our bonds and securities, and nobody ever tied those two together.

(Laughter.)

reported. But that's only about 12 percent of their business is Medicare. But overall, we massively underpay them. Not us. The states set the rate in Medicaid. They chronically underpay them and it's going to get worse in every session.

So, when you look at the net Medicaid margins, they're pretty low, and a number -- some of them, they brought themselves and I won't torture you with the reimbursement of nursing homes, but when my analyst went through and wrote their first report, it turned out that nursing home margins were minimal. We weren't drawing much more capital into the market, things weren't going very well. And I can tell you that OMB in the White House last year, we had the option of putting a billion dollars a year, which out of a $12 billion base for nursing homes is not small, back into the nursing homes or not. And because of that report last year, we put a billion dollars, called RUGS payments, back into the nursing homes without any great debate.

It was an administrative change we could make in the Medicare program because we thought the nursing homes needed money. It was done 100 percent on the merits. So, you can imagine, OMB doesn't put a billion dollars in anything unless they think it's a pretty dire system.

We just decided, again, to put another billion back in for the next two years for nursing homes because we believe, on the merits, looking at the economic information, that their margins are not great.

With the hospitals, which I'm sure many of you don't like to hear, I've been saying that I think hospitals are about where they should be. We shouldn't cut them, we probably shouldn't add much back. Now, there's lot of definitions about leaving them where they are. But I really believe that in Washington too often those kind of decisions aren't made based on economic reality, they're based on who hires the best lobbyist and I don't think that makes a lot of sense. So, I'm a real believer that when you run a big agency like we do that dominates that big a part of the health care sector, then we ought to be looking at bond ratings, equity ratings, returns, you know, what the access to capital is, and that hasn't been done before.

I think tying together with the private equity markets and the private debt markets look at with what decision makers make in Washington, because we basically are giant government contractors. CMS is the biggest government contractor in the government. Social Security is slightly bigger than we are, but they pay money to individuals. I pay out $570 billion a year largely to

they never talk to each other. And when you find out that you set those different rates, you get enormous changes in behavior. If the ASC rate is off, all of a sudden you start seeing ASCs pop up all over the place to do colonoscopies or to do outpatient surgery. If the doctors get paid a little less, they're more likely to move their practice into their doctor's offices. If the hospitals get paid a little more, they're going to have more outpatient centers.

But people in the government don't look at it that way, and it's not because they're not trying to think well-intentioned, but I can tell you when I drive around the country and see where ASCs are popping up, I can tell who we're overpaying. You go back and check the rates and, hmm, there you go. That's why we've got more ambulatory surgery centers for orthopedics.

But we need to start thinking more about the impact we have on the market because we're such a big player. So, hopefully, we'll make HHS a little more responsible to the market and a little more of a better player. I also think that if you look back at health care in the last 20 years, people buy health care stocks and health care bonds because they expect health care to be a boring government contract. In the last 20 years, it's been anything but. The nursing home industry has

been a big roller coaster. Some of it's self-imposed, but usually driven by stupid government policies, where they've had huge margins and then the government whacks them and they have huge cuts. Big margins, big cuts.

Same thing with the home health business. The home health business, just to tell you how bad it is, in home health, the Medicare program in 1992 spent $3 billion; in 1997, it spent $18 billion; and in 2000, it spent $10 billion. There's nothing like that in the history of the government, where you went from $3 billion to $18 billion and back to $10 billion. You can imagine if you're in the home health business, it's like being on a big yo-yo. There are a lot of big yo-yos that got in the home health business there for a while, but the fact is you're --

(Laughter.)

MR. SCULLY: We're back to where we probably should have been all along without the big bulge. But the fact is, if you're in the government, I think the goal should be to understand better about what our impact is and to become a more predictable, better partner in the market because if the market is going to work better, the government shouldn't be distorting the outcomes as much as we are.

We'd obviously like to get more market based,

non-price fixed payment into that market, and I think in a good market, the government will have a lot lesser role. But in the long run, that might change. But in the short run, we're still going to be, by far, the biggest player in the market, and to the extent that we're screwing up the dynamics of the market, that makes everybody's life more difficult.

Now, trying to tie this back into the FTC and Justice and what happens with antitrust, I've always believed that the most important player in the market is the FTC and Justice in balancing out antitrust because health care is a local business. You can look at big chains, you can look across the country. What you have across the country is a market power that's making a difference. What you have in Washington, D.C. or Baltimore or Richmond or Paducah, Kentucky or -- what was the other one -- Poplar Bluffs, Missouri, that's what counts, is how much market power you have in those places.

And I've always believed, and I've been in the health care business for a long time, if you go to a town that has a healthy health care market, the doctors hate the hospitals, the hospitals hate the health plans and the health plans hate the doctors. That's a happy little triangle. Those are the three big players and that's the

way it should be. The hospitals should be a little bit unhappy, the health plans should be a little unhappy, the doctors should be a little unhappy, and if you have that kind of tension and balance, you usually have a reasonably efficient, well-run health care system. Over the last 10 years, that’s just a fact.

I mean, I wouldn’t pick Washington, D.C., but I was in Milwaukee last week and I can tell you Milwaukee

regulator, I don't believe in over-regulating. But I believe if you're conservative, the right regulation is keeping the market in balance, not diving into the market and micro-managing, and I would much rather have these guys manage the market and oversee it to make sure it's in balance from 30,000 feet than to have my people get in and micro-manage every little detail with every hospital and every nursing home. And I think in the long run that's the best thing for the health care system.

So, what I think are the problems here, I'll give you a couple of examples which will probably irritate a whole bunch of people in a couple of cities, but that's my specialty. So, I'll go for that.

I think that when you look at, for example, and I'll pick out some examples because I think that's the only way it works. I'm from Philadelphia. Everybody in Philadelphia, it's a fact of life and they don't like me saying this, Philadelphia's market right now is totally -- and Mark's from Philadelphia, Wharton -- I would guess if you walked down the street and asked anybody that knows anything about health care, they'd tell you that Independence Blue Cross is the dominant player in Philadelphia. They have too much market power.

Now, is that their fault? Aetna has weakened in Philadelphia in the last 10 years; other people have;

been helpful a little bit to Tim. I've given him a few suggestions of where to look. We, as regulators of the health care system, should be working with Justice and the FTC to say maybe there's a problem, maybe there's not. You are the ones that understand HHIs and all that kind of stuff and you're the ones that should be looking at these things, not my agency. But I've got to see the impacts on the health care system every day.

You e

about as close to a group boycott as you'll ever see. They have driven all the Medicare managed care plans out of Long Island. They have way too much market power and they throw it around like a ton of bricks. I would not say -- I've had to beg Empire Blue Cross, for instance, to stay on Long Island the last couple of years because they're getting squeezed out by the two hospital systems in New York. That's not healthy. That's a bad thing.

Now, does it meet your indices, I don't know, but I sure as hell hope somebody looks at it because they need to be looked at.

You know, I know they already lost the Inova case across the river in Northern Virginia. I like the guys that run it, they're very nice, but I've lived in Northern Virginia for 25 years and you've got to drive a hell of a long way to get to a hospital that's not owned by Inova of Northern Virginia. That's probably not a good thing.

I know that the lawsuit that they lost defined that as the Washington, D.C. market. I can tell you, if you live near Mount Vernon, that's not the Washington,

was probably the wrong case to pick. The hospital history is not great. But the fact that whether you win cases or not, the fact that Justice and FTC look at this and at least keep people honest on the margins to make sure nobody gets too strong in a region is critical. Because I can tell you market by market where I see either hospitals or health plans, or Tim's been very active in some of the group practices on the physician's side, when any one of those three legs gets too strong,

We'll try to distort it as little as we possibly can, but I think in the last 10 years, one of the real missing links in making the health care system work efficiently has been antitrust and I think it's very nice to see two players back on the field. We'll provide as much as we can to help you out, and I'd like to see it be a very happy, healthy partnership, even if there's a little bit of a competitive tension between the two agencies. We'll help both of you.

And I say that as, I hope, a friend of the health care industry because I think healthy hospitals -- hospitals don't have great margins, doctors aren't real happy these days, and health plans, at least in Medicare, have been dropping out and I would say the health plans, it's been a tough few years in the health system. But no matter how that happens, we're still getting 11 percent a year inflation, and for the government to keep those competitive tensions as tight as they can between, I think, the three big players in health care is pretty critical.

So, I will tell you, just to wrap up, the other day, Bob Novak came by to have lunch with the Secretary and I joined them and his opening question to me was, Scully, did you take that picture of Stalin off the wall of HCFA? And I'm trying to do the best I can to change

the image of my old Eastern European agency, and we'll do the best we can to try to help you do your part to get

I'd like to now turn this over to Leslie Overton, Special Counsel as well, but at the Department of Justice.

MS. OVERTON: Good afternoon. Thank you all for being with us today. I'm, again, Leslie Overton from the Department of Justice. We're very fortunate to have three esteemed experts with us this afternoon who will present framing presentations. Biographies are available in your materials, but let me just give you a little bit of information.

First, we will have Dr. Paul Ginsburg, who is President of the Center for Studying Health System Change. That organization was founded in 1995 and it conducts research to inform policy makers about changes in organization and financing and delivery of care and their effects on people.

Next, we will have Dr. Mark Pauly, who is one of the nation's leading health economists. He currently holds the position of Bendheim Professor and Chair of the Department of Health Care Systems. He's also a Professor of Health Care Systems, Insurance and Risk Management in Business and Public Policy at the Wharton School at the University of Pennsylvania, and a Professor of Economics in Penn's School of Arts and Sciences.

Finally, we will hear from Dr. Martin Gaynor,

who holds the E.J. Barone Chair in Health Systems Management and is Professor of Economics and Public Policy in the H. John Heinz, III School of Public Policy and Management, the Department of Economics, and the

And the final point is that many markets have only limited prospects for effective competition and we need to think about that and adjust to that.

Just a brief word on the Center. Leslie Overton said what we do. I want to mention that we're funded by the Robert Wood Johnson Foundation and our emphasis in our research is on health care markets, and you'll find a copy of this presentation and a lot of other things on our website, hschange.org.

A few things about our site visits, we do them to get some insights into changing market trends and I mentioned the 12 markets. We go to the same markets every two years so that we can track them. We chose them through a random process, the sampling frame was metropolitan areas with 200,000 population or greater. When we go to a particularly large, a consolidated metropolitan statistical area, we choose one of the primary metropolitan statistical areas as our site.

This slide is out of date, saying what our most recent visits were. We're in the middle of a round that began in September of 2002 and will be completed in late April of this year. When we go to a site, we conduct a large number of interviews with a broad section of local health system leaders and we triangulate the results, meaning that we don't take anyone's word for what they

say. So, when the hospitals are telling us about their relationships with health plans, we'll also hear it from the health plans' perspective, and we always do this before we can gain confidence in saying something about what's happening in that market.

Here are the sites, briefly. They reflect where the population is. And just briefly, what I'm going to do is after talking a little bit about this history, the experience of the 1990s, then I'm going to talk about hospitals, about physicians, about insurers and then about provider-insurer relations, say a few things about purchasers or employers who buy health insurance for their workforces because they play an important role in the nature of competition in local health markets, and then talk about the overall potential for competition.

I'll talk about the 1990s briefly. I think the key -- there really are two parts of the 1990s. There was the ascendancy of managed care, which brought with it narrow provider networks, risk taking by providers, authorizations for services, and they became core components of health care financing. National and regional managed care plans were formed and they expanded vigorously during this time. Hospitals formed systems and they consolidated. Managed care and Medicare cuts

both put very significant pressure on hospitals to contain costs and probably the mid-1990s was the height of that pressure. And physicians, basically, you know, they seem to be the losers. They chafed at the loss of autonomy and the loss of income as a result of the growth of managed care.

Then came the retreat of managed care, spurred by the combination of a backlash against managed care by consumers and by physicians and this happened to come at the same time as our economic boom. The very tight labor markets, high profitability, I believe, let employers be particularly responsive to this backlash. This has led to changes such as broader provider choice, fewer requirements for authorizations and reduced use of provider risk contracting.

Providers responded in very important ways to managed care or to the retreat of managed care. For one thing, many of the structures that were developed, some of the integration -- we used to have the term “integrated delivery systems” that were formed to prepare for restrictive managed care with risk contracting, all of a sudden didn’t have a purpose in the market and they have started to unravel. One thing we’ve noted in another study is that the various hospital mergers that were particularly frequent in the mid-1990s, tended not

to follow through when it came to clinical integration and ultimately providers have regained the leverage with health plans that they had lost.

Now, I'm going to turn to some of the most recent observations. For one thing, we see a real slowing of the trend of hospital consolidation and there's national data that show a sharp decline in mergers and acquisitions in recent years.

Some of the reasons for it: Well, for one thing there are fewer players left, fewer potential mergers. There are many communities where there are only two hospital systems and it's apparent to those two hospital systems, no, we won't be allowed to merge. So, no more mergers in those communities.

Managed care is less threatening and I believe that a real stimulus to hospital mergers in the mid-1990s was the fear of not having leverage in dealing with managed care plans, and particularly now that managed care plans are pressed to have broad provider networks, particularly for hospitals that, in a sense, this is not that much of a force for mergers anymore.

A third consideration is that there's less excess capacity in the hospital system now, both because some capacity have been taken out of the system. As hospitals were pressed to cut their costs, they had

health system is the same story, that what's profitable? Cardiovascular services. After that comes orthopedic services. And hospitals are going where the money is now as far as this is where they've emphasized their expansions. We're also seeing a sharp increase in promotional activity, a lot of advertising, both that our hospital is better than the other hospitals and also, I think more recently, advertising, I think you need this, you might want to come in and take our special heart screening for only $49.

So, all of these activities, as far as a consolidated market where the hospital systems are competing, it seems, quite vigorously, on the dimension of perceived quality or non-price dimensions is Cleveland, where we've really seen all the ones that I've mentioned on this slide.

Now, hospitals which traditionally are considered not to have much of a threat of entry by competitors, many of them perceive that they're facing a very significant threat today by the entry of specialty facilities, and I'm talking about heart hospitals, orthopedic hospitals and ambulatory facilities that also specialize in one or both of those services.

This focus on the profitable services that I mentioned before, I believe a part of it is flawed

signals that the payers are sending into the market. The payers have never intended that cardiovascular services be more profitable than other services, but I think for various technical reasons, that seems to have happened.

I ask people about it periodically and one of the things most convincing to me, but I don't know for sure, is that, well, you know, we set the rates -- see, this is Medicare, then Medicare sets the DRG rates and that, you know, after the -- but their productivity gains are much faster in cardiovascular services so that, in a sense, the rates become obsolete fairly quickly and these pricing distortions probably didn't matter that much a number of years ago. So what if the hospital was paid too much for cardiovascular services and too little for, say, medical admissions. But now with specialty facilities, it is more important and these pricing distortions may be a significant driving force towards that.

What we've seen as far as specialty facilities is, for one thing, hospitals have used it as a tool to invade other hospitals' geographic turf. One of the markets we've studied, Indianapolis, on the surface looks competitive in the hospital market. There are four significant hospital systems. But when you go there, you learn that each of them kind of has a geographic area

that they are the dominant hospital in. Well, there's been a lot of activity of building specialty facilities in the other hospitals' backyards. So, in a sense, the industry is being entered.

Of course, what really bothers the hospitals is a threat from physician-owned facilities and that bothers them because of the potential of physicians to be selective and admit the most profitable patients, the privately-insured patients, or in the case of orthopedics, auto accident injury patients, to the specialty facility that they are a part owner of and admit their Medicaid patients to the general hospital.

Certainly, this threat for specialized services does have the potential to erode some of the traditional cross subsidies that the health system is run on. So, in a sense, hospitals today are counting on extra revenue from, say, cardiovascular services to fund their emergency room or to fund uncompensated care for uninsured individuals.

In some areas, the plans have been resistant to contracting with the specialized facilities usually because of concern of, well, you know, more facilities are going to lead to more volume and, well, maybe the quality won't be there. I know in Lansing, this was about four years ago, Michigan Blue Cross-Blue Shield

refused to contract with some ambulatory surgical facilities and, in a sense, it was pushed to do this by the major employers and the United Auto Workers Union who thought this was going to be a negative thing for health care in the Lansing market.

Turning to physicians, now, we've seen a recent trend of physician consolidation into single specialty groups. I think probably the most key motivation has been to achieve the scale necessary to purchase profitable equipment, that as technology is changing, you know, there is increasing numbers of tests or procedures that can be done on an outpatient basis, and one of the reasons for forming such groups is in order to be able to provide those services within the physician practice, and in a sense, the facility fees for these services may be much -- have much more of an impact on the bottom line than the professional fees that the physicians are earning for their services. Also, increasing leverage with health plans, I'm sure, is a consideration.

We have not seen a growth of multi-specialty groups, and this may be part and parcel of the retreat from restrictive managed care that the potential of multi-specialty groups is to truly integrate delivery, but people are not valuing that in the marketplace now.

Also, and this is no surprise, we see a sharp

decline in physician hospital organizations. There really isn't anything left for them to do because risk contracting that screens plans and providers has declined so much, probably more at the initiative of the providers than of the plans, but sometimes the plans as well have given up on that.

Talking about insurers, I think much of the consolidation that we've seen has been across markets and that there just haven't been that many opportunities for significant consolidation within markets. There have been some opportunities for national plans to enter markets through purchase of hospital-owned plans. In some communities, you know, back in the early 1990s, hospitals started health plans, they started it because they saw health plans being very profitable. Why can't we get those profits? I don't think any hospitals are trying to do this today, but some of them actually had reasonably successful health plans and this is the way that national insurers enter a market.

But in our markets, particularly the smaller ones, we've seen many examples where national plans entered the markets and they didn't succeed, or at least they weren't able to build the market share they had hoped for and they have since exited. You know, it's hard to -- examples actually we've seen are both Little

Rock and Greenville where national plans have tried to enter the market, these are markets with dominant Blue Cross-Blue Shield plans, and they haven't succeeded. It's possible that the insurance underwriting cycle played a role in that, in a sense they entered the market when insurers were expanding into new markets and they left when insurers had a different attitude on that expansion, that they weren't that active in pursuing things that weren't profitable that might be profitable in the future.

Most of the plan mergers have been across markets and I think they're oriented towards scale economies and information technology, care management technology, economies in marketing, but I think that these scale economies are difficult to achieve, and frankly, I'm struck at the rate of mergers across markets, given that it's so much easier to achieve these economies within a market than across markets.

Health plan competition today, given our attitudes about managed care, a lot of it focused on product innovation. Plans are customizing their products for diverse employers. They've always done this for self-insured employers. They're increasingly offering fully insured products with more and more variety.

Plans basically are competing with other

the way they were in the mid-1990s.

Blue Cross-Blue Shield, we see they've solidified their dominance in some markets. Now, they have a history of large market shares in many markets and they have benefitted recently from a shift in consumer preferences towards broad networks and they traditionally have emphasized broad networks and preference for PPOs versus HMOs. Blue Cross-Blue Shield plans never really put that much emphasis on HMOs. So, in a sense, the market is coming back to where they're traditionally strong.

Consolidation in the Blue Cross-Blue Shield world is intertwined with conversion. One thing we're seeing now is that the states have become less resistant to efforts by Blue Cross-Blue Shield plans to convert to for-profit status, and I think a factor in this is the potential to gain state revenue in the process. In the early days, in a sense, the value of these non-profit enterprises went to foundations. I think, today, it's much more likely to go into state treasuries and I don't see that as being unreasonable because they've had tax advantages from the states for a long time.

I don't know what I meant by greater attention to price. Oh, yes. There's been a lot more attention to the prices paid and the prices paid out in these

conversions and right here in Maryland and D.C., we can read about that in the newspaper. There's certainly a split within the Blue Cross world about the virtues of conversion. Some of the plans in our markets seem to be very committed to maintaining their non-profit status long term, while others, of course, have converted to the for-profit status.

Talking about relations between insurers and providers, hospitals are gaining leverage over plans. A key thing is the must-have status of leading hospitals that, today, with the demand for broad networks, if a network does not have a prominent hospital, it is not that viable in the market and hospitals have recognized the power.

The fact that hospital capacity is constrained is also relevant to greater leverage and, in fact, we have seen instances in our sites where hospitals have resisted tiered networks, such as in California, basically by threatening not to contract with the plan if they're placed in the lower, less attractive tier.

There is evidence of moderately higher price trends for hospitals using the producer price index, hospital component for non-Medicare and Medicaid services. Hospital prices were going up at about 2 percent a year, around 1998, 1999. In 2002, the first

nine months, they were up 4.7 percent in that year.

This is not that sharp an increase in price when you consider hospital wage trends, that as a result of shortages of nurses and others, hospitals have, in fact, been paying much higher wages.

Basically, there are three possibilities of why the trend seems so moderate. Well, for one, maybe the numbers aren't that accurate. These numbers are not easy to do accurately. Number two, it's possible that ordinary hospitals aren't doing as well as prominent hospitals and we certainly have a lot of anecdotes about prominent hospitals having price increases a lot higher than 4.7 percent. And the other thing is that maybe prices are heading a lot higher and we just haven't seen it yet. We'll have to look at that.

Now, physician leverage vis-a-vis health plans has grown less than hospital leverage. I believe the reason is that the brand name status carries less clout for physicians in dealing with insurers. You know, if there are three hospitals systems in a community, it's a lot more noticeable not to have one of those three than to not have 20, 30 percent of the physicians in a market, including prominent individuals.

A key exception for this is in some single specialty groups where they have sufficient market share

or reputation that they do have a lot of leverage with insurers. For the most part, in negotiations, most physicians continue to be price takers. The plan says, here's my price schedule, will you sign up or not. And you don't have the negotiations that you have with hospitals.

Again, if you look at the producer price index for physician services for non-Medicare, Medicaid, that suggests that the price trend for physicians has remained very low. You just don't see an increase like you do for hospitals.

There is a trend towards physicians leaving networks and managed care plans, and in some areas, establishing boutique medicine practices. There are a lot of anecdotes, although I don't have a good sense about how important a trend this is. We heard about it most in Seattle and in Boston.

Purchasers, employers that buy health insurance, have influenced the nature of plan and provider competition. I believe their demand for broad networks is a very significant thing. We've seen in our sites, employers taking sides in some of the well-publicized showdowns between hospitals and health plans. And in one in Boston, I guess a couple of years ago, the employers clearly took the side of the hospital and they

told the health plans, you better have Partners in your system or we're leaving you.

More recently, we've seen some examples in Lansing, Michigan and in Seattle where the employers have supported the health plans in this sense and egged the health plans on about don't meet that hospital's demands. We're going to stick with you.

The shape of the benefit package is very important as more financial incentives work into the benefit package, this is going to set the stage for a possibility of more competition on the basis of price. And a final thing is employer willingness to pay for care that is of higher quality when it can be measured. And traditionally, employers haven't been willing to do that, but there are some very well-publicized demonstrations in some states where specific large employers have gotten together with their insurer and told the hospitals, if you meet these requirements, we will pay you more per day or per case than we would otherwise.

Purchaser behavior is changing. There never was the amount of collective activity in communities of large employers that people thought there were, but it's definitely declined since we started watching it. Some of the things that have led to it have been national mergers among employers, because it seemed as though the

only time you had significant collective activity by employers was when there were headquarters of a number of large corporations.

HR departments have been slashed and, perhaps, the lack of success at some of the coalition activities that employers have pursued has influenced the decline today.

I believe that purchaser behavior does follow economic cycles. It depends on the profitability of employers in the economy and the tightness of labor markets, and now we're probably in somewhat of a middle range. Certainly, there's more concern about costs than there was three years ago among employers, but not as much concern as there was in the early 1990s when the very large shift towards managed care began.

We don't see much competition based on clinical quality, and I think as Tom Scully was pointing out to you, the lack of information is a real barrier. Experience with hospital report cards, when we've seen them, has been that the hospitals pay a lot of attention to them and they actually have a beneficial effect from hospitals seeing where they're weak and looking into why they're weak and trying to do something about it. We often don't see much use of report cards by employers or consumers and hospitals have been resistant to them and

have closed down some efforts.

We're seeing a private regulation approach of the Leapfrog Group in a sense saying hospitals should have these processes which we believe lead to higher

in some markets where it’s not an antitrust enforcement

think that the slogan for Philadelphia is the City of Brotherly Love. It actually isn't. Some relative of some alderman got a contract about 10 years ago to come up with a new slogan for the city. This is the honest truth. The slogan is, Philadelphia, the City that Loves You Back. However, recently, people have been pointing out that when tourists come to town, especially in their cars, and if they happen to, by mistake, cut off local drivers on the freeway, they may not perceive Philadelphia as the city that loves you back. And so, there's a competition for a new slogan, honest slogans about Philadelphia.

So, my proposal is to put on the signs coming into town, Philadelphia, the Home of the Health Insurance Duopoly. At least that would be truthful. And that sets the stage for some of the things that I want to talk

is different, but it's not that different. Having said that, though, on the other hand, there are some considerations that need to be taken into account in applying kind of our standard theory of the desirability of competition to the medical care sector.

About 20 years ago, I wrote a paper called, Is Health Care Different, and I think I haven't changed my mind on some -- I still agree with myself. And one of the things I said there was that by my back-of-the-envelope reckoning, about 20 to 25 percent of medical care actually looks pretty much like ordinary markets, kind of like apples and oranges and haircuts and things like that. There are a lot of medical services that you don't have to be an epidemiologist or a physician to evaluate that people buy fairly routinely and that at least they pay enough of the price that they would pay attention. So routine pediatric care, private nursing home care would be such examples.

But that leaves a large share of the market which is not like that, and probably because of the spread of health insurance, the fraction of the market which is like an ordinary market, has changed. So, it's worth thinking about how different it is.

The perspective I'm going to take here is, I guess, at the other end of the spectrum from what Paul

nevertheless, so you don't get too depressed, is that in those circumstances in which competition can't be shown, at least on a theoretical basis or with empirical evidence to be the correct answer, there's something you could call Competition Plus, which probably is. And another way to say that, that's sort of the good news version of it.

The bad news version of it is competition is necessary but not sufficient for maximization of consumer welfare in a lot of circumstances in health care. We can identify what the other things are. That's sort of the good news. The bad news is, the other things that need to be done to accompany competition may not be under the jurisdiction of the Justice Department or the Federal Trade Commission. They may, for example, be under the jurisdiction of the Treasury Department or some other part of government. So, no single agency -- any single agency trying to improve welfare on their own is going to have to either be restricted or get some cooperation.

So, that's the basic question. Competition improves welfare in the Econ 101 model and the question is, will it work as well in medical services and health insurance markets? Basically, what I want to do is identify the exceptions and talk about them and talk about how far you can get? How much of a plus do you

need? What do you need to change?

In general, I'm going to give competition the benefit of the doubt. So, I'm not going to -- at least I haven't given myself the charge, because I know I couldn't do it, of proving beyond a shadow of a doubt that competition will make us as happy as we can possibly be. You can never prove that, and if your alternative model is one of, as Paul was mentioning, either a public utility type regulation or some other kind of arrangement administered by angels, it will always do better than the market, which is bound to still have a few glitches. But I'm going to at least assume the absence of angels for purposes of discussion this afternoon and, as I said, try to get things to be reasonably competitive and then call that good enough for government work.

So, which markets -- there's actually two markets to talk about and they are, obviously, the market for medical services and goods and mostly I'm going to be talking about medical services. The most important medical good, of course, is prescription drugs. It's protected largely by patents and has actually been a major source of the recent increase in health care spending, but at least for purposes of today's discussion, I'm not going to try to think about competition policy in the pharmaceuticals market.

Then the other is the market for health insurance and with about 86 percent of health expenditures paid by third parties, I had to say this, the two are inextricably intertwined. It's so much fun to say inextricably intertwined, but as a matter of fact, they are, and that's one of the issues, one of the circumstances in which a straightforward application of the idea that more sellers and more entry is good doesn't necessarily follow.

In fact, I might as well say at this point -- I think I didn't put it on the overhead -- for Econ majors who went beyond Econ 101, the name of the problem here is the generalized theory of the second best and the proposition in economics is, well, there's this beautiful model of perfectly competitive equilibrium and a certain set of conditions that have to hold for it to apply, free entry and well-informed consumers and no taxes or subsidies or distortions, and then you get the beautiful result that if that happens, as if by an invisible hand, everybody's welfare is maximized.

But the problem is, if one of those conditions is absent, you don't necessarily improve things by doing more of the other condition. In fact, sometimes you can get a situation where, in a sense, two wrongs make a right. Having less competition, if there's some other

glitch, might actually be better than having more competition if you can't get rid of the glitch.

As I've already said, though, my version of Competition Plus, which I'm trying to get a trademark on that name, Competition Plus, envisions that you would do something about the other thing and then do competition.

So, these are the things that I want to talk about that potentially represent deviations from the Econ 101 apples, oranges, widget type model. Variable quality, widgets were widgets, apples were apples. Actually, today apples are not apples at all anymore. They're just red blobs. But in my day, apples were apples. But in health care, as everybody knows -- well, actually, people kind of ignored this for many years, but as we're now talking about in great detail, product quality is variable. A doctor is not necessarily a doctor, a hospital is not the same as any other hospital, even though they're all licensed by the state and reimbursed by Medicare.

Second, consumers are imperfectly and asymmetrically informed. Actually, the asymmetry works both ways, if you think about it. About the process of care, of course, my doctor knows more than I do about what I want to get out of care. I know more than my doctor knows about that, and we have to kind of tell each

other.

Then insurers set prices or administer prices. I'll fuss a bit about whether we really ought to call them that, but there's some economic models of administered prices that I want to use, so I'll stick with it.

Some suppliers are not-for-profit. That must make a difference, mustn't it? I mean, the last time I worked for a for-profit firm was when I worked my way through college selling shoes. So, I probably am guaranteed not to be too nasty to non-profit firms here, but I do want to say some things that are not completely complimentary about them. And then we may, and often are in a situation -- this is the Philadelphia situation, perhaps, where insurers with market power faced providers with market power. So, that's what I want to talk about.

So, a few definitions and postulates to clear away the underbrush. Competition can obviously mean a lot of things, and I mean here the general idea of free entry by many firms subject to a break-even constraint. Whether or not that actually reproduces the perfectly competitive equilibrium of the textbook, of course, is what the discussion is all about. But at least the medicine is free entry, lots of firms subject to a break-even constraint.

This is actually a somewhat argumentative proposition from the viewpoint, at least, of some of what I heard today from Tim Muris and from some of what I saw in some of the publicity material for this session, and it's an example of where the economists and antitrust lawyers maybe aren't quite marching arm in arm.

So, here's what economists think is great. We think the best possible thing is whether arrangements maximize the sum. That should be S-U-M. I have to revise these. These were dictated rather than -- or maybe the spellcheck made up its own mind here. But the sum, the arithmetic combination of consumer and producer surpluses is what we want to maximize. Net welfare. And why that has an edge to it is that sometimes, the arrangement that does that doesn't necessarily maximize consumer surplus alone.

So, maximizing consumer welfare is not really what economic efficiency is necessarily all about and that, particularly in the case of monopsony, I'll get to, raises some issues that I think need, at least, to be recognized and thought through. And then I've talked about the theory of second best. I've already said something about that.

What competition alone can never do, it can't get all or even most of the uninsured insured. I

personally think that's the biggest problem in the U.S. health care system at the moment. Compared to that, I don't lay awake at nights worrying about the absence of competition nearly as much, although every other Thursday I do try to do that. But the problem of the uninsured, I think, for the most part, is actually not cherry picking. It's the fact that there are a lot of -- it's because of two facts. One fact is there are a lot of low-income people who have a lot better things to do with their money than spend it on health insurance, and the other is -- it's sort of the opposite of cherry picking -- there are a lot of people who don't value insurance as much as it costs. So, they don't buy it for various reasons.

Competition, alone, can never stop the real growth in medical care spending. The primary reason for that is from the beginning of time up to the present and even now, we know that the primary driver of growth and medical care spending is the development of beneficial but costly new technology.

Now, if the biomedical engineers would just stop, we could get control over health care spending, but I personally wouldn't want that. If we could make the market more competitive than it is now, assuming it's not perfectly competitive, the best thing that that would do would be to produce a one-time cut in health care

spending. But if technology continued to progress in the same way, presumably the rate of growth would be about the same. There may be some more complicated story about the relationship of competition to the rate of adoption of new technology, but that's not something I'm going to get into here.

This is why I left out pharmaceuticals. Competition alone cannot lead to optimal rates of product innovation. That's why we have patent laws and I'd certainly be willing to argue about patent protection and whether it's optimal, but that's another argument for another day.

Here again, the second to last one is also a point that, I think, is kind of my anti-PR protective shield line of thinking. What competition will do in a perfectly competitive equilibrium is give consumers the optimal level of quality, which means the level of quality essentially where the marginal benefit for improving quality more, which can almost always be done, isn't efficient to do because its marginal cost would be greater than the marginal benefit.

And so, it's perfectly possible, and I will offer some examples which I think have actually occurred in health care, to have quality that's too high rather than too low. I don't believe that is a problem for the

a pretty big variety, you get pretty close to the ideal.

And this was the second point I made, but I'll make it again here. Compared to its absence, the introduction of competition will reduce price or improve quality, but not necessarily both. And as a little bit of a preview, in some circumstances where the market might have been dominated by a non-profit monopolist that attached very high weight to quality, you could, by having more competition occur, actually reduce quality. That would be good, but it wouldn't necessarily look good to the institute of medicine. But they're not mostly economists. And the last line is the reason.

So, what about competition under administered pricing? This is the model. Suppose some large buyer -- I won't mention the name of anybody who was up at this podium a few minutes ago, but you know who I mean -- sets the price for a product of variable quality and says this is what we're going to pay for this, flat dollars period, and then forbids or deters balance billing. So, nobody is allowed to pay anything extra. It's absolutely illegal for you to exercise your constitutional right to overpay.

Well, then what does economics predict will happen? We actually have a model for this which has been around for a long time. It's sort of got polyester pants

and long sideburns. It's the regulated airline industry competition model where the argument was, back in the days when airline fares were regulated, because airlines couldn't cut their price, they engaged in competition in non-price ways, and the poster child for a way to engage in competition that didn't sound like it was a very efficient thing to do was the pub lounge. I think that was Continental where they did some other even less politically correct things from today's standards to try to boost ridership on their airline.

But one of the things they had in a couple of places in the plane was a pub lounge where you could -- it's hard to believe thinking back -- you could unbuckle your seatbelt and go up and drink yourself into pleasure. And that was why you should fly their airline.

The comments that were made about that model at the time were, that doesn't seem very efficient because that actually led to too high a level of quality. I mean, actually, the main competitive device then was schedule frequency. There were too many planes leaving on a given day from State College, Pennsylvania. That doesn't happen anymore now that we've deregulated, thank goodness. But that was the idea.

But it still can happen and probably does happen in health care where you do have this administered

price arrangement and it is fair to say, I think, that Medicare is probably the primary source of administered pricing these days.

Personally, actually, as I was thinking about it, I think we want to wait until Tom Scully moves on, but I don't see any problem with, say, breaking big Medicare, traditional Medicare into four parts, say, you know, just randomly assign beneficiaries to four different firms, clone the CMS administrator -- we don't want to clone Tom because that's impossible, but clone some CMS administrator and have them compete with each other. That's kind of what the Germans did. I don't know if it's been too successful, but you can actually do it and then have competition.

But in any case, when you do have administered price, the general idea is that competitors do things and spend money on things that would be called quality, at least as perceived by people making the choice of what firm to patronize, that attract business that bids away profits. Is it efficient or not? Well, it kind of depends on whether you assume that you're stuck with the regulated price being where it is or whether you think the regulated price would change. If the regulated price is too high, you'll get excessive socially inefficient quality. If the regulated price is too low, you'll get

socially deficient quality, but at least you'll do as good as you can, and if Tom can just figure out how to do this and get the price exactly right, it can actually be just as good as the competitive market. But that's asking a lot of even a very unusual and accomplished person to figure out exactly what the right price is.

We do see some evidence that this actually happens in Medicare. There's some research that I did some years ago, but I think it probably would stieoson to6doeueol

forth. And now that we've cut down on that cherry picking by those Centrum Silver Medicare HMOs, a lot of people are upset that they don't any longer have the same benefits they did before.

Paul already mentioned this. We usthirh think

competitive market of the real sort or set optimal prices.

Imperfect consumer information can lead to monopolistic competition even with free entry. So, it's never going to be exactly perfect. But what are you going to do? I mean, doctors are different, and so, it does mean that any given doctor with any given bedside manner or technical skill probably won't lose all business by raising price a dollar above the going level in town. But the best solution, which I think we've already talked about here, is the best information and competition.

It is true, in a second best sense, if consumers were uninformed in a particularly biased way, meaning they over-demanded rather than under-demanded and they paid something out of pocket, monopoly may actually improve efficiency, but a far better solution to first stimulate consumer demand to a situation in which consumers' demand is first over-stimulated by incorrect information about medical care being more valuable than it is, and then trying to dampen that demand by overcharging them. It's pretty obvious it would be better to get rid of both of those things. So, that would be the idea there.

The most recent manifestation of imperfect

consumer information is, of course, the medical errors controversy stirred up by the Institute of Medicine. I think I'm probably just going to be saying here what a number of the other speakers have said. I don't understand if there are all these medical errors around why they exist. Other industries don't seem to have this problem. What's the problem in medical care that allows firms that continue to offer care that can kill you to continue to exist, at least if that's known and knowable?

Where is the health care system that advertises not we care, but we don't screw up? It seems it's possible. And I think the debate that we are in the midst of having, and probably will continue to have, though, is what to do about it. And the alternative, of course, to informed competition is what I call a compassionate conspiracy of right thinking providers. Let all the leaders in medicine get together and agree on a set of rules and regulations and looking over each other's shoulders at self-regulation as a solution. Ultimately, you have to answer that empirically.

I personally wouldn't bet on self-regulation, but it's worthwhile to think seriously about how to deal with the question of what would be the best solution to this problem, and at least show the flag for informed competition and markets as a device for improving

quality, as opposed to rules and regulations guided by former editors of medical journals and other saintly persons.

Insurance in a world of provider monopoly. This is actually one that both Marty and I have fussed about a good bit. The general proposition which actually I wrote about when I still wore short pants is the idea that insurance, the kind we usually have, can cause over-consumption because of moral hazard. And a potential solution to that problem, if you think about it -- and this actually only holds if coverage is less than 100 percent and it takes the form of a percentage co-insurance, but if it does take that form, having a monopolist get in there and raise the price can actually cause consumers to stop the over-consumption.

If consumers could choose their insurance without any interference and without any imperfections,

solution. A little bit of monopoly might be a good thing. But, again, you can see my real plan here is to argue against the other defect. If two wrongs make a right, let's get rid of both wrongs. In this case, the tax subsidy and monopoly. It's more efficient and more just.

Suppose providers have market power. A question which actually was discussed today and which is of great interest to me is, does it help if insurers get countervailing power in the form of monopsony? I think Marty will say a little bit about this, too. Without solving for kind of equilibrium strategies, I think you can see that if you started off with providers having some monopoly power, if you had an insurer with market power that had either the wisdom or the luck to set its administered price at the competitive level and say, that's what it's going to be, boys, that would actually be better than being at the monopoly level. Quantity would expand. Quantity demand would expand because price would be lower and things would work out fine.

Monopsony, I want to make a point here, is not necessarily implied just because there are a small number of sellers of insurance. The other thing you need to have it happen is that the supply curve of care be upward sloping and it isn't necessarily, if you think about it,

for all kinds of care, like home health care. It uses a relatively small fraction of nursing personnel. There's a price that covers their cost. If you don't pay it, you can't be a monopsonist and get the price below that. People will just stop rendering it. What the supply curve of hospitals looks like, it would probably be interesting to explore.

Monopsony, though, doesn't necessarily -- removing monopsony -- monopsony is inefficient because it helps buyers less than it hurts sellers. Now, of course, if the buyer, as in health insurance, also has a monopoly in their product -- so the monopoly health insurance, the two duopolists in the Philadelphia are not only duopsonists, that's even more fun to say than monopsonist, but they're also duopolists if they're profit maximizers, you can show that's actually worse than not having monopsony at all. But at least it's possible to think about. And, occasionally, our Blue Plan argues it's like this. To think of it as not a profit-maximizing entity but a consumers' cartel, in

who will work in the health care industry, I'm not sure I want those provider surpluses totally diminished.

How about non-profit firms? I'll try to move quickly through these. In competitive markets, of course, all firms are non-profit effectively. Among hospitals, the evidence that I've reviewed suggests that there isn't really much difference. For other services, like nursing home care, it looks like for-profits may be better, at least in terms of quality and efficiency. At least in terms of quality, at least there's something good to be said about -- I'm sorry. Non-profits may be better in things like nursing home care, dialysis units and so forth, at least in terms of quality. I don't know about efficiency. It seems like non-profit ownership and insurance -- Paul did some of this work years ago -- it doesn't seem to have any socially redeeming value.

I think I've already said this -- oh, no, I haven't said the first one. Monopoly is bad if the not-for-profit is a for-profit in disguise or a doctor's workshop. So, just because a hospital is nominally not for-profit, at least we've speculated, and nobody has proved to the contrary, that it might not actually be setting the price a monopolist would set and then, in effect, using the money either to enrich doctor's -- there's a complicated story of how that can be done -- or

even if it's run in the interest of the Little Sisters of the Poor, so you're setting monopoly price in order to maximize charitable contributions, that's still bad for consumer welfare and there's a way to improve efficiency. That's what the second point says.

So, my conclusion is that Medical services and health insurance are not so different. After all, for one thing, people are people, and for another thing, they respond to incentives. So, most of the time, it's just a matter of getting the incentives right as usual. The whole world looks like that to economists.

Secondly, though, while there are some differences, more competition is usually the best medicine and I guess this is the primary take-home message. When competition isn't the best medicine taken alone, which is sometimes the case, it usually is best if combined with something else.

Thank you.

(Applause.)

DR. GAYNOR: Great. Well, that sounds two cheers, maybe two-and-a-half cheers for competition on Mark's part. I'm from the other monopsonized, monopolized market at the other end of the state of Pennsylvania, Pittsburgh, in which we have one dominant health insurer and one dominant hospital. I don't know

talking intrigue to some degree. Now, I suppose today's

facts are critical and while I say there's no single aspect of health care as a product or market that is unique in and of itself, there are other markets with asymmetric information. There are other markets with insurance. There are other markets with variable quality.

Health care is unique in having a particular constellation of these characteristics and in their importance. Quality, in particular, is prominent in health care. Not in all kinds of health care as Mark said very ably. There's actually a large chunk of services bought and sold that look pretty much like any other kinds of service. But there's certainly services for which quality variation is large and that variation is particularly significant.

Can markets give us what we want in health care? We're asking the question, is health care different, can health care do the job? We're very comfortable with markets doing the job for us with things like pencils, food. What about health care? This is 100,000 foot policy question, if you will. Well, let me back up. There is a 100,000 foot policy question about whether we want a market system or not for health care in the U.S. Let me suggest that this is not on the table at present and won't be for the foreseeable future, which in

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Washington, of course, means the next election.

So, at present, we rely on a market system for health care. The presumption of antitrust is that competition is good and, in particular, unregulated monopoly is bad, and I'm going to come back to thinking about a monopoly as an alternative throughout my talk. So, the question is, is this true for health care because that is presumption of antitrust?

Well, let's think about two alternatives. I'm not going to suggest these necessarily exhaust all of the

proposed to exempt physician practices from the antitrust laws, the Campbell Bill of a Congress or two ago, Barr-Conyers, another version of that. The quality improvement movement presumes that it's all done by the profession and ignores markets.

Now, this presumes that physicians, say, care about patient well-being and will enforce behavior among themselves that maximizes social welfare. It certainly takes care of patients' welfare. Another way of thinking about this, well, could we put Marcus Welby in charge? Well, how likely is this to give us what we want? I think there are some very serious flaws with this.

Doctors certainly do care deeply about their patients, but I don't think it's a bad thing to say that

lot of sense. But patients care about money as well as medicine. Self-regulating doctors, like any other self-regulating profession industry, may not do a very good job of balancing these things.

We probably want physicians concentrating on medicine. At least, I think, when I see my doctor, I think that's what I want him concentrating on. Last, I think professionals have a hard time regulating themselves. Of necessity, there is a great deal of individual situation-specific judgment that's called for, and this implies a lot of individual independence. Again, I think that's the nature of the beast and want a lot of that. But that means a couple things. It's going to be hard to detect problems, it's going to be hard for colleagues to discipline one of their own.

So, where firms' goals -- and firms you can think here are physician practices, hospitals, insurers, any of the market participants -- conflict with those of society, which will win? And I'm not suggesting that we absolutely know the answer to that, but I think if we think about it then, it becomes obvious that there's some potentially serious problems with that.

The experience that we have in medicine is not particularly reassuring. Mark mentioned medical errors that were described in the Institute of Medicine report a

couple years ago and have been the focus of a great deal of attention. That's certainly not very reassuring in terms of not so much necessarily quality issues but more price issues. There's a long history of antitrust violations going back to the 1930s on the parts of organized medicine. That, again, certainly gives one pause in this area. There have been numerous attempts to limit entry into profession, taken from restricting establishment of new medical schools, trying to restrict the entry of foreign-trained medical graduates and so on, that, again, perhaps are not extremely reassuring. Not to criticize physicians individually or even as a whole, but there certainly are these activities that have taken place.

So, let me then suggest that self-regulation won't do the job alone. We're going to need market incentives that markets will complement self-regulation. If we look at any industry, there are always standards boards, there are regulatory bodies internal to the industry and they work in concert with markets, but will not work particularly well on their own.

So, my conclusion is that antitrust enforcement is a critical element of health policy. It preserves the functioning of markets on which we base our system and perhaps I don't need to say this, but I will, it's

potentially patients and, again, more broadly speaking, we're all members of this society. So, I think these are easy questions to answer.

What do we know? I want to divide my presentation about what we do know into two pieces. What do we know from economic theory and then what do we know in terms of empirical evidence on the impact of competition on quality and health care markets up to this point.

high prices and low quality are probably bad. Low prices and high quality are probably good. Other combinations can be good or bad. So, let's take that as a general point.

Let me now talk about what we know from economic theory when prices are fixed. In this kind of situation, and this is like the regulated airline world, which some of you may remember. Unbelievably, one of those models had competition not over pub lounges but over meals per flight, which takes some of you way back. Competition over non-price aspects of the product, which I'll call quality, but quality here could be a technical quality or clinical quality or some kind of amenities. Competition is going to lead to more quality in that kind of a world.

The level of quality will vary with the price. It could be too high, too low or just right, and the price will determine whether that's the case. So, again, here, what we're really talking about for the most part in health care is Medicare.

One other result from economic theory is that even if competition doesn't lead us to the right amount of quality, if it's too high or too low, monopoly is worse. It always results in insufficient quality. So, even if competition leads us to too low a level of

quality, monopoly will provide even less. So, monopoly is never a good thing in a world with fixed prices or administered prices. Theory is very clear on that.

Where prices are variable, where firms can choose both price and quality, theory is very unclear. The response of the economic theory here is definitely maybe and that's final. Anything can happen. A monopoly can under-produce quality, it can overproduce quality and similarly for competition.

Now, in specific models under specific conditions, you can get definite predictions about whether monopoly or competition is better and, indeed, with careful thinking, one could take some of those competitions to a real world situation and try and examine whether they hold. That may not be quite so easy, but in principle, it is feasible to do that if there are some models which give you results that intense competition does result in lower prices and higher quality and consumers are better off. But those are only general models. There are no general results that point in that direction.

So, economic theory here is not a general guide. What this then implies is this is an empirical question and, in particular, what happens could vary across markets because conditions could vary across

markets, and that's important to keep in mind. One of the longstanding empirical observations in health care is there are very wide variations in amount and types of care and expenditures on care across geographic markets. In some sense, that's not particularly surprising because we do see conditions varying across markets and all of those could be good, all of those could be bad. More careful thinking is required on this.

Let me say one last thing about theory and then I want to move on to empirical evidence. I want to talk about monopsony here or buyer market power. What do we know from theory? There's no question that buyer market power, monopsony, is bad. If the other side of the market is competitive, introducing market power on the buyer's side is bad. It definitely reduces social welfare just like monopoly.

Now, those results are when price is the only factor. The quality is not variable, it's not free. We don't actually know from economic theory what would happen in markets where there's monopsony power and both price and quality or product diversity are choices of firms. We do not have results on that. But certainly it's true for price, that there's no question monopsony is bad.

What about countervailing power? Say if

there's monopsony on one side of the markets, suppose that an insurer had market power as a buyer, increasing the market power of sellers, like physicians -- and these are proposals behind the Campbell Bill and Barr-Conyers, for example -- that is very unlikely to improve matters. The most likely outcome is it makes things worse and you're just going to reduce consumer welfare further. It may improve the well-being of sellers, but it will reduce the well-being of society as a whole, under most circumstances.

As I already said, we don't actually know anything from theory about impacts on quality. We might expect monopsony to make things worse, but so far as I know, there are no results.

Let me now talk about empirical evidence. There is a clear prediction from theory about what should happen when prices are fixed, when they're not variable. Theory does not have clean predictions about what will happen when prices are variable and quality is variable as well.

Let me first talk about evidence from studies that look at Medicare, where prices are fixed, and then I'll move on to studies that look at other insurers as well, or services for other insurers.

Let me say a couple things about where the

evidence comes from. These are econometric, statistical studies using secondary data. There's not a lot of evidence at this point. It's not like there are only two or three studies. There are a number of studies, but there's not a large amount of evidence. The evidence that I'm aware of to this point entirely has to do with markets for hospital services. So, let me move on.

Evidence on fixed prices, the first study I'll mention is a study of Medicare enrollees with AMI and this, in my opinion, is the best, the most careful, the most rigorous study out there at this point in time. This study is the gold standard. There are a number of other studies, and I'll tell you about some of the results. But I think this is the best study that we have at this point in time.

The authors looked at all Medicare beneficiaries who did not live in rural areas, the AMI for four selected years, 1985 to 1994. They found that risk adjusted one year mortality, not just inpatient, but one year mortality was significantly higher in more concentrated markets. So, markets with fewer sellers or if the market share was concentrated in the hands of one or a small number of hospitals had worse outcomes in terms of risk adjusted one year mortality. And the numbers are actually pretty eye opening. Comparing

concentrated areas.

Now, this is only Los Angeles County, so it's a little hard to know exactly what that means. It's not clear that there's really sort of significant variation in competition within Los Angeles County or not. But these are the results and they do run in the opposite direction from the study that I just told you.

Mark and Phil Held, a number of years ago, looked at dialysis facilities. One of the results which he didn't mention is they found fewer dialysis machines per patient provided in more concentrated markets. In other words, less concentrated markets, presumably more competitive, there were more dialysis machines per patient which means that's easier to get in and get scheduled, more convenient and presumably better service.

Literature on the medical arms race, which looked at data prior to the mid-1980s, found things like hospital costs, hospital inpatient length of stay, service offerings, excess capacity were higher in less concentrated markets. Again, presumably in those markets, more competitive. The notion there was some kind of an arms race going on between hospitals, that may be the case. I think that most analysts concluded that that was over by the early '90s, though as Paul mentioned, there may be some regeneration of those kind

of strategies at present.

Let me move to the evidence on variable prices, where prices are not fixed, and there are a few different studies here. One study looked at the effect of a number of hospitals in a market on hospital profits and on the quantity of hospital care consumed in the market. They looked at isolated markets in the United States in 1990.

So, some large, but usually 100,000 is the

They did not find any detectable impact on inpatient mortality for heart attacks or stroke patients that was inpatient mortality only. They did find some mergers increased readmission rates for heart attack patients, which is an acknowledged bad outcome, and early discharge of newborns.

Another study looked at New York State over most of the 1990s, looking at patients receiving angioplasty, PTCA and CABG bypass surgery. This study found the following, that risk adjusted mortality was lower as a result of a specific kind of hospital acquisition, an acquisition where the acquiring hospital already provided angioplasty or bypass and the target, the acquiree, did not. There were 28 such acquisitions.

In addition, I classified this under variable prices, but rate regulation in New York State went off the books in 1996. So, prior to the period here, prices are fixed; part of the period, prices are variable. The author of the study did not explicitly account for that.

Another study looked at all heart attack patients, AMI patients, and compared New Jersey against New York, looking at the period 1990 to 1996. Now, what's interesting about this study is that New Jersey got rid of rate regulation in 1992 and New York did not.

So, they contrast the change before '92 and after '92 and New Jersey did the change before and after '92 in New York. Rate regulation went off the books in New Jersey. After '92, it stayed on the books in New York. They found that for these AMI patients, that risk adjusted inpatient mortality increased in New Jersey after the end of rate regulation.

Another study, this is the Los Angeles study, looked at not just the Medicare beneficiaries, but also HMO enrollees, also with AMI and pneumonia. For HMO enrollees, they found that risk adjusted mortality was significantly lower -- less concentrated -- that slide reads wrong -- less concentrated parts of Los Angeles County. So, the reverse of what they found for Medicare beneficiaries. For Medicare beneficiaries, they found that concentration was good for them in the sense of lower risk adjusted mortality. Here, concentration is bad for HMO enrollees. It's a little bit hard to square these two results together, but that's what we have at this point.

One more study here looked at angioplasty patients using a sub-sample of California hospitals. There were about 400 California hospitals in 1995, a little less. They found that excess mortality was lower for angioplasty patients in less concentrated markets.

So, again, if we think that competition is more intense in less concentrated markets, this has a positive effect on health and lower mortality.

Let me say a little something about volume outcome. I haven't talked about this explicitly up to this point, but one thing with regard to hospitals that one might want to think about in the context specifically of, say, a merger is the following: There's a longstanding observation that there's been a positive relationship between volume and outcome for treatments of a number of different kinds. So, heart surgery is one example of that. And that's not too terribly surprising. That accords with a lot of popular wisdom.

If we think that there is such a positive relationship and it's real, then we might think that a merger could provide some benefits potentially, because if we have a merger and volume goes up in the post-merger, in the (mergj -6 sIty then wutcome scould pe2tkke) Tj -68

probably a little bit of both. Trying to think of some third factor that affects, say, volume but not outcome, is not so easy to come by.

There is a recent study that looked at angioplasty in California, and this is not a perfect study, but it is a study that, I think, does shed some light on this. This study measured outcomes in hospital mortality and also by whether the angioplasty patient required an emergency bypass. That's a bad outcome if that happens.

So, the finding was that all hospitals achieved substantial improvements in outcomes over time. That over time, hospitals learned. But that volume didn't have all that much to do with it. So, annual volume of hospitals did have an impact, but it was relatively small, and cumulative volume at a hospital had no detectable impact on outcomes.

So, I don't know if this is the final word, but this study does cast some doubt on the notion that there's this strong relationship between volume and outcome, and in terms of thinking about, say, a merger, one might want to rethink this.

So, let me summarize, what do we know? The evidence that I told you about, the empirical evidence is only for hospital markets. The empirical evidence is

mixed. The strongest evidence I think that we have thus far is that quality is higher in less concentrated markets, which is consistent with the notion that competition does improve quality. But I do want to emphasize that there are conflicting results across these studies025

virtually no evidence on the relationship between competition -- empirical evidence -- relationship between competition and quality and physician service markets or insurance markets.

In conclusion, quality is an important aspect of performance in health care markets. It certainly should be considered in economic and antitrust analyses of competition. The antitrust presumption is that monopoly is bad and competition is good. The scientific evidence that we have at this point is not sufficient to reverse that presumption with regard to quality. As I said, if anything, my take on it is that the preponderance of evidence is that more competition promotes quality rather than the other way around.

But, certainly, there's not sufficient evidence to overturn that presumption. There is no question, however, that quality should be considered in assessing competitive impacts and I think that will be an important part of antitrust to come.

Thank you.

(Applause.)

MR. HYMAN: Just a couple of brief wrap-up

home.

Second, all of the slides that got shown today will be up on the FTC web site early next week. I'm not sure about the Department -- no, Leslie's telling me not on the Department of Justice website.

Professor Pauly referred to a compassionate conspiracy of right thinking providers. The compassionate conspiracy of right thinking enforcers, that's Leslie and myself, have decided that we're going to cancel Friday afternoon, the Little Rock session, and that is primarily because there are ice storms in Little Rock and we don't think anyone will be able to get here. The weather forecasts for Boston are more promising, so we're planning to continue Friday with Boston.

However, we are intending to schedule Little Rock at a later date. So, we won't have them juxtaposed morning and afternoon, but we will get the benefit of both.

Finally, I'd like to thank you all for coming and thank all the speakers for the wonderful presentations they gave and I think all the speakers should get a round of applause at this point.

(Applause.)

MR. HYMAN: And we will continue tomorrow morning at 9:30 in this room. Thank you again.

(Whereupon, at 4:35 p.m., the meeting was adjourned.)

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

MATTER NUMBER: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW

DATE: FEBRUARY 26, 2003

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

DATED: MARCH 5, 2003

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SONIA GONZALEZ

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

I HEREBY CERTIFY that I proofread the transcript for accuracy in spelling, hyphenation, punctuation and format.

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ELIZABETH M. FARRELL