FEDERAL TRADE COMMISSION

HEALTH CARE AND COMPETITION LAW AND POLICY

Thursday, March 27, 2003

9:15 a.m.

Federal Trade Commission

601 New Jersey Avenue, N.W.

Washington, D.C.

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

FEDERAL TRADE COMMISSION

I N D E X

P R O C E E D I N G S

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MS. MATHIAS: We're going to start on time so that we can also finish on time. It's about 9:15. Welcome to today's session of the FTC/DOJ Health Care Competition in Law and Policy hearings that we're having. Today, I assume you all know that we're going to be looking at single-specialty hospitals and seeing various issues that have arisen in the emerging single-specialty hospitals.

We aim to end today at about -- or end this morning's session at 12:15, and then we'll reconvene at 2:00, so that hopefully everybody will have a chance to get lunch and then come back and watch for this afternoon's discussion, which is hospital contracting practices.

As I'm sure everyone here is aware, the emergence of single-specialty hospitals has been going on for a while, but seems to have taken new interest. A lot of people are paying attention to it. And, you know, we are interested in seeing the various issues that have arisen, spend some time discussing those issues, and listen to voices that are involved in it. Some of the things that we were interested in hearing about today are some of the factors that have led to the unbundling, what has been the effects of this, have we increased competition, have we had a quality increase or decrease? There is also a question of access to various

consumers and patients that needs to be addressed. And we will consider whether the development of single-specialty hospitals like cardiac and cardiology is different than single-specialty hospitals such as children's hospitals and psychiatric hospitals.

I am extremely grateful to the panel for spending time to get here, to prepare before you came, and we look forward to listening to your wisdom and insight.

professor at the American Enterprise Institute.

Next, we'll move to George Lynn, who is the President and CEO of Atlantic Care, and on the Board of Trustees for the American Hospital Association. Mr. Eddie Alexander is -- do I have my order right -- I do -- unfortunately he is not in the bio handout, because we had a substitution at the last minute. We're very happy that he's here; he is the President and CEO for the Surgical Alliance Corporation.

And next is David Morehead, he's Senior Vice President for Medical Affairs and Chief Medical Officer for OhioHealth. Following David, we have John Rex-Waller, who's the Chairman, President and CEO of the National Surgical Hospitals.

After John, we have Dan Muholland, who's a Senior Partner at Horty, Springer & Mattern. And to conclude at that first conclusion is Dennis Kelly, who is the Executive Vice President of Development and Government Relations for MedCath. We will take a break after everybody's had a chance to give their seven to 10-minute presentation, and then we'll reconvene after 10 minutes and have a moderated roundtable.

And I forgot to mention that I am joined here by Bill Berlin, who's with the Department of Justice. He is one of my cohorts in pulling all this together. We couldn't do it singly. We need both agencies, and I think it gives us an

opportunity to explore these issues fully and hopefully address it in a manner -- in a unified manner later on.

Anyway, with no further ado, I'd like to introduce Cara and have her begin.

MS. LESSER: Thanks. Well, good morning. I'll get started a little while we're waiting for the slides to come up, if that's okay. David's been kind enough to help me out, since I'm about eight and a half months pregnant; I'd prefer to be seated for this presentation and not to have too much drama at these hearings today.

But I'm here this morning to share with you some of the work we've been doing in local health care markets

changes and providing information to policymakers about the implications moving forward. And website is there for those of you not familiar with us to check out some of the work we've been doing over the past several years.

At the core of our work is the community tracking study, which is an independent research effort to track health system change and its effects. It's a longitudinal study and it's been ongoing since 1996. As the name implies, the study has a community focus, based on the notion that ultimately all health care is local. We define our communities based on MSAs, so we have a consistent measure of a geographic market over time, and that's what we're really tracking in each of our rounds.

We focused on 60 communities that were selected randomly to be nationally representative, and this gives our study a unique advantage of being able to identify changes at the local level but then aggregating those findings up to speak to national trends. We have multiple ways that we collect data. We conduct surveys of households and physicians, and we also conduct site visits every two years in 12 communities of the 60 that were actually also randomly selected from the 60. These are communities with a population of 200,000 or more, so they're large metropolitan areas and representative of the areas where the majority of the population lives.

In our site visits, we interview leaders of local health systems, health plans, hospitals, hospital systems, and physician organizations. We speak with representatives of major local employers, and state and local policymakers. We really make an effort to speak with the broad range of stakeholders in each of these markets.

This map shows the 60 study sites and the subset of 12 where we conduct our site visits. You can see the sample is geographically diverse. The communities vary in size and health system characteristics. We have large metropolitan areas, like Boston, Orange County, Miami, places with, you know, large population and also extensive experience with managed care, and then other smaller communities, like Little Rock and Greenville, South Carolina that have less experience with managed care. So, it's really a broad range.

Today, I'm going to draw on early findings from our most recent site visits, which are actually still in the field right now. They were started in September 2002 and will be running through May 2003. And, as I said, I want to talk about, you know, what we're seeing with respect to specialty hospitals across the country.

I'm just going to start with a brief overview of the prevalence and key characteristics, and then describe the market context for this phenomenon from our perspective,

focusing on the various forces that are driving specialty hospital growth and the effect it's having on market dynamics. And then against that backdrop, I will just talk a little bit about the implications of specialty hospital growth for cost, quality and access to care.

Not news to anyone in this room, I'm sure that we've seen rapid growth of specialty hospitals, really over the past seven years that we've been tracking markets, but especially in the past few years. In the 12 markets that we tracked, there have been 11 new free-standing facilities that have come online during this time. Some of them are independent facilities; and some of them are joint ventures between community hospitals and local physicians. In addition, there are a number of hospitals within hospitals that the general acute care hospitals have set up as designated units that provide certain specialty services. So, while there's a great deal of attention to specialty hospitals started by national entrepreneurial firms like MedCath and National Surgical Hospitals, we're actually seeing the general acute care hospitals in local markets as very active players in this arena, as well.

Key characteristic of the speciality hospitals is physician ownership, and this is something that really distinguishes the speciality hospitals of today from the traditional acute care hospitals and from some of the

children's hospitals and other single-specialty hospitals that we've seen in the past.

There's a great deal of consistency in the services that these hospitals are focusing on. Cardiac care and orthopedics are by far the most common. We're also seeing a smattering of facilities focusing on general surgery. And one place where there's a lot of variation is in the scope of emergency services provided. Some have full-service emergency departments; others have no emergency services and rely on agreements with local hospitals for transfers; or in cases where the specialty facility is affiliated with part of a larger system, local system, they'll have an agreement as part of that system.

There are a number of market developments that are contributing to the growth of specialty hospitals. First is the retreat from totally managed care and the associated utilization controls and expectations about selective provider networks. In the absence of these constraints, there has been a shift in provider strategy from managing hospital services as a cost center toward an emphasis on promoting key services as revenue enhancers. And, in fact, many hospital administrators are quick to point out that there are certain procedures and services and service lines that are clear winners for them because reimbursement is so much greater for those services. And that's often both under

Medicare and private payors' reimbursement schemes.

Cardiac and orthopedic procedures, no surprise, are commonly noted and that's why, you know, a major reason why we're seeing a lot of the growth in this area. Actually, in our most recent visits there was a hospital CFO who told us that his entire -- the institution's entire 2.5 percent margin, which isn't a huge margin, but that entire margin was based on cardiac services alone.

A third major market development that's contributing to the growth of specialty hospitals is just the squeeze on physician income. And this is really as physicians are facing declining professional fees, they're looking to capture at least a portion of the facility fees that can help them to supplement their incomes. Plus, physicians are -- this income pressure has left them really frustrated over hospital control over management decisions and investment decisions that affect their productivity and is really pushing them to look to have a greater say in those decisions.

And, finally, just the growth of entrepreneurial firms such as MedCath and National Surgical Hospitals certainly has helped to spur the development of these facilities.

Okay, so as I mentioned, the services that specialty hospitals tend to target are a key source of

revenue for general acute care hospitals and consequently the growth of these facilities worries them a great deal. And there are three main ways that we've seen the general community hospitals respond.

First is the kind of preemptive strike strategy where the hospital establishes its own specialty facility in an effort to ward off the establishment of the competing facility in the market. Sometimes this occurs in direct response to talks between a national firm and local physicians; and in other cases hospitals appear to be pursuing this strategy, just on their own, before something like that happens. Typically, these arrangements will offer physicians some attractive features, like better O/R hours, you know, access to new, better technology, but it generally doesn't involve physician investment, so it really remains a hospital-owned entity.

The second strategy is to joint venture with local physicians. This is the "if you can't beat them, join them" strategy. And it's really what we've seen hospitals turn to more, as there's a direct threat from potential competitors in their market. And this is really a way to just stave off the total loss of business for the general acute care hospital. And one hospital executive said it pretty succinctly, I thought, which was, "a half a loaf of bread is better than no loaf of bread at all." So, this is really, I

think, for the most part viewed as a second-best strategy for hospitals, but it's something we're seeing a lot of in our markets.

Finally, there are some hospitals that have taken a philosophical stance against specialty hospitals and have refused to consider joint ventures as an option. These hospitals instead have focused on really fighting physicians who are the organizations that try to establish competing facilities. One strategy has been to use economic credentialing, which is really essentially denying admitting privileges to physicians who have an ownership stake in a competing facility. Or some hospitals also have informally discouraged plans from contracting with competing facilities in their markets. And this is something we've heard alleged in one market where a heart hospital that was opened a few years ago still has been unable to obtain any commercial contracts in that market. They're relying only on Medicare at this point.

So, in many cases these actions have been challenged in courts in a number of communities, and there are questions obviously about the legality of these actions.

From the perspective of people concerned about competition policy, the growth of specialty hospitals and the competitive response they're evoking from traditional acute care hospitals raises a number of questions around cost,

quality and access. On the one hand, specialty hospitals are based on the premise that practice makes perfect and that focused factories can promise higher quality and lower costs for consumers. But the ability to achieve this is really dependent on a number of factors, including their effects on per-case costs and quality, the relationship between supply and demand, prices for these services, their effects on patient mix and the distribution of volume across the market and their effects on access to other less profitable services. And I'm just going to quickly go into a little bit more detail on each of those.

The "practice makes perfect" argument assumes that specialty hospitals will be able to generate lower per-case costs and higher quality by becoming more expert and efficient at the services they provide. Physicians and health care executives who are involved in establishing these facilities argue that this -- the speciality facility is like a blank slate and it gives them the opportunity to redesign the care delivery process in a way to be more effective and efficient, especially since it's targeted to a narrower set of services.

They also allow the opportunity to recruit nurses and technical staff who can become more expert at this care. And it's really viewed as an opportunity to make improvements in the care delivery process. In addition, simply by

concentrating more cases in a particular facility, specialty hospitals may help to lower per-case costs and boost quality. Certainly, the health services research literature that is established literature on the volume outcomes relationship that says that the more volume you have concentrated at a particular facility, the more likely you'll have better outcomes. But these effects really are -- the effects on patient volume remain to be seen, because if you have the growth of more facilities and you spread volume across a greater number of facilities, there actually could be negative effects, both on quality and costs, and the per-case cost.

This leads to the question of the effects of specialty hospitals on supply and demand on the market. One important question is whether the growth of specialty facilities, and again, this is both on the part of independent facilities and the activities of traditional acute care hospitals, whether this is creating more capacity than there is demand for. This, obviously, is a pretty tricky question, especially given the recent capacity constraints that have emerged in markets over the past few years. And this is, you know, really for the first time in decades that we've seen capacity constraints in markets again.

On the one hand, there are a number of forces that

are driving increased demand today. There's the aging of the population, population growth, and just higher functioning and higher quality of life expectations associated with the baby boom. But on the other hand, we have new technology, such as drug-eluting stents that can have a sharp downward effect on demand. And demand, especially for specific procedures that some of these facilities are targeting. So, for these reasons, the demand curve is very difficult to predict in health care, and it's a risky proposition, because unlike in other markets, excess capacity is rarely taken out of health care markets and can play a major role in contributing to underlying health care costs.

Another area of concern for specialty hospitals is the potential for supply-induced demand, or demand that's generated due to the presence of these facilities. Again, the health services research that has been done over the past decades really has shown that this issue of supply-induced demand is particularly problematic when physicians are owners and when there is excess capacity. So, the implication here is that specialty hospitals may actually create additional demand in driving appropriate utilization that's actually cost-increasing and has negative effects on quality.

Of course, the critical question is what specialty hospitals do in terms of price, and theoretically, the more competitors, the more capacity should spur greater price

competition. But, again, the way that the specialty hospital growth is playing out in markets, there may be some real constraints to this phenomenon. In many cases, when the general acute care hospital in a community, either partially or fully owns a specialty hospital, the rates for the specialty hospital are negotiated as part of that larger system. And the desire for the system to maintain sufficient profits from these services to be able to cross-subsidize their less profitable services, such as emergency care and trauma, depresses the incentive to compete on price.

That said, it's important to point out that even if specialty hospitals don't do much to lower prices or improve the per-case cost and quality, there still is ample room for them to do well financially and be profitable if they're able to attract a more favorable patient mix. And by that, I mean patients with coverage that yields higher reimbursement, so Medicare and private-pay patients as opposed to Medicaid and the uninsured, patients with less complex cases to treat and patients who need services that are paid at higher rates. So, in that way, speciality facilities certainly can be successful on their own terms, but will not generate the broader societal gains in terms of lower costs and better quality.

While specialty facilities may lead to improved access for certain services and for certain patients, there

may be a cost from the broader system and societal perspective also in terms of the ability of general hospitals

to monitor over time. There are no clear-cut answers to these questions at this point, but I think that from our research, it really again underscores that we need to think about these within the context of the broader market environment and the effects that they're having on competition.

Just very briefly I wanted to close on some of the policy options that are out there as ways to potentially address these issues as we get a clearer sense of what the implications are. One is to look at Medicare payment policy, which many point to as a key driver in the payment differential for some of these services. And this is important because Medicare is -- many private payors use Medicare payment as a benchmark, so changes in Medicare payment potentially could have effects beyond just the Medicare population alone.

The courts provide another forum for policy influence over this activity. As I mentioned, there are a number of cases pending at the moment, looking at the ways that hospitals and physicians have responded to this activity

rules, for example, that govern physician self-referral and are looking to address these types of facilities specifically. At the state level, there has been proposed legislation looking at requirements around emergency services and really just setting some parameters for these organizations.

Finally, one other policy option to consider is alternative approaches to funding critical services such as emergency care, that don't rely on cross-subsidies. And this is something that if we do find over time that specialty hospitals are effective in providing higher quality and lower cost care, but are undermining this source of revenue for these other services, one strategy would be to look toward other payment schemes to ensure that those services are available in community health systems.

So, with that, I will wrap up.

MS. MATHIAS: Thank you very much.

(Applause).

MS. MATHIAS: Next, we'll move to Ted. You can stand or sit. By the way, for all the panelists, we allow you to choose whether you want to be up at the podium or

going to talk about is the basic fundamental economics of the single-specialty hospitals, sort of why do they exist? Most of what I say would fit for any industry, but I'll focus on hospitals.

And the first thing is diseconomies of scale and scope. Hospitals are multi-product firms supplying thousands of different services. And they have economies of scale. Larger hospitals are more efficient, up to a fairly large scale, and in my research, 200 beds or more. They also have economies of scope, most of the time, that are benefits to supplying lots of different services together. It's cheaper that way. You can spread overhead over many different services, say, MRI machines serve many different diagnoses; scheduling and nurses; the same space can be used. So, the scale and scope interact, so if you can have more of a scope of output, you can also attain scale economies in some of these services you might think of as kind of support services.

From the consumer point of view, there are also economies of scope. If you have or develop some condition that was not expected in the hospital, it's very convenient to have the services you need for that on that campus, and not have to be shipped somewhere or have some specialist shipped in.

Now, does this suggest that every hospital should

have 10,000 beds and every possible service? No. If it did, you might -- there would be a problem. There are diseconomies of scale and scope that eventually come in to play. And hospitals can obviously be too large. Information flows may be limited. There may be too many layers of bureaucracy. The competition and coordination of different resources for different parts of the hospital gets to be difficult.

So, certain services may be more efficient in more narrowly focused hospitals -- the focused factory idea. And this may work especially well if you can take those services out of several general hospitals and concentrate them on one single specialty hospital. Now, at least one thing to note in passing, that even what we call specialty hospitals still provide at least hundreds and often thousands of services. So, they're still multi-product firms, okay? They're just not quite as big of a bundle of different products.

Okay, so diseconomies of scale and scope could be one reason to carve-out a specialty and start a specialty hospital. The second thing I want to talk about, and Cara talked about this some in slightly different terminology, is price discrimination by general hospitals. Hospital competition at its best is quite imperfect. So, hospitals have market power, and so they charge more for some prices relative to other prices -- or some services relative to

other services. Or, in other words, some services are more profitable than other services. This is price discrimination.

Some types of surgery are reported to be high profit. Well, as entry barriers decline and hospital markets get more open and more competitive, what attracts entry are the high profit services, the ones with the high prices that are -- where the hospitals -- the general hospitals are benefitting by the price discrimination. So, you would expect entry to be in the most profitable lines. In fact, it could easily be the case that no one could afford to enter with a broad-based hospital, that it would have to be a hospital focused on the high-priced, high-profit lines.

One thing to note is this could happen, you could have entry, specialized entry, into the profitable lines, even if there were no particular production advantages. It's just that the less competitive lines, with the highest prices, attract entry more.

Another reason why you get single-specialty hospitals is price controls on physicians. Some physicians have very strong reputations, or they are in specialties that are scarce in their geographic area. These physicians could charge very, very high fees in a fully open market and still be busy. We don't observe this very much, because there's price controls of two kinds. One is a formal governmental

price control on Medicare and Medicaid, Medicaid Fee for Service anyway.

Then there's also informal kind of price control even in the private sector. Maybe you should call it quasi-price control and not -- I'm not quite sure -- there isn't really a standard term for it. This is the social and political and bureaucratic pressure not to charge too much over the going rate. Even if you are in a very scarce specialty or a very famous guy somewhere. This gets enforced by insurers, you know, telling the consumers what's the reasonable rate and helping them sometimes if they get sued, the courts being reluctant to enforce payment of very high fees that are much higher than average fees.

So, this private sector version is softer than the

Another reason, different reason, is the politics and economics of competition for resources within a hospital. Physicians compete for patients, of course, but they also compete internally for hospital resources, time in the operating room, and good times, not just some time; nursing support; technician support; all kinds of resources they compete for. Well, some physicians lose out in this competition, and some specialties. And one way to deal with that is to create a single-specialty hospital that you control, and then you can decide yourself on how many resources you should have.

The last general category I want to talk about is starting a single-specialty hospital can be an excellent competitive strategy for a general hospital, especially for a general hospital that's weak in that specialty, and especially in markets with not so many hospitals. So, for example, suppose there are two competing hospitals, and I actually have a town in mind for this, but for various reasons, I can't say what town it is. There are two competing hospitals. Hospital A is very strong in cardiology; Hospital B is kind of weak in it. Hospital B may start a single-specialty cardiology hospital to attract cardiologists and business from Hospital A and thereby neutralize Hospital A's advantage.

This can work even if the hospital that helps the

founding of this new specialty hospital in cardiology has no control over it. It obviously works better if they control it, but they don't have to for this to work as a competitive strategy.

So, just in conclusion, there are several economic factors that give rise to the creation of specialty hospitals, ranging from production economies to competitive strategies by existing general hospitals. It's very hard to say a priori which ones of these are more powerful, and I'll be fascinated to hear from the rest of the panel about these things.

(Applause).

MS. MATHIAS: Thank you.

MR. LYNN: Good morning, everyone. My name is George Lynn. I'm President and Chief Executive Officer of Atlantic Care, an integrated health care network based in Atlantic City, New Jersey. Atlantic Care provides a comprehensive range of health care services and serves the southeastern region of New Jersey. I also serve on the board of the American Hospital Association and I'm here today on behalf of the AHA and its nearly 5,000 member hospitals, health systems and other providers of care.

The delivery of health care in America is changing rapidly. This change is fueled by many factors, including the development of new care settings. In the midst of this

change, one thing has remained constant. Communities across America rely on hospitals to provide them access to basic health care services. They look to the mission of hospitals and the physicians who serve with them to provide care to all people, including those who are uninsured or under-insured. Community hospitals serve as the medical safety net for those in need.

We appreciate the opportunity to participate on this panel and address the effect of specialty-care providers on meeting the health care needs of communities. Specialty-care providers, those that focus on a specific set of medical services, condition or populations, aren't new, but the nature and pace of their growth is new. Historically, they were children's hospitals or psych. hospitals; now they include heart hospitals, cancer hospitals, ambulatory surgery centers, dialysis clinics, pain centers, imaging centers,

providers threatens community access to basic health services and jeopardizes patient safety and quality of care. The trend among these providers is to carve-out the more profitable services and to serve the more profitable patients. They leave the community hospital to provide unprofitable services, such as trauma, and to care for all, regardless of their ability to pay.

Specialty care providers have little or no obligations under the Emergency Medical Treatment and Labor Act, EMTALA, either because they operate on an ambulatory basis or because they don't have to have emergency departments. Specialty-care providers rely on the emergency capacity of local community hospitals. Many specialty-care providers do not participate in Medicare or Medicaid, or limit their participation when they do, and then many provide very little uncompensated care. These business decisions allow some specialty-care providers to produce service less expensively, while often being paid the same or more than community hospitals that carry the social obligations to provide care to all 24 hours a day, seven days a week, 365 days a year.

Secondly, specialty-care providers are undercutting the ability of community hospitals to meet the needs of the broader community. As profitable services are drawn away from general community hospitals, it becomes more

difficult to support services needed by the community that are unprofitable: trauma centers, burn units and emergency departments are not self-supporting. Caring for the uninsured, Medicaid patients and others who have limited coverage can only be accomplished if the hospital can rely on revenues from profitable services. If these profitable services and more profitable patients are removed from the community hospital, its ability to continue meeting the needs of the entire community deteriorates. The result? The community loses access to specific services or ultimately to all the hospital services as the general hospital deteriorates or closes.

Communities are also losing access to specialty physicians because of the growth of specialty providers. The consequences for emergency patients can be life-threatening. Many communities are already experiencing this problem as the hospital emergency departments go on diversion for all or certain types of cases. A primary reason, lack of specialty physicians willing to serve on call and treat patients in need.

At the same time, specialty providers are drawing profitable services and specialty physicians away from the community hospital. They expect those same hospitals to be their backup. Consider the safety of a patient admitted to a specialty hospital for a routine surgical procedure who then

develops complications beyond the capacity of that specialty. This surgical patient has to be transferred to a general acute care hospital for needed care. Or consider the nearby resident out for a jog who experiences chest pain outside a specialty hospital, goes inside to seek assistance and is told to call 911.

Specialty providers are increasingly owned by the same physicians who make decisions about when and where patients should receive care. Specialty physicians are making decisions about care for their patients that will also have an effect on the physician's personal financial interest. Even in a competitive environment, caring for sick people transcends to simple buy/seller relationship. Patients need to be able to trust that decisions about their care will be made on the basis of what is in the best interest of the patient, not the provider. Left to market forces alone, the incentives in a competitive market may leave some providers to make business decisions that raise issues for patients and the communities they serve.

In closing, communities will not be well served if the growth of specialty providers is viewed solely from the perspective of bringing more entrants into the marketplace. Their growth must also be looked at from the perspective of meeting the health care needs of the community. In that context, these providers do not add a satisfactory

coordinated patient-focused care.

I had actually hoped to be joined today by Dr. Adolf Lombardi, an orthopedic surgeon from Columbus, Ohio, with whom I work closely, so you could hear firsthand his rationale and support as a practicing physician for an alternative orthopedic surgical hospital model. Unfortunately, Dr. Lombardi's practice and teaching obligations did not allow for him to be here today.

Working together with our physician partners, who, like Dr. Lombardi, regularly face the challenges of our current system of delivering patient services, we have undertaken to develop a new orthopedic, neurosurgical specialty hospital that we believe will enhance patient care and also stimulate competition in the central Ohio health care marketplace.

Specialty hospitals are emerging throughout the United States, establishing new models for success in patient treatment. What motivates the evolution to specialized ambulatory surgical centers and specialty surgical hospitals? It is a common-sense, intelligent response to a mature health care delivery system and industry gripped by inefficiencies and to health care spending being out of control. Health care spending represents over 13 percent of our gross domestic product, or approximately $1.3 trillion. Over a third of those costs are tied to hospitalization. While

medicine. Our shared purpose is to establish a premier Central Ohio facility dedicated to offering the patient the latest in technological advancements in the field of orthopedic surgery. Our primary mission is to provide our patients with the best orthopedic care in the entire world. Further, we share a common commitment to continue to be a positive asset to the community in part by doing our fair share in treating those who cannot pay, sometimes referred to as charity care, and by devoting significant resources to the training of new professionals and to the research and development of better care and treatment for musculoskeletal disease.

What prompted this undertaking? It was not a decision made lightly. Our physician partners have established well respected practices based in Columbus, with patients from across Ohio and every state surrounding Ohio. Quite simply, we and they believe that the New Albany Surgical Hospital, or NASH, set to open later this year, will allow our physician partners to provide better, more timely patient care, at a reasonable price in a more patient-focused and friendly environment. In essence, we want to provide our patients with the best care possible in a cost-effective manner.

For hospital services, the geographic distances that patients must travel tend to define a market, and be

barriers to competition. Our new hospital will be located in New Albany, a suburb of Columbus, Ohio. The local health care marketplace in Greater Columbus is dominated by three major hospital systems: OhioHealth Corporation, Mount Carmel Health System and Ohio State University Medical Center. Our proposed venture has met with stiff and coordinated resistance from these large, not-for-profit hospital systems that control all eight general hospitals and 100 percent of the in-patient hospital beds for adults in the Columbus market.

Their efforts to maintain the status quo are driven not by quality, cost efficiency or the desire to preserve the delivery of charity care to the community, but rather by the fear of having to compete, of having to look within their respective institutions to improve efficiencies and to enhance the timely delivery of patient care.

The operating rooms at in-patient hospitals in Columbus are at capacity. Physicians try to block or reserve operating room time. However, if the physicians are unable to negotiate adequate time, then they must simply wait on standby for an operating room to become available. Recently, two of our physicians have had waits of over 30 days in the Columbus market before gaining operating room time, certainly not an optimal situation for a patient needing orthopedic surgery.

Given the relative small size of NASH, eight operating rooms and 42 beds, our intention and expectation has been that much of the work of our physician partners would continue, as always, at their traditional general hospital facilities. NASH cannot accommodate, nor was it designed to accommodate, all of the operating room time and staffing needs of our many physician partners.

When completed later this year, NASH will account for less than 1 percent of the hospital beds in the Columbus area. Our initiative will certainly help the problems that our practicing physicians now face of insufficient operating room time options, but it is not really a realistic threat to the general hospitals.

NASH is under construction and is scheduled to open this November. In an effort to forestall competition, two of the hospital systems in Columbus, OhioHealth and Mount Carmel, recently passed resolutions to revoke existing privileges of medical staff members and to withhold new privileges solely on the basis of a physician's investment interest in NASH or any competing specialty hospital.

Dr. Lombardi has dealt with this prohibition firsthand. Although Dr. Lombardi has performed virtually all of his in-patient surgeries over the last few years at an OhioHealth hospital, he has been put on notice that OhioHealth will revoke his privileges at that hospital after

a short list of accepted facilities serves only the interest of the accepted hospital and rarely is it in the best interest of the patients. Not only is this activity anti-competitive, vis-a-vis the affected physician, but it also has a chilling anti-competitive effect on the entire marketplace for the delivery of those medical services.

Not-for-profit hospitals or NFPs account for about 85 percent of all hospitals in the U.S. and 100 percent of the hospitals in Columbus. They hold a great advantage over specialty hospitals, given their existing market domination. Despite their complaints of unfair competition, these large hospitals have more capital, more resources and the leverage of possessing dominant market position.

In addition, they are accorded, in exchange for certain unprofitable community services, a wide array of special treatment from the legislature and the regulatory community. Not the least of these preferences is the fact that the hospitals, not-for-profit hospitals, pay no state or federal income taxes or local property taxes. In many states, the hospitals have also been protected from competition through certificate of need programs, yet another barrier to new market entrance.

Ohio's certificate of need program for hospital expansions was eliminated by the Ohio General Assembly in 1995. State Senator Lynn Watchman, the Chairman of the Ohio

Senate's Health, Human Services and Aging Committee, observed recently that this deregulation is just now beginning to yield good fruit with a more competitive landscape in Ohio.

Specialty hospitals and surgery centers are not a new idea in Columbus. They're not a new idea in the State of Ohio or most of the United States. Currently in Central Ohio, OhioHealth, Mount Carmel and Ohio State all are in the process of building specialty heart hospitals. Within the Mount Carmel Health System, St. Anne's is currently constructing a specialty women's hospital. It is widely acknowledged and accepted that organizing care around a particular disease or population, such as children, creates tremendous efficiencies and precipitates better patient outcomes.

Our new orthopedic specialty hospital affords the same benefits to the community. It seems, however, that the current dominant market leaders would prefer that the creation of these new specialized centers only be permitted if undertaken by them rather than others.

The natural barriers to entry for a potential entrant into the marketplace, money and acceptance are supplemented and strengthened in the Columbus area by the existing hospitals. These competitors are using several actions as barriers to entry. Threats of denial, staff privileges to physicians who invest in NASH, adverse

publicity about NASH, and legislative lobbying to try to obtain legislation that would bar physicians from referring patients to in-patient hospitals in which they have an ownership or investment interest.

Our specialty hospital will provide better patient care at a more reasonable price and in a more patient-friendly and caring environment. The argument for specialization in health care is too compelling and affords too many benefits to be thwarted either by policy or anti-competitive conduct. Instead, we must encourage superior models of health care delivery to promote innovation and

prestigious medical facility in Ohio, operates its Florida hospital as a for-profit facility.

MS. MATHIAS: Mr. Alexander?

MR. ALEXANDER: Yes.

MS. MATHIAS: You need to wrap it up, please.

MR. ALEXANDER: Okay. I'll quickly say that our struggles need not to have come at all. We made overtures to the hospitals in Columbus to actually be our partner, but were rebuffed. In addition to engaging in economic credentialing, the hospitals in Columbus are essentially colluding. An OhioHealth media spokesman basically said in a September news article, "We are all on the same page. The coalition is far enough along now. It's just an understanding, we're all on the same page."

In closing, let me reiterate that Surgical Alliance Corporation and the NASH physician partners have a primary interest in creating in the New Albany Surgical Hospital, a specialized environment that not only assures, but nurtures, collaboration among the most skilled medical and support staff, which, when combined with high quality patient care that is focused on a distinct specialty, results in better patient outcomes.

Thank you for your time and attention.

(Applause).

MS. MATHIAS: Thank you.

DR. MOREHEAD: I'm here to tell you a simple story. And, Edward, after your presentation, to use a Paul Harvey term, maybe the rest of the story. Our story begins in the first few months of calendar year 2002. Members of the OhioHealth Board of Directors learned of two different orthopedic groups that planned to build competing orthopedic hospitals that provided in-patient services; that is, beds, whereas in-patients would be admitted.

The news invoked intense concern among members of the Board of Directors. First of all, these were orthopedists who had practiced for many years in our facilities. Second, they were concerned about the impact on the overall health care delivery system in Columbus. For many years, the four major providers of care, hospital providers of care, in Columbus had provided excellent, effective, efficient services in Columbus and, in fact, all of the uncompensated care without a tax base. They were concerned whether or not their hospitals could continue their missions, because it is correct, as you've already heard this morning, that it is the profitable services they are taken away that jeopardizes a hospital's capability of providing unprofitable services.

And, finally, they were concerned about taking any action at all against the medical staff. It is highly unusual for the Board of Directors to have an adverse impact

on the interests of their medical staffs.

The Board set out on a journey, and the journey was a journey of discovery. And the discovery was to analyze in great detail these different concerns that they had and to develop a response. I wish that I could introduce you to our Board. You'd be impressed, like I'm impressed. Twenty-eight outstanding leaders in our community; industrialists, bankers, lawyers, physicians, dentists, psychologists, business owners. These are people, some of whom represent the largest employers in the Columbus and surrounding areas. All are volunteers. All are deeply committed to the best interest of the community. None are compensated, nor do they receive any perks. These are people who are doing a difficult job because their heart is in their work.

I want to review for you the journey of discovery that led this group of committed, thoughtful, credible citizens in Central and Southern Ohio to make a very difficult and a very painful and a very bold decision to terminate or withhold privileges from physicians who invest in a for-profit, limited-service hospital which provides in-patient services. Now, as I say this, I realize that we're in the midst of a national debate, and that is good. But this is the story of a single group of people who made the decision that they could.

I'll go through some of the insight that the Board

had and struggled with as they discussed this over a six to eight-month period. First of all, the Board members realized very quickly that they had the fiduciary interests of the charitable trust. Ohio law very clearly places the burden of protecting the charitable interests of non-profit hospitals upon the Board of Directors. They are responsible for monitoring and maintaining and preserving fiscal stability. They must protect the non-profit corporate interests. In hospital lingo, that is protect the hospital mission. That's their job, and they set about with great energy to be faithful to that trust.

The first thing that they responded aggressively to was the insight that investment in a competitive in-patient facility created a very severe conflict of interest. Let me describe conflict of interest as we see it. Conflict of interest is when a physician has privileges, and that means the ability to admit patients to different hospitals, but that physician has a financial interest in one of those two hospitals. The concern is self-evident: A physician would make a decision to admit a patient -- that was profitable -- to the hospital in which he or she had that financial interest to enhance return.

I'd like to talk about this conflict of interest in two different ways. First of all, I'd like to describe the inherent conflict of interest. Good, competent,

to pay you for direct patient care, but we really don't want you to make money on your decisions that don't involve direct patient care." That's been society's stance to this moment and that was a major conclusion from the Board.

Let me point out right away that competition is not the issue. Competition is good. Competition in terms of quality of care and service is very healthy, and it will make us all better. But competition ought to occur on a level playing field. There should be some justice in the competitive rules. The model used to develop for-profit boutique hospitals in the past has always been to capture physician investors, so that referrals will be guaranteed.

Physicians determine where a patient goes for care, some 80, 90 percent of the time. And to give the physician of referring patients to a facility in which he or she has financial interest appears to the OhioHealth Board as being definitely unfair competition.

The Board decided that it was not required, in face of these insights, to sacrifice the interests of their charitable institution in favor of the physician's self-interest, and this was particularly notable because of the strong affiliation and the rich heritage of the Methodist Church, of which OhioHealth is a part.

I'll never forget one of our Board members sitting in the Board meeting, and we had had a lively and a spirited

discussion, as many of them were. And he finally pounded his fist on the table and he said, "You know, you just can't be a partner and a competitor at the same time." And that's a fairly self-evident statement from one who struggled with this issue.

I'd like to close my comments and read to you a quote. Last week my sister and I came to Washington on a sightseeing tour. And we happened upon the FDR exhibit, and I took a picture of one of the quotes from FDR, and I'd like to read that to you. "The test of our progress is not whether we add more to the abundance of those who have much. It is whether we provide enough to those who have too little."

I thank you.

(Applause).

MR. REX-WALLER: Well, thank you to the Department of Justice and the Federal Trade Commission for organizing this hearing, and I appreciate the opportunity to participate on the panel. I'm John Rex-Waller, and I'm at this hearing representing both the inairo parplausetaA, tha.ring

freestanding specialty surgical hospitals. We're pleased with the FTC and the Department of Justice's interest in competition in our industry. We're yet a relatively small part of the $1.3 trillion that is spent on health care in the U.S., but I think we're on the leading edge of health care innovation in this country.

Given the opportunity to participate on a level playing field, free from unfair trade practices, specialty surgical hospitals create choice and provide competition in the health care marketplace, in addition to providing

room. And in San Antonio, the Spine Hospital of South Texas is not a full-service multi-specialty facility. It focuses on spine surgery only. That's the only thing that it does. It just does spine surgery. It has an E/R, as it is mandated by the state licensing requirements for an acute care hospital. All of these facilities have acute care hospital licenses and they all are subject to EMTALA. We take our EMTALA responsibilities very, very seriously.

Whatever form they take, the case for the specialty surgical hospital is compelling. These facilities have arisen from a demand from physicians, patients and payors, for a more efficient patient-friendly and cost-effective location to provide medical care that has been traditionally provided in the full-service hospital. Although perceived as a new phenomenon, these hospitals are simply another manifestation of trends that have been evident for decades.

Witness the growth in ambulatory surgery centers from which surgical hospitals have grown. No single factor can be said to be the cause of the unbundling of surgical care from the full-service hospital. Rather, it's the confluence of the following factors that have caused the emergence of the ambulatory surgery center 25 years ago and

In excess of 80 percent of all surgical cases are done in an out-patient setting. This is up from less than 20 percent in 1980. On average, 85 percent of the cases done in our surgical hospitals are done on an out-patient basis. During the past few decades, surgery has been transformed as surgeons and their patients have migrated to ambulatory surgery centers and more recently their close cousins, surgical hospitals.

This has been driven by technology, technological advances, particularly in endoscopic surgery and in surgical techniques and in advanced anesthetic agents. It's also physician demand for efficient surgical facilities and specialized staff dedicated to elective procedures. It's also patient demand for a non-institutional, friendly, convenient setting for their surgical care, and payor demand for cost efficiencies as evidenced by the ambulatory surgery center industry, as well.

practices and are demanding to regain control of their work environment. The facility that allows surgeons to start on time, do more cases in a given amount of time, and get back to their office on time has a huge impact on their practice efficiency. So, surgeons have decided to put their own money and reputations at risk and have developed their own surgical facilities which will be less bureaucratic, less political, more accountable, and will provide better, physician-oriented, patient-friendly, superior patient care.

The consumer choice movement, patients as consumers, the single largest growth sector within the managed care industry is the point-of-service plan. This allows patients to choose their own provider. Patients are voting with their feet, moving to plans that give them freedom of choice. What patients want is more control, more personal attention, and again, a less institutional environment and better value, all of which are provided in a specialty surgical hospital.

Last on this topic: Employee satisfaction. Nurses are the principal employees of a hospital. The working environment in a large hospital, and in any large institution for that matter, distances employees from their customers, the patients in this case, and administration. Nurses are unhappy with their work environment, and they've left the profession in droves, leading to the chronic nursing

shortage that we have.

Smaller work settings offer a better, more customer-focused service orientation and a smaller, flatter administrative structure. Just being small makes it a lot more convenient for employees to work there. It makes a

seeing: Exclusionary contracting; economic credentialing, where the owning a competing facility is cause for the removal of a physician from staff; abuse of the appeal for a CON process in those states where there are CONs; regulatory legislative efforts to encumber specialty facilities with unnecessary regulation and mandatory services. I'll comment on that later if we have time. Direction of cases through hospital ownership of captive health plans. The salaried physician to captive health plan referring into an existing hospital. That's certainly a clear conflict of interest. Threats and actions against surgeons in allocating prime operating room times. It happens all the time. Threats and actions and interference in the referral patterns of primary care physicians to specialists.

We're not so naive as to expect that when we announce to a community the development of a new competing hospital it will be welcomed with open arms by the existing acute care hospital, but truthfully, we've been surprised and disappointed by the antagonistic and sometimes irrational contact we've encountered. For example, in Logan, Utah, Logan Regional is an IHC, Inter-Mountain Health Care, hospital located in Northern Utah. When faced with competition from a new surgical hospital, Logan Regional did not hesitate to use its size and contracting power. Logan Regional and IHC, which control approximately 75 percent of

relationships with competing facilities, so that the hospital may use this information in its medical credentialing process.

Durham, North Carolina. Duke University Medical

National Surgical Hospitals certainly hope that the Department of Justice and the FTC take note of these concerted efforts by large hospitals and associations to impede, if not eliminate, the development of specialty surgical hospitals.

Just as the development of surgery centers was first opposed, but I note later embraced whole-heartedly by hospitals, they are now opposed to the next innovation -- the delivery of surgical care. That is, unless, of course, it's they and not a new competitor who is delivering the new care.

The old-line establishment of health care cannot be so parochial as to believe that blocking progressive forms of health care delivery is in the best interest of our nation, our communities or our patients. I think that a quote from Roscoe Starek, who is a former FTC Commissioner, and this was echoed by Chairman Muris in November of last year, is appropriate. He said, "The Commission does not favor one type of health care delivery system over another. Rather, we work to keep markets open to new and existing" -- my emphasis -- "competition so that consumers and providers can make their economic decision. The Commission seeks to ensure the delivery systems may develop and grow if they meet the preferences and needs of consumers and that anti-competitive behavior does not impede the development of health care alternatives." I think this must be the position

of federal and state policy.

We encourage the FTC and the Department of Justice to actively promote innovation in the delivery of surgical care by doing everything possible to prevent the anti-competitive behavior that threatens the viability of our new and recent industry. Thank you very much.

MS. MATHIAS: Thank you.

(Applause.)

MR. MUHOLLAND: Good morning, everybody. My name is Dan Muholland. I'm from the law firm of Horty, Springer and Mattern in Pittsburgh, Pennsylvania. We're a single-specialty law firm of 14 attorneys who only represent community hospitals around the country. We have over 300 active hospital clients in all 50 states. And let me just preface these remarks by saying that in making the presentation today I'm only representing the views of myself and the firm and not of any client. We're not here on behalf of any client.

I'd like to thank the Department of Justice and the Federal Trade Commission for this opportunity. The last time I had any official communication with the FTC was when they served a subpoena on me, trying to depose me regarding legal advice I gave in the Freeman Hospital merger case. But, fortunately, that had a happy ending, and it's nice to be here on less than contentious terms.

As I said, all we do is represent hospitals. And not a day goes by that we don't get a call involving this particular issue: The effect of carve-out competition, single-specialty hospitals, out-patient surgery centers or independent diagnostic facilities on community hospitals and their ability to perform the services that they provide to the public.

And I just wanted to make a few observations today in response to the questions that the FTC and the DOJ raised regarding this issue. Now, many of these have already been discussed by the other speakers, so I won't dwell on them, but there are a few things that I think need to be covered, in addition to the observations already made.

As to the factors that drive the unbundling of hospital in-patient services, it isn't all about money, but that's a big part of it. Obviously, doctors would like to supplement their professional income with the facility fees or technical component income that comes with having an ownership interest in a facility. But that's really a small part of it. Another big revenue driver is the fact that because of some of the efficiencies that can be done in a facility only devoted to one specialty, they're able to drive more volume through the facility and thus increase revenue that way.

Most of these organizations do not have the same

level of charitable obligations or commitment as their non-profit counterparts because they're organized as for-profit facilities. And in many cases, but not all, as some of the speakers observed, they have minimal amount of existent emergency obligations. Even when they do have an emergency room because they're focused on a single specialty the scope and type of emergency services they have to offer, especially with respect to the emergency room call coverage that has to be provided in different specialties, is limited.

Finally, one thing that's often overlooked is that the single-specialty hospital, when it involves physician investors, gives the physicians an opportunity for diagnostic revenue, from MRI, CT scans, nuclear cardiology. This tends to be fairly high-paying, along with some of the procedural things done in the hospital that wouldn't otherwise be available to them -- either because of the type of things that they can have in their office or some of the existing legislation and regulation that applies to relationships between physicians and entities to whom they refer services.

Some of the fraud and abuse laws have quite the opposite of their apparent intended effects in terms of driving more hospitals and more physicians towards ownership interests in single-specialty hospitals. Of course the Stark "whole hospital" exception specifically permits doctors to have an ownership interest in the hospital. But the in-

office ancillary service exception is fairly limited and would not allow competing physician groups to pool their resources, except in rural areas, to get diagnostic revenue outside of the diagnostics that they can offer in their offer.

Finally, the safe harbor by the Office of Inspector General on ambulatory surgery centers limits participation to physicians who do a predominance of their work in an outpatient setting. So, if you had an orthopod, for instance, who did a lot of hips or a lot of complicated in-patient procedures, that orthopod might be outside of the safe harbor for a surgi-center, but could come back into a safe harbor with respect to ownership interest in a whole hospital.

Now, what have been the effects of this unbundling? Well, a lot of the speakers have mentioned that physician ownership interests influence referrals. That's almost intuitive. And there have been some studies that suggest that utilization increases. The real problem, however, is how this kind of competition can adversely affect a full-service community hospital. Hosptals may be the victims of patient dumping or cherry-picking in terms of more highly paid patients having services done in a physician-owned hospital as opposed to the full-service hospital; whereas those physicians would still treat indigent patients

or Medicaid patients in the hospital.

We once looked at -- very recently, one of our clients in Tennessee who was looking at some competition from some surgery centers, once the surgery center opened, one of the orthopods on staff had previously done only about 20 percent of the work in the hospital was Medicaid work -- TennCare as it's called in Tennessee. After the surgi-center opened and the doctor moved most of his practice there the doctor's TennCare load at the hospital jumped to about 80 percent. This suggested that he was using the hospital almost exclusively for his TennCare patients and diverting his paying patients to the surgery center.

Another thing that's often overlooked is that staffing shortages (which are already pretty bad in various nursing specialties, anesthesia providers and pharmacists, as well as some technical professions) become much worse when a new hospital opens, a single-specialty hospital, opens in a community. Already short staff are diverted over to that hospital, bidding up the costs of nursing services and other technical support services for all the hospitals in the market.

Peer review sometimes can be ignored or even outright abused. There was an example of that recently in the plea bargain case in Michigan, where a hospital and two of its medical staff leaders pled guilty to various fraud

charges because, according to the Department of Justice, they

can begin to suffer.

Have costs and access been increased or decreased? Well, we think that cost increases are quite likely as a result of this competition, as the result of increased utilization, competition for the support staff that I mentioned, as well as duplication of facilities in communities that probably don't have the demand to support two facilities unless, as the Professor suggested, it's supply-induced demand.

Access can also decrease as a result of the

becomes diminished and they become a weaker competitor of their fully integrated, full-service counterpart.

Is this development any different than the emergence of specialized hospitals for children, rehab or psych? Well, I'd suggest that if it wasn't different we'd be seeing a lot of for-profit plays in obstetrics and pediatric hospitals. We simply aren't seeing that. We're seeing it when there is a possibility of favorable reimbursement, which makes sense from the standpoint of the investors.But traditional specialized hospitals usually serve populations with limited reimbursement and high numbers of indigent patients.

Physician ownership, however, will skew competition. Basically, the physician owners of a hospital, single-specialty or otherwise, will have a de facto exclusive arrangement with that hospital. And because of that de facto exclusive arrangement, their decisions about where and how care is provided will be influenced by that investment interest.

But what actions have hospitals taken in response to the emergent single-specialty competitors? Well, there's a number of things. Some people mentioned preferred and exclusive managed care contracts. We helped litigate the Surgery Care Center of Hammond case in Louisiana recently where the Fifth Circuit ruled in favor of the hospital. At

the nub of that controversy were some preferred relationships that North Oaks Medical Center had entered into with managed care providers in the New Orleans area. The surgery center complained that this constituted attempted monopolization, but the court found in favor of the hospital. First by saying the hospital lacked market power; and second by saying that even if it had market power, this would be a reasonable way to compete -- basically trading lower volume or lower prices in return for higher volume.

Refusal to cooperate with single-specialty hospitals, we think it's perfectly legitimate. And this issue came up in the North Oaks case, as well, for a full-service hospital to decline to enter into a transfer agreement with a single-specialty hospital or surgery center, unless the surgery hospital or specialty hospital agrees to indemnify the full-service hospital for uncovered costs as a result of the transfer.

We also have seen a number of things that hospitals have done to compete with single-specialty hospitals by way of denying certain types of relationships to physician investors. This was discussed by a number of the previous speakers. Certainly, we would think that a physician who has an investment interest in a competitor would be barred from board membership on a full-service hospital by virtue of the fact that this would violate the

fiduciary duty of loyalty, as well as possibly causing some problems under Section 8 of the Clayton Act.

Hospitals have also determined to deny medical

community's ability to provide for its health care resources.

And when we work with hospitals, we usually tell them to suggest to their physicians that because of all of the other hostile factors in the health care environment today that it's best that they stick together, and that they quote Ben Franklin to them, by saying that, "We all have to hang together, or else we'll hang separately." And if that doesn't work, we revert to the immortal words of Bart Simpson, who said, "Listen to your heart, not the voices in your head."

(Applause).

MR. KELLY: Good morning. My name is Dennis Kelly. I serve as Executive Vice President of Development and Government Relations for MedCath Corporation. MedCath is a national provider of cardiovascular services, publicly traded and headquartered in Charlotte, North Carolina. Currently we have approximately 5,000 employees throughout the United States.

We appreciate the opportunity to speak on behalf of our organization, our physician partners, other professional staff, and the patients who have utilized our hospitals and our services. I want to especially thank the Federal Trade Commission and Department of Justice for framing the following questions for our response. And those questions have been covered previously: the factors driving

market are somewhat unique to other places.

When we talk about a heart hospital -- that is a freestanding, general, acute-care hospital designed to focus primarily on cardiovascular care. We treat all patients regardless of their ability to pay. And, in fact, studies have shown that we either are comparable to the Medicaid and indigent patient provision or we're in the top half in those respective markets. The typical hospital has 32 to 112 beds; all of these are intensive-care or coronary-care equipped. Typically it has two to six cath labs and two to four operating rooms. And we partner with physicians, both economically and operationally.

The medical staff of our facilities also is a little bit unique and candidly has not been described. We have basically -- the typical staff is 250 to 300 physicians. Of that 250 to 300 physicians, only 15 to 70, 15 on the low end and 70 on the high end, the average probably 35, are investors, but of that 250 to 300, that includes all of the

suggests the reverse is true. We are adding capacity to the emergency system and are able to treat a significant portion of the non-cardiac patients that come to our facility.

Also, on the other side of that, though, is the transfers from other hospitals to our hospitals. I think this gives you some idea of what is the role of our type of hospitals in the communities that we serve. Transfers to MedCath heart hospitals from other short-term hospitals, in the last 12 months, through the end of February, we received over 7,000 patients, in-patient admissions, from other short-term hospitals. That represents 22 percent of our entire in-patient admission base for that 12-month period.

The high percentage of our admissions that were transferred from other short-term hospitals confirms that our hospitals are providing a tremendous service to the regional health care network by adding critical cardiac capacity to the system. We believe the majority of these transfers come from rural hospitals that are part of the 76 percent of all hospitals in the United States that do not have open-heart surgery. And when we talk about having a critical mass, as several of the speakers have talked about, you know, if you look at cardiac, and I'm not speaking for the other specialties, cardiac is very unique. Seventy-six percent of the hospitals in the United States do not have an open-heart program. So, it's hard to say that you have to have that

program to survive.

One of the things that we've done is we look at, obviously, to secure a lot of contracts, managed care and third-party contracts in the United States, you have to have your facilities reviewed and certified by the Joint Commission on Accreditation. This gives you the latest survey results for all of our hospitals.

Competitive impact: What has been the impact of our hospitals in the markets that we enter? We increase access to cardiac-monitored beds; we improve access to emergency services; we improve clinical outcomes; we reduce the costs resulting from shorter hospital stays; a higher percentage of our patients are discharged directly to their home; and an efficient use of critical nursing labor pool. If you, you know -- and this is a big issue. We have a labor shortage, a nursing shortage throughout the United States. I can tell you that if you give us the same 100 nurses that you give another health system that's doing cardiac care, we'll treat more patients with those 100 nurses.

Higher patient satisfaction -- it's a new competitive benchmark in the marketplace. We measure lots of things. One of the things we measure is patient satisfaction. This gives you an idea. We try to survey every patient upon discharge, and this just gives you some idea of how patients feel about being treated in one of our

facilities. The thing we look at, of course, is the very last one, would you return, and that scored 98 percent as a cumulative score for the last three years.

Let's talk a little bit about this issue of outcomes. The good news is that the Lewin Study -- Lewin is a nationally recognized health and human service research firm -- does a lot of work looking at government programs, to make sure that the value being provided for the government dollar is a good value. We've looked at them now for the better part of the last four years. They've done a lot of research for us, and we've shared a lot of this research. I think we're the only national health care company that actually has released clinical outcomes and published those results.

This is on a risk-adjusted basis, using a common APR-DRG risk adjustment, similar to what the CMS has used for years. If you look at it, in fiscal year 2000, we had eight hospitals up and running. There were another 946 hospitals in the United States that had open-heart surgery programs that were not major teaching facilities. In addition, there are 193 major teaching facilities. If you look at the bars on the far right, the case mix index, you will see the red bar, MedCath has a significantly higher case mix index than both the peer community hospitals, as well as the major teaching hospitals. And this is not a sample. This is all

Medicare discharges in the United States for fiscal year 2000. The length of stay for that population of patients was on a risk-adjusted basis for -- everyone's been -- you know, it's a comparable measurement, 4.12 for MedCath, 4.99 for peer community, and as you can see, 5.31 for the major teaching hospitals.

And the thing we look at most is in-hospital mortality. Okay, we're treating a sicker population, or a more complex patient population. They're in the hospital for a shorter amount of time. What is the mortality at discharge? And as you can see, we have a significant difference in the mortality at discharge, which is why we have such patient satisfaction and word of mouth referrals from our patients.

In addition, one of the studies -- what the study pointed out, what happens to our patients when we discharge. Ninety percent of our patients are discharged directly to their home versus 72 percent for the peer community hospitals and 70 percent for the major teaching facilities. That resulted in saving the Medicare program over $1,000 per discharge for the discharges that we treated that year. We

discharge designation, and you apply that times the 1.5 million Medicare discharges during this same period, you would have a savings to the Medicare system of $1.5 billion.

We recently received the data for 2001. The results were very, very similar to what we had in 2000. In fact, the deltas are larger now. Everyone's improved, which we're grateful for, both the peer community hospitals, the major teaching hospitals, and our facilities.

What actions have existing competitors taken? The approach has been interesting. You've got -- as I just flip through it -- you've basically heard all of them: economic credentialing; trying to deny privileges at a hospital; basically denying, as Cara talked about earlier, in one market, the managed care plan is owned 50 percent by the health system that has a dominant, monopolistic position in that market. As soon as the hospital was opened, they took the physicians off of that insurance plan, even for those patients treated in their office and in the other hospitals where the physicians have still, to this day, maintained privileges. That's been one of the common things.

It's interesting, the emergency department is one of the areas that concerns us the most, because on the one hand, we're told, we want you physicians to continue to support call panels at your community hospitals. On the other hand, though, we're now going to take you off the

emergency department call rotation because we're trying to punish you.

Additionally, they tried to remove the physician from provider panels for hospital-sponsored or affiliated insurance plans, managed care plans and others, as has been talked about. Removing investor or potential investor physicians from extra assignments under the control of the hospital under which the physicians have the opportunity to earn professional fees, for example, graphics panels that are interpreting x-rays, EKGs, and ultrasounds that help determine a patient's need of care. Removing a doctor from the post as chief of cardiology at the competing hospital, reserving these opportunities only for physicians that do not support competition.

And then, in addition, probably the most aggressive tactic that's been used is to go to a group of physicians already in that market and basically tell them if you'll leave the practice you're currently in, we'll go ahead and guarantee your salary for the next two years, and we'd like you to form your own group to come over. So, they're basically just trying to fracture the existing practices.

What's interesting about all this to us is the, you know, how do people view --

MS. MATHIAS: Mr. Kelly, I'm going to have to ask you --

MR. KELLY: Yes, wrapping up. I just have -- so, can I finish up now or --

MS. MATHIAS: Yes.

MR. KELLY: Okay.

MS. MATHIAS: Go ahead and finish.

MR. KELLY: The last thing I would like to do is just share with you a letter that we received from the Secretary of Health and Human Services, Tommy Thompson, last July, upon the announcement of a project up in Milwaukee, Wisconsin. "As your governor for 14 years, nothing was more important to me than the health and well-being of my fellow Wisconsinites. Now, as Secretary of Health of Human Services, I'm focused on the health of all Americans, but I don't mind saying that it's still Wisconsin that holds a special place in my heart. That's why it's such joy to know that Milwaukee and MedCath are joining to improve the quality of cardiovascular care in Wisconsin. This is the sort of public/private partnership combining the resources of government with the innovation of the business world that makes America great. In teaming together to find new ways to serve your fellow Americans, you truly have shown yourselves to be foot soldiers in what our President called the armies of compassion. It is something to be proud of. As I said, this is a great day for Milwaukee and Wisconsin. On this site, you'll do more than just treat heart disease, you'll

give a father another day with his daughter; you'll give a son a chance to have his own children; you'll give a mother time to see her grandchildren. You'll save lives, my friends, and there is no higher calling. For all this and on behalf of the President of the United States, let me say thank you; and on my behalf, congratulations on helping

going to at least shoot for the week. And then later within about 30 days, we'll have the transcripts from these sessions also posted on the website. The extra materials are actually on the FTC website, and not the DOJ website, because of certain rules that the various government groups have, so I'm sure Justice would love to have them, but it's just not an opportunity that's available. So, I wanted to be sure to mention those opportunities.

And, Bill, do you want to start with the first question?

MR. BERLIN: Sure. This question really is for anyone on the panel, but perhaps it's addressed to the people that are more pro, is one group, and more con is the other and then perhaps at the end Professor Frech and Ms. Lesser could give an overview. And basically, it's pretty fundamental, and that is: What is the impact on cost to consumers and perhaps this could even be extended to quality and access to care, of single-specialty hospitals?

On the one hand, I think that we've heard -- I mean, I think the theme that I'm picking up is that as to the particular specialty that a given single-specialty hospital may be engaged in, that perhaps the cost could that lower quality of care might be better, and patient access might be better.

But, on the other hand, that perhaps it's

diminishing each of those factors, you know, market-wide when you talk about the loss of income, loss of cross-subsidies to hospitals.

So, I guess, to the people here that are on the pro-single-specialty hospital side, what is your response to that? Do you think that there is an overall loss to the market as a whole? And for the other folks, sort of the flip side of that, would you concede that perhaps costs are lower to consumers for that particular specialty, but that is, you know, outweighed by the overall detrimental effect?

MS. MATHIAS: And just a quick point, I think you were done with your question?

MR. BERLIN: I was.

MS. MATHIAS: So that we -- I assume we have a panel that wants to add a lot to all of these questions. To help us organize and moderate, if you would like to answer one of the questions, if you could just -- I know it sounds silly -- but turn your tent sideways. That way we make sure that you are recognized and we can address everyone that way. Thanks.

MR. BERLIN: I mean, we'll start at this end if you -- one of you want to jump in there, I'll pick on people, since I wasn’t overly specific.

MR. KELLY: Would you like me to respond?

MR. BERLIN: Mr. Kelly, yes.

physicians working directly with us is one of our advantages.

On the physical plant side, yes, we're adding, you know, bricks and mortar and a physical plant, and so I think it will take some time to figure out, you know, what's the impact of that, adding that additional cost to the marketplace. In some cases, there's pure consolidation, so you introduce it, as Professor French said, you end up basically closing or consolidating a couple of existing programs for all the right reasons into that heart hospital. And, therefore, in that case, it definitely is beneficial.

MR. BERLIN: Mr. Muholland?

MR. MUHOLLAND: I think that the cost on consumers would widely vary, depending not only on market conditions but on what kind of consumer you're talking about. The cost to most consumers who either have governmental or private health insurance is the out-of-pocket cost, the co-payor deductible. And what we see a lot of markets, in terms of some favorable effects on consumer cost, is the result of what some of the single-specialty hospitals are complaining about. Their full-service counterparts will negotiate an exclusive or preferred relationship with an HMO, that the exclusivity or preferred status comes in return for lower prices. Those lower prices will eventually go down to the consumer, as well.

On the other hand, we've seen some markets where,

if the physicians who participate as investors in the for-profit single-specialty hospital do not have participation of Medicare and Medicaid, they'll actually be doing Medicare and Medicaid patients more than what they would be responsible for out-of-pocket if they were participating providers.

that additional capacity is going to be taken up with the natural growth in surgical specialty. So, short-term, dislocation, yeah, possibly, but long-term, I think you're right in capacity where it's appropriate.

MS. MATHIAS: George?

MR. LYNN: Thank you. I think the presence of specialty hospitals adds costs to the system. In most communities the resources that we talked about are present. They may be approaching capacity, but the cost of adding an O/R in a community hospital versus building a freestanding hospital, I think, are obvious. One is significantly higher than the other.

Typically, I think not-for-profit community hospitals have a lower cost of capital by having access to capital in many states through tax-exempt authorities. And I think this whole notion of cost, as we think about it, if you compared the cost of a community hospital and a specialty hospital, if you removed the responsibility to provide care for uninsured and under-insured, which is part of the missions of those community hospitals, their costs would come down substantially. So, that's a huge factor in terms of cost.

In terms of quality, I just don't think there are a sufficient number of specialty hospitals and studies done to really enter into a discussion about quality. There's no

data that has really emerged from this. And we tend to kind of talk in terms of specialty hospitals being generic, but there are clearly differences between pediatric hospitals and orthopedic hospitals and heart hospitals and cancer hospitals. So, I'd avoid that blanket kind of view that says that this model is superior in terms of quality. We know enough about quality to know that it varies from community to

you can't find them by just examining A versus B. For example, if we disturb this delicate cross-subsidization that takes place in every hospital, whether it is a good one or a bad one, cross-subsidization exists and it's how we provide care to our communities.

Our community's expectation for our performance as community hospitals is increasing; it's not declining, particularly since 9/11. The expectations for our hospitals to be prepared for virtually everything is increasing. And that balance is very fragile. It's impacted by -- we listed some of the things today -- by a shortage of labor, by new technology, and by the preparation for bio-terrorism.

So, if you take away those profitable services and leave the hospital, the community hospital, with just the unprofitable services, one of two things is going to happen. Either services will be diminished to the community in a way that is not transparent, in a way that they cannot see that happening, or costs will be shifted back to other payors, and business and labor and consumers end up absorbing them, once again, not in a transparent way where they can see what's happening.

So, the consumer doesn't really get to vote in this. They really don't get an opportunity to say A versus B produces value for me. And I think the value equation is the piece that we really have to take into account.

MR. BERLIN: We haven't heard from you folks down at the end. How about your views on this?

PROF. FRECH: Okay, I think the comments just made by George made a lot of sense. I think you think of basic research that shows that more competition leads to lower prices and lower costs among hospitals. And that's the good news and the bad news. It's the bad news because it reduces the profits for cross-subsidization. And that's a process that has been going on as hospital competition has gotten freer and more open for the last 30 years. It continues.

I would just like to suggest that this cross-subsidization that the U.S. uses as a way of funding uncompensated care and other services is itself not such a great idea. For one thing, it's very opaque. It's very non-transparent and it's wildly variable across areas. So there are cities where it works great, you know, really efficient hospitals are making enormous monopoly profits on one group and just subsidizing all kinds of wonderful things on the other side and access is real easy, even if you do not have insurance. Santa Barbara is like that, where I live.

There are other places where it doesn't work for beans and it's very opaque. It's a very poor way to run a railroad, I think.

MS. LESSER: Yes, I would echo those concerns about the cross-subsidies that we rely on. I think that it's

not a question that we need to have a way to finance essential services in communities, but there are a number of inherent problems in relying on cross-subsidies as the strategy to do that.

I wanted to come back to some of the capacity issues that were talked about just a moment ago. And I think it really is an open question of whether the type of capacity that's being added with the single-specialty facilities will help or hurt the current broader capacity problems that we have in communities. And, again, this is through the actions of both the firms that are establishing independent facilities and the actions of the community hospitals in response to that. So, we're seeing a lot of investment in the build-up of these specific specialty services at the expense of investment in other areas, whether that be specific services that are in demand, such as emergency services, or just investment in infrastructure to promote more efficient throughput in hospitals.

And our analysis in the past two years, looking at this issue really closely, is that the throughput problems are more of the problem than are the bricks and mortar issues. And there are questions about the sort of syphoning of attention to these specific specialty services, where profits are leading everyone's attention, how much that's really diverting resources from the broader capacity

constraint problem. And that's something that we'll have to watch over time.

It was noted earlier that there is the potential that this activity is actually exacerbating the nursing shortage and the increased wage rates that are needed to attract skilled nursing labor today. And certainly that could be a cost contributor.

And then you have the issue of just adding bricks and mortar, which, as I mentioned earlier, is really very rarely taken out of health care markets, that we're creating an increasingly inflexible system that has the risk of increasing costs over time.

MR. BERLIN: Dr. Morehead, I see you have your --

DR. MOREHEAD: Yes, and I'd like to just make a comment first of all about cost and then about quality of care. And I'll just speak from the OhioHealth perspective in Columbus, Ohio. The major problem, in our opinion, in Columbus is not lack of beds; it's lack of personnel. We don't have all of operating rooms operating or functioning at a given time. We can't keep them going as long in the day because we only have enough nurses and surgical techs and that sort of thing to do the one shift. So, again, we need to solve that problem first and then decide is there a capacity problem or not, at least in our particular community.

to that?

MR. KELLY: I appreciate that. Dr. Morehead and I had a chance to sit in the National Airport one night and talk a little bit about this. You know, when you look at the efficiency argument, I mean, you talk about the efficiency of the physician, the efficient use of the labor pool, and, you know, looking at length of stay data, does give you some measure of that. Looking at the number of patients a physician can treat in a given period of time in cardiovascular care, and as I said, we have a very, very narrow focus as far as looking at the data and trying to understand the impact of the operation.

You know, there will be 500,000 patients diagnosed with congestive heart failure this year. There are some studies that suggest that the current number of physicians, cardiovascular cardiologists specifically, that we have trained in the United States, will need to see twice as many patients as they're currently seeing today in 10 years. So, you know, they're going to find a way to be more productive or we're going to have a much bigger crisis on our hands as the population continues to age.

With the nursing pool, I mean, it's fascinating, there is a shortage in every community in the United States right now. We do not pay above market rates. In Dayton, Ohio, presently right now, we have 14 nurses on a waiting

list to join our staff at our hospital because nurses like working in this environment where it's not bureaucratic, there are not a lot of layers of management to deal with, they know where they're going to work every single day, they know they're going to take care of basically the same patient they took care of the day before. And that has a dramatic impact on patient care and quality.

So, when we talk about quality, I completely understand Dr. Morehead's concerns about the APR-DRG risk modifier. All we can promise you is that when Lewin has used that scale and when other people have used that scale they use it for the entire population of Medicare discharges. It is based on discharge data, so some of the things that occur while the patient is in the hospital does go into that risk modifier, but it's as good as we've got out there, and so we have relied on that and we will continue to do so. But I think we have complete agreement on the issue of releasing more quality data.

MS. MATHIAS: One of the issues that we've been addressing, that has come up again in these questions for the panel, is the issue of cross-subsidization.

UNIDENTIFIED SPEAKER: Cost shifting.

MS. MATHIAS: Cost shifting, thank you. And as the Department of Justice and FTC look at this we are partly looking at it from the role of monitoring competition. Is it

$10,000. And if the hospital is costing it out at $12,000, I'm not sure that you can.

MS. MATHIAS: George, I think you raised your tent next.

MR. LYNN: Thank you. I think it's important to understand the cycle in terms of how the cross-subsidization begins because we have focused on it today, but remember that the government acts as a price setter for health care. Medicare sets the rate and Medicaid follows, and those rates are typically below cost. And if you look at how community hospitals deal with that, I believe 13 out of the last 15 years the cost of living increase, to use layman's terms, has been less than inflation. So, there isn't an ability for a hospital to be able to make up on volume what begins with a shortfall.

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produce a profit to offset those that lose. So, it is the system itself. And that's why, as you take a look at the proliferation of specialty hospitals, you tend not to find them in certificate of need states where the government is playing a role. To take a look at the broader impact on the community, and you tend not to find them in specialties that are inherently unprofitable. You don't find freestanding trauma centers; you don't find, as was mentioned before, children's hospitals and others, because they don't produce a profit.

So, I think to take the light away from cross-subsidization you would really need to reform the entire system. It's the hand of cards that hospitals are dealt.

MS. MATHIAS: Cara?

MS. LESSER: I guess I would just add to that by saying that I think that this is an important -- it is an important component of what should be considered in competition policy around these types of facilities, because I think that if we are looking to specialty facilities to be pro-competitive and to help to bring down the price of these services, then we have to look at what the implications are in terms of the loss of that profit margin and how we will finance other services.

So, I think that from a government agency perspective in understanding the effects of competition, that

So, the efficiency index of that method of providing a broad set of care delivery is that you become very, very inefficient. You add administrative and supervisory costs. You add clerical costs. You now have this thing called a transportation department because the buildings are so large you have to have a staff dedicated to moving equipment and people from point A to point B.

MR. MUHOLLAND: Sort of like the Federal Trade Commission. I saw your van outside. I think that cross-subsidization is relevant in another sense and that's to the extent that a single-specialty hospital were to challenge a full-service hospital's response to its presence in the market on anti-trust grounds. The cross-subsidization argument, I think, goes a long way to justify the kind of responses that we talked about today. For instance, the attempt at getting a preferred relationship with a managed care company is a legitimate and reasonable and pro-competitive response to the building exclusivity of the for-profit single-specialty hospital.

In terms of the staff privileging disputes, if the hospital were the victim of further cross-subsidization problems by virtue of cherry-picking of the physician owners of a single-specialty hospital, then it would be reasonable and justified, based on its community service mission for the hospital to say, if you want to have staff privileges here,

you can't be admitting or referring an inordinate number of indigent or non-paying patients to us and keeping all the cream for your facility.

All these arguments would be relevant under Sherman I or a rule of reason analysis in Sherman II analyzing whether the conduct was predatory or was justified by a reasonable business purpose. And I think the cross-subsidization in many respects, both of the types that Dennis talked about, are at the heart of why hospitals are taking this action. It's not just to be mean to doctors or to get even with somebody because they pull business away. It's attempting to level the playing field, which is rendered uneven by the ownership interest the doctors have.

the FTC, as they should be encouraging new and different mechanisms to deliver that health care. And the reimbursement system shouldn't be coming into it.

MR. BERLIN: I was debating whether to ask another sort of open-ended question that would certainly be the last one today.

(Laughter).

MR. BERLIN: Instead I'll try to ask a somewhat more targeted one and maybe we'll get in another question. This one is for you, Mr. Kelly, and you, Mr. Rex-Waller. And that is, what is your response to Mr. Muholland's statement that the scope of the emergency room coverage provided by a single-specialty hospital, to the extent it exists, is somehow less than that provided by general acute-care hospitals? I sort of wrote the question and then heard your presentations. You know, do you think that your facilities are unique? What I'd like you to do, if you can, is speak to your facility but also, if you can, characterize, as you know it, sort of single-specialty hospitals across the board in making this comparison.

MR. KELLY: John, I'll go first.

MR. REX-WALLER: And we have different perspectives on this.

MR. KELLY: Right, we do, we do. First of all, I'll just -- the reason John commented -- made that comment

is we don't have -- I don't have knowledge nor experience of what the other specialties are doing.

What I can tell you is the data that I showed you, because I just pulled it again this week. One of the advantages of being involved with multiple facilities, we have 10 in operation right now, is that every month we can look at the same data from every facility which, you know, within -- which I spent my Monday looking at emergency department statistics. And I shared that with you earlier.

Sixty percent of our visits, 59, 60 percent of our visits on the trailing 12 months come to us and are non-cardiac patients. You know, less than 3 percent of those we have to transfer out to another facility.

The fact that only 24 percent of the hospitals in the country have open-heart surgery and the fact that we have relationships and transfer agreements, where hospitals transfer to us, in rural America, which is mainly, you know -- we're in urban settings, but we work throughout a region, that they're really regional referral centers. We end up having 22 percent of our admissions transferred in.

So, speaking on behalf of, you know, 600 physicians that work with us in our 10 facilities, we think we're part of the solution to that crisis, not contributing to the problem.

MR. REX-WALLER: Yes, I think we have -- the

nature of cardiac care is that generally you can't schedule a heart attack. It's that they come, they need an emergency room and people go to emergency rooms, and as Dennis had pointed out, their emergency rooms receive almost 60 percent of the cases coming through are non-cardiac.

What we have chosen to do is instead focus ourselves on a particular specialty. We focus on elective orthopedic and neuro-surgical cases. That's what we do, that's what we do incredibly well, that's what we do very, very efficiently. And our hospitals are set up and have the services to deal with exactly that.

And, so, we have typically well patients coming through that don't need emergency care. They don't need the emergency room. We don't need a full-service E/R. In some states, we're required to have it, and so we certainly have it and we are subject to EMTALA. And all of our facilities are general acute-care license, so we're subject to EMTALA like everybody else. But I think that you have the -- we offer the services that we need for our particular specialty with the kind of cases that we've got coming through.

The example has been used of what happens if you have a jogger out that runs past a surgical hospital and has a heart attack and goes in and the only thing you do, 911. I think that if you take that argument to its logical conclusion, if you have a massive traffic accident outside of

a hospital that doesn't have a trauma center, what happens there? Well, I'd say you'd probably transfer that patient. You stabilize the patient, if they present and you transfer them to a facility that has greater capabilities.

And, so, in the spectrum of things, if you continue that argument, every single hospital, everywhere in the country, and in fact every surgery center, everywhere in the country, should have a trauma center. Well, that's ridiculous. I mean, there is a certain amount of specialization that is required, and you focus on those particular areas that you do best, and you do that well and you provide the services that you need there.

Not every facility in the country has a neonate intensive care unit. Why not? Well, we focused on a particular set of services that we do best and we have taken that down and we focus on surgery, which we do exceptionally well.

MS. MATHIAS: Eddie?

MR. ALEXANDER: I thought John had an excellent slide earlier that shows how difficult it is to pigeonhole what is a specialty hospital. And on that point, as far as it pertains to E.D.s, E.R.s, our facility in Columbus, without question, follows the pattern that John sets at National Surgical Hospitals, but in Nashville we're building a hospital that looks more like a MedCath facility in that

hospitals have missions. They're either explicit or implicit. I think for most organizations they're explicit. And if you look at community hospitals, you'll see a commonality among missions that's remarkable. It's designed to serve the needs of a community and the community is defined in different ways. But the community, the significant thing is the community has a big “C”, it's not exclusive, it's inclusive.

The mission of specialty hospitals are equally valid but not the same, and I think it's important to draw the distinction, as you just raised, between the two. In the act of making a profit, the specialty hospital serves the community with a small “c”. It may be patients who have a certain common disease: heart disease, orthopedics; or certain patients who have insurance.

If you compare that narrower definition of mission, the mission with a small “c”, and compare it to other organizations, like children's hospitals or psychiatric hospitals, I think one of the startling differences that you'll find is that even within the narrow definition of a type of patient, you will find in those missions a comprehensiveness, a taking all of the patients who suffer from psychiatric disease or all of the children of a community.

So, I think there are distinctions, and they're a

little subtle. They're not obvious, but I believe that the existence, the opportunity for a company to joint venture with physicians around narrowing that definition is only effective because all of the other providers are treating the community with a large “C”. If all of the providers in a community were to adopt that same narrower mission, that we will pursue profit by segmenting the market into profitable segments, partnering with our physicians to drive volume.

You could make a catalog of all the unmet needs in the community and it would be startling. And that, I think, is what the community hospitals in this country are trying to say -- that this is upsetting a balance that is invisible to the people that we serve and it's incredibly complicated and we ought to take care, as you are doing, to examine it thoroughly and see the total implications of these decisions on delivering health care to the community.

MR. KELLY: In regards to treating the large “C”, as he's referred to the large community, I will tell you, we would be ecstatic if we treated all of the heart patients in a large community. We would expand our facility or add another facility in the community to accomplish that and accommodate it.

What we do treat, we don't decide who comes in. We basically say that we are participating in a federal program, that federal program has certain legal and

regulatory requirements that you must meet. Our partners know it and we know it and we take them all. And the data reflects it. The data shows that the level of Medicaid patients, the level of indigents we care for come to our facility.

And, you know, one thing that's interesting about us as Americans, you know, we like to go to "the place that's the best." And, so, as soon as you said you name a facility a heart hospital, it's amazing once it establishes its presence in a community, it is viewed by the community as the best. And typically it's not the best -- for those that are wealthy, it's the best.

So, we get everybody that comes in, and that population of 100 percent includes those that can't pay. Our physicians treat them; we treat them. It includes those that have good insurance and, for the most part, as you saw, two-thirds of the time it includes Medicare. I think they are common, to answer your question. Where's the commonality? The commonality is that a group of medical professionals have deemed that's the best clinical environment in which to provide care. They're different from the standpoint that there is some economic driver involved.

MR. BERLIN: Dr. Morehead?

DR. MOREHEAD: Thank you. I'd like to speak to that. I happen to be a pediatrician. I've done a lot of

training in children's hospitals and so I have a fairly strong passion about why there are children's hospitals. And I think it is a different kind of concept.

Pediatric hospitals came into effect because the number of complications and unusual conditions are much smaller in number than in adults. So, we need to get a large number of specialists together with a large population and that matches very well. And when a mother brings a child to a pediatric hospital or anybody less than 18, for example, they know that when they're there, whatever the problem is, whether it's heart or kidney or lung or a combination of all those, there's somebody there that can take care of it.

I think the problem with the single-specialty hospital is you need to know you've got a problem with your heart or you've got a problem with your bones or you've got a problem with something else, because the real issue is for those unusual or unexpected incidences, when somebody has a problem with a bone but also two or three other problems, then it's less -- the care there is less comprehensive and less highly technical in terms of capacity than in the other situation. So, I look at it as kind of a horizontal/vertical kind of difference.

MS. MATHIAS: Cara?

MS. LESSER: I just wanted to add that I think that a key -- from my perspective the key differentiating

factor for the specialty hospitals from the general, acute-care community hospitals is physician ownership. And I think as others have pointed out, this is not -- this is not the first time we've had physician ownership in hospitals. It doesn't mean that it's totally new under the sun. But that does seem to be a common characteristic across these and is central to the model that the specialty hospitals are developing and it's something that the general, acute-care hospitals have responded to with joint ventures. I think this is a signal that this is sort of a key defining characteristic, is that economic investment and the participation and governance and design of the facility.

So, from my perspective, that's another key difference, and I think the distinctions that Dr. Morehead about the children's hospitals are also good ones.

MS. MATHIAS: This is for the panel, one of the -- and maybe the single-specialty hospitals will want to respond first, or the people representing that voice. One of the allegations that has clearly been raised is that the hospitals are engaged in cream-skimming or cherry-picking, and maybe, Eddie, if you could address this first, what is your response to those allegations?

MR. ALEXANDER: Well, it's a little harder for me to address that because our hospitals are all under development.

MS. MATHIAS: The microphone.

MR. ALEXANDER: I'm sorry. It's a little harder for me to address that because all of our hospitals are under development. But I can tell you that, using Columbus as an example, there are four separate physician practices that have invested in our hospital. If you look at the amount of charity care they provide within their practice as a percentage of their net revenues, it's greater than any of the hospitals in Columbus by a significant factor. It's not even close.

And our physicians are on record as stating that that same patient base that they see in their practice will come to our hospital. We have no intention to not accept someone strictly on the basis of them not being able to pay. I don't think that's an appropriate stance in any way, shape or form. And that's really where we are with that particular facility.

In Nashville, we've partnered with one particularly large orthopedic group. There are two large orthopedic groups in Nashville. One does not take TennCare, I think Dan referenced TennCare earlier. It's essentially -- it's Medicaid for us. And they don't take any patient that's a TennCare patient. There's another group that's about the same size that essentially sees all the orthopedic TennCare in Middle Tennessee, that's the group that we've affiliated

with. So, those TennCare patients are coming to our hospital. So, time will tell. This time next year, I'll have the ability to prove that to you, as opposed to just my hypothetical.

MS. MATHIAS: Dan?

MR. MUHOLLAND: I think it clearly is hard to make a generalization about all of these hospitals, as everybody's observed. But cherry-picking can happen a couple of different ways, one direct and one indirect. The direct way is if a single-specialty hospital either didn't participate in Medicaid or had physicians who didn't participate in Medicare and Medicaid, or if those physicians were still on the staff of a full-service hospital, they would be able to select where they were going to do a particular procedure. That's why some of these credentialing responses can be reasonable in terms of preventing that.

But there is an indirect way that you can cherry-pick, and that goes back to the emergency facility issue again. If you either have limited or no emergency facilities, you're far less likely to get the kind of indigent load that would normally come into a full-service hospital through the emergency room. So, configuring a hospital in a way to minimize your emergency responsibilities will necessarily minimize any overall responsibility to the indigent or people who maybe have less than favorable payment

mechanisms.

So, you know, it can happen either as a result of design or as a result of the intent of the people who own the hospital or may not happen at all, depending on the market.

MS. MATHIAS: Dennis, I think you flipped your tent next.

MR. KELLY: I just wanted to comment on it very specifically. We do not do that. The design of the emergency departments, the design of the hospitals, the structure of the businesses, everyone knows and, you know, is widely discussed. We have a very strong compliance program to ensure that there are the checks and balances in place, just to ensure that if you come to our facility, whether you didn't know what our focus was or not, and that's -- I think the data speaks for itself. Sixty percent of what comes in isn't cardiac to the emergency departments, and we can treat it and we take care of it.

And as far as the economic cream-skimming, only taking those that have insurance, I think it just -- when you decide to deal with cardiovascular disease, you're going to get, as I said, you know, a mixed bag of that population. And we'll take the good with the bad.

MS. MATHIAS: Eddie, I think you're next, and then George.

MR. ALEXANDER: Just a comment on Dan's comments.

If you accept economic credentialing as a reasonable response to cherry-picking, my only comment there is why invoke economic credentialing before you have evidence that physicians, in fact, will cherry-pick. This is what has happened to us in the Ohio marketplace. I just throw that out for thought.

MS. MATHIAS: Thank you. George?

MR. LYNN: One comment about the future. We've spent a lot of time today narrowing the focus and looking at specialties, but I think we're looking at this problem from the inside out. If you take a community point of view and look back at the provision of care in a community, at least in the communities that I'm familiar with, the call for the community is to become more comprehensive, not narrower in focus, broader in focus.

If you look at the first Anthrax case in the United States, the patient didn't know that we would have told that patient to go to a university center. They went to the closest hospital. And, so, if the closest hospital is a 14-bed spine hospital... I think the community has a set of expectations that we haven't explored in these discussions and I think they extend to a more comprehensive suite of services and a better preparation for a total set of needs that present themselves. I think to ignore it creates a danger, particularly as we try to prepare for the threats of

decline to do E.R. coverage -- decline E.R. coverage.

We have 300, 400 physicians who are involved with our facilities. We do not have one that has dropped coverage in the E.R. because they have an investment in the hospital or because they're associated with the hospitals. It is that all of our physicians feel that they have a community responsibility to cover the E.R., to cover the big “C” community, and they do that by doing E.R. coverage. So, we don't have any examples of that particular instance happening. And I think that there is an assumed causal relationship which I don't buy. It just -- I don't think it

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now instead of waiting to see what happened is that it is a conflict of interest response, not an economic credentialing response, and the conflict of interest is real once the hospital opens. And that's why we did the bright line instead of trying to be detectives and figure out whether anybody's done anything wrong.

My conclusion, I've talked enough. Thank you.

MS. MATHIAS: Okay. Dennis?

MR. KELLY: I share a similar sentiment. Our commitment and our focus is going to be continue to -- in the communities we serve -- focus on what's best for the patient, try to enhance the care delivery model on a continuous basis and make the physicians -- help the physicians become more productive and just be good stewards of Medicare dollars, which is where a large portion of our revenue comes from.

You know, we think that the level playing field does exist as long as people want to play by the rules that are out there and we're committed to doing that. Thank you.

MS. MATHIAS: Thank you. Dan?

MR. MUHOLLAND: Just by way of summary, this issue is not going to go away. It's happening in every community in the country at one degree or another and it's going to continue to evoke a lot of heated discussion. But I think that from the standpoint of the community hospital, they not only have the right, but the duty, to take appropriate steps

the inherent flaws that have been well discussed today in that system. I think that as we do that, though, let us not sacrifice something that's better for patients just simply in order to maintain the status quo.

MR. MATHIAS: George?

MR. LYNN: Thank you. I think AHA is concerned about the ability of our member hospitals to continue to provide safety net services to communities if profitable services are taken out of the hospital and incentives for physicians to refer patients to settings in which they own a share continue to evolve in communities. And we appreciate the opportunity to participate in this dialogue. It's a

put it on the DOJ website so it's available. Of course we really love having an audience too, so if you can, spend the time to attend. I think it adds to the panel.

Second, a quick plug, is yours open for the public?

MS. LESSER: Yes, it is.

MS. MATHIAS: Do you want to give it?

MS. LESSER: Sure. We are sponsoring a conference on single-specialty hospitals on April 15th, and there's information about that on our website, which is hschange.org. It's open to the public and it's free, so I would encourage everyone to comme.

MS. MATHIAS: And, finally, if you brought cups or trash in with you, if you wouldn't mind taking it with you. It makes my job a little easier. Thank you.

(Whereupon, a lunch recess was taken.)

CONTRACTING PRACTICES

MR. COWIE: Good afternoon. This is the

Contracting Practices session of the FTC/DOJ health care hearings. We are going to start with speaker presentations, moving from my right to left. At the conclusion of each presentation, or rather at the conclusion of all of the presentations, we're going to take a break and then follow with questions. We'll start with Tom McCarthy of NERA. Bios are in the hallway.

MR. MCCARTHY: Thanks, Mike. I'm pleased to have been invited. I think these are important and impressive and ambitious hearings. I suspect that they will have significant effect on antitrust policy in health care, so let's hope that today's roundtable can make a contribution to that.

One of my roles is as a stage setter in this, and I'm going to start by reviewing just a little bit of history. Some of it's history you know, but I want to make sure we understand why hospital contracting is changing, as well as what is changing about contracting.

Now, some of this is a fairly stylized presentation of history, but I'm going to try to get this broad sweep of two decades of changes in health care done in five to 10 minutes, so some of these trends that I'm going to talk about won't look sensible to your locale, if you're thinking of a particular city and a particular health care market. I suppose that obligates me to suggest that almost

any case we discuss, whether real or hypothetical, will be very fact-specific. So, please don't depose me on these generalities I'm about to throw out in the next five or 10 minutes.

Not too long ago, meaning the last couple of decades, we, of course, had rapidly escalating costs. I'll try to remind you of this painful moment quickly. Most people thought this was due to inefficiency in the insurance markets, having to do with substantial moral hazard, too much care being purchased and unnecessary care.

So, we got the hew and cry from the buyers. What came in, of course, was managed care, HMOs, and very importantly, the Federal DRG system. What went out for the most part, not entirely, was cost-based reimbursement, paying providers on a usual, customary and reasonable basis and most regulatory solutions. Certificates of need still exist, but it's substantially less. Rate setting is substantially less.

As a result, hospitals were forced to become more efficient. They were faced with fewer admissions, falling lengths of stay, and surgery and ancillary services moved to the out-patient setting. Technology sort of facilitated this, but also this movement drove the kinds of technology that was developed.

There were also a variety of cost containment strategies that were adopted, particularly through the supply

chain, group buying and the like. Anyway, hospitals found themselves with a lot of empty beds. As a result, they slowly made structural changes. And the change that you see listed there are the ones that the agencies have concerned themselves, many of them, anyway: horizontal mergers, closures, bed reduction, systems were formed.

Also, buying of medical practices really is a form of vertical integration. The increase in the service mix that also occurred was in anticipation of handling these global capitation contracts, where you'd be responsible for all the health care. So, we had that sort of vertical integration, as well as horizontal integration.

The result was excess capacity through this period, even though they were in the process of adjusting, and that created bargaining strength for managed care. Importantly, the method of bargaining strength, the method by which managed care got low prices was selective contracting, including steering. And what steering meant is they could keep prices down by negotiating discounts for delivering volume.

Now, the antitrust authorities coming out of this period faced a number of frustrations with hospital mergers that were challenged but they did not prevail on. In part, I think in retrospect, this is probably too sweeping a characterization, but a lot of this has to do with the

insurance market being able to take off itself. We found also some physician investigations, mostly about messenger models and mostly about IPA behavior. Again, this is sort of a way of doctors walking up to the line of how they could effectively collectively bargain but not quite collectively bargain.

And then, I would say in some sense the high point of where the insurer was seen as the driving force in health care, I think came with the Aetna-Prudential review by the Department of Justice. And I say that because it gave us a fairly narrow product market to consider. That meant that monopolization as a claim, market share as a claim, was easier.

It also raised a concern, a novel concern at the time, that monopsony power might be an issue. And I think the lesson to draw from that is that at least in Texas the insurers were, if anything, getting too strong. So, in effect, what we have is a period of time when the insurers are in the driver’s seat.

At the same time, there’s a hot economy that is

networks, fewer gatekeepers, and less risk sharing.

That means that managed care has more difficulty steering patients. That also means there are fewer opportunities for selective contracting, because you're having to build that broad network. That leaves you with fewer chances to get discounts in return for volume.

At the same time, the managed care organizations, as part of the consumer reaction, are not managing care as tightly, at least that's what I see in some of the folks I've worked with. And in some areas, capacity has fallen. So, what we have is increasing demand, decreasing supply, a demand for more choice and therefore the bargaining strength shifting.

What has been the hospital's response to this newfound bargaining strength? As you might imagine, the hospitals are catching up. They're catching up through higher reimbursements. In my humble opinion, in many markets it's more than justified. There have been a lot of years of less than full cost reimbursements for some hospitals.

Secondly, less risk bearing, some of the contracts have less risk bearing in them. And various other contract provisions, like wanting to be paid case rates instead of per diems or per diems instead of case rates, percentage of charges for, let's say, premature babies that can be very, very expensive. You don't want to take the risk on that, so

you ask to be paid percentage charges, things like that.

Now, let me emphasize, before I move to the insurer response, that when I say there has been an increase in bargaining strength, I do not mean necessarily that

canceled, hospitals don’t cover their own physicians’ people, and sometimes the physician group is not covered and they’re all busy explaining to patients why they can’t get care at the price they used to get or the site they used to get.

The antitrust authorities will hear about this, I think. I think probably rather than more focus on providers,

though, I think comes from two sources. One of them is employers, and that's largely through their supportive insurers. If insurers begin to offer narrow network products, will they buy them? But from the economist's point of view, the old, reliable discipline is always expansion by existing rivals or new entry. So, these are sort of the highlights of what to look for.

Now, let me talk about two contracting issues. One of them is selective and exclusive contracting; the other is system-wide contracting, also known in some discussions as full-line forcing. First, selective contracting. It's been effective, as I suggested already, in holding down provider prices. It's provider-driven. It's a very logical, economic process of seeking bids and having people respond to those bids.

The technique, of course, is the threat of

direct it to a given provider for a discount.

Now, usually the results are quite pro-competitive. In fact, I think one could argue that they've helped constrain costs. But there are definitely lawsuits that follow. Excluded providers sometimes file them. The typical claim is that you get an antitrust foreclosure, anticompetitive foreclosure designed to monopolize the hospital market, and as I'll show momentarily, I think the economic logic of a lot of these claims is pretty confused.

What does a typical excluded provider claim look like? Well, often it starts with a conspiracy with a big insurer. And this is a buyer conspiring with a seller, which is in and of itself pretty hard to prove. In order to make the insurer conspire with -- I'm sorry -- the hospital conspire with -- I said that backwards -- the insurer conspire with the hospital, one possibility that's been claimed is that there's predatory pricing, where, let's say, the big tertiary hospital in town says we'll give you predatory prices on primary and secondary if you contract exclusively with us and foreclose our little rival across the street. So, predatory pricing is one technique.

Coercive tying, where it says if you want access to my high-level neonatal care, you must give me an exclusive. That's usually a pretty overt act and is usually pretty easy to discover. And, of course, there must be

sufficient foreclosure to drive out inefficient rival. All of this requires barriers to entry or the strategy doesn't work.

So, when might it be a problem? Well, you could -- I think the answer is rarely. It's usually buyer-driven. There's not much evidence of coercion in these things. There's net savings to the insurer. And, again, the mechanism of the foreclosure is usually questionable; predation, tying, conspiracy. And, you know, whether the foreclosure is sufficient, usually it's not. It's usually an exclusive contract with just one insurer that's being complained about. Similarly, barriers to entry are probably not robust and recoupment wouldn't be possible under these theories.

All right, let me turn to the issue of full-line forcing or system-wide contracting. That kind of contract, as I think most of you probably know, a hospital system says it will sign, if you will, a take all -- a contract for all the services in the system, including its related entities, and in all the geographic locations that the buyer could purchase those services.

Usually, there is no exclusivity involved; however, inclusion is required. In other words, the insurers can contract with other hospitals, but you have to at least include all of the services offered by the system.

In some cases, though, I confess I get this more from trade press than an actual example. Tiering may be blocked; that is, if you're going to do this, you cannot then steer people. You'll take a contract with all my hospitals and you can't steer them, and carve-outs are sometimes also forbidden.

What's the economic logic of this? Well, let me go through a couple of possibilities. Fundamentally, this is a tying theory. And that involves two products. So, we get into things like geographic market issues that were discussed yesterday. You have a market, let's call it market A; you have a hospital in A with relative market power. Let's assume they have market power, something to be proven, obviously. And then you have a very separate geographic market where the system also has another hospital, hospital B. So, those are the -- and C and D and E, if we want to talk about a bigger system.

In a tying theory, you need a tying product, that is, essentially, the hospital or doctor services at the must-have location. There are also the tied or forced products, which are the services at the location that the insurer would rather not contract with, given the alternatives that are available at that location. As a threshold condition, you know, Jefferson Parish and beyond, you need substantial market power in the tying market.

There is the economic theory question, though, about can you leverage market power from one market to another. And the answer is it's fairly rare. It's fairly hard to do. I'll come to that in a moment. Is there evidence of coercion? Are there legitimate business justifications? The evidence of coercion is, of course, that the buyer is having to buy a mix of products at a higher price than what they would prefer to buy and there's no offsetting benefits such as higher quality, better service, lower transactions cost, lower administrative costs.

What is the hospital's logic for this kind of contract? Well, I think there's some relatively pro-competitive logics and there are some questionable logics. One logic is transaction cost efficiencies. If you're a 10-hospital system, it's clearly easier to sit down and negotiate once over 10 hospitals than 10 separate negotiations. While that's important, I don't know how significant that is as sort of an antitrust reason for possibly raising prices. But that's a separate question to analyze.

I think the bigger reason, and probably the main reason for these kinds of contracts, is that the hospital system wants to stay a player in every location. And you go back to the cost structure of the hospital to think about this. If there's a high fixed cost component to all the

hospitals, a patient in, let's say, market B who's been run through your hospital out there, at roughly average total cost some reimbursement, his average total cost, is going to contribute substantially to your incremental profitability. So, if you have multiple hospitals out there where you don't have any argument about market power, you would like to see them all included and generate incremental profitability for your system by being sure they are included. So, this to me, see, is probably the driving logic of a lot of these hospital system transactions.

Now, there are some more questionable approaches. One, maybe this is a way to avoid the threat of punishment by a geographic carve-out. Remember, the geographic carve-out is to say if you don't give me a good price at A, I will refuse to contract with B, but now you're being forced to contract with B.

Another issue has to do with this tiering issue. Even though there is a contract, you're forced to take a contract with B. You could steer them away from that hospital if you had the techniques to do it, and it's what I call, in the L.A. area, I call this the Cedars-Sinai problem. Cedars-Sinai, as you know, is a very prominent hospital in the Los Angeles area. If you talk to them, they will tell you it's one thing to get a contract, it's another thing to get a patient. So, everybody likes to list Cedars on their

panel because it's a prominent hospital, but not that many patients actually go to Cedars. There are steering -- there have been in the past anyway -- steering mechanisms by which the patient goes to the lower cost alternative. So, if you had -- even if you had this sort of requirement to buy in another market, to take a contract with hospital B, the real question is can you steer around that contract?

There is a theory in economics that has some importance here. It's called the one monopoly power theory. And think of the initial question as this: Why not, if you have a monopoly or a market power in one location, why not just charge the monopoly price at that location? Can you actually take your market power in A and somehow move it over to B? And the answer that the one monopoly power theory gives you is not very often.

One possibility for doing that is a predatory strategy. The predatory strategy would be used to actually change the market structure. The idea would be you use your monopoly power in A to require something else –- I'm sorry, let me do it –- I'll do it specifically as a predatory strategy. You use your market power in A to help fund the predation strategy in B. And by predatory pricing in B, you drive out allegedly the competitors if you -- and the parentheses matter here -- if you have a substantial barrier to entry or reentry, than no new providers can come in once

you've driven the others out, so you end up with actually being able to transfer a monopoly power in one area into a monopoly power in another area. It's a strong assumption that that's going to be possible. Well, I've already addressed a little bit of what that means.

Let me -- these are the steps as to what you would

services they would otherwise prefer to purchase a la carte, even if they had to pay the monopoly price at location A as part of that a la carte purchase. And they can't do that at a lower price, which is another way of stating that the contracts have caused -- and I mean the contracts have caused -- the current market prices for the whole package to be driven above super-competitive prices.

Normally, this would mean a monopolization in the tied market, as well, but I suppose it doesn't have to mean that. There are other outcomes, but the package would be in total at super-competitive rates, where it wasn't before.

A couple of very final thoughts here. I think the question is in these full-line forcing or system-wide contracts, is there a less anticompetitive alternative, and I don't know that you can decide that these contracts are anticompetitive until you go through all of that analysis. But I think some of the issue could be diffused quite quickly, or at least the sort of competitive danger could be defanged with one controversial sort of change. And it's the practice in this contracting that raises my antitrust antennae most. That has to do with the refusing to allow tiering.

First, it's not clear to me that that provision is tied somehow to whatever the efficiencies are of the full-service contract. But you can see what the effect is. It

during the roundtable. Thank you.

(Applause).

MR. COWIE: Next is Meg Guerin-Calvert.

MS. GUERIN-CALVERT: I hope I will prove here that economists can be complimentary and not necessarily fungible. What Tom has done is covered about one-third of my talk, so I can move through the slides very quickly and hopefully focus on a related set of issues. I want to echo his words that I very much appreciate the opportunity to be here today.

I think that contracting practices, not just system-wide contracting, but the developments, as Tom has set out, in contracting are vital for all of us to understand because they form the baseline in the set of mechanisms, both in competitive markets, as well as markets that may have problems, to understand how prices, quality and competition are functioning in these markets.

What I'd like to do, just by the way of overview, is to look at three basic things today. First of all, and this again echoes Tom, what is important to us about examining today in this set of hearings contracting trends and practices? Second, what have those trends been in terms of contracting? Particularly I think at issue are trends between hospitals and payors. There's obviously another whole subset of issues in terms of contracting between physicians and payors that's also of great interest. But I

regard as contracting provisions.

And then lastly, the practices have changed a great deal, so views and thoughts as to what was prevalent, even as recently as three or five years ago, when some of the health care cases were litigated, are fundamentally different now. That's important, not only for thinking about evaluating what is going on now in terms of assessing any merger or practice, but particularly as one is doing retrospectives. It's very important to take into consideration, as Tom did, the kinds of changes that may have resulted in what appear to be higher prices where the product that's being purchased has changed and it's not as simple as saying the price was 10 two years ago and now the price is 20. It may be that the product is fundamentally different, and if you could adjust for product quality, the price was 10 there and in real terms the price is 10 now. And, so, that's something that one needs to think about.

I think overall, to an economist and to all of us who are concerned in terms of antitrust, I think the first point is that contracts are an important mechanism by which competition occurs in the marketplace. And one of the perspectives that I would like to bring is you can best understand how contracting practices work -- not by looking just at the markets that have the problems, but looking at the markets that don't, the markets that all of us would

consider, for whatever reasons, as competitive, because of the level of structure or the nature of competition on the payor's side, the level of structure, competition on the hospital side, so that we can get an idea in an environment that we would all consider as competitive, how are contracting practices working there?

What I have found that is very useful is that oftentimes, seeing how they work there or in pre-merger contexts, gives you a great understanding as to why they may also appear in other kinds of markets. But you can't look at the second problematic markets in a vacuum.

As a third point, with any contract in any industry, it's very important to try our best to understand where did this practice come from? What's the rationale? There are two parties, at least, to any contract. What are the business rationales for specific terms and conditions from both sides and not just from one side of the transaction.

In quick review, because I think Tom covered a lot of this: What are the elements of contracting; what is the importance of those elements in terms of commercial volumes; what was the contracting process; what are the terms and conditions of the contract. We should look at how these contracts get assessed before people enter into them ex ante and then how they evaluate the profitability of them ex post.

And there's a rich amount of information sitting both within the payor side and the hospital side as to why it is that people abandon certain contracting types and come up with new ones. And then I want to just reiterate the point that Tom made, and I'll make it a couple of times. A contract in a hospital environment means that you're in the network. It is not a guarantee that a single person will show up in a bed. It's not a guarantee that anyone will purchase the service. And that, I think, is very important.

If we hang on a second here. Okay, let me just -- somehow I managed to hit end. Okay.

Again, the reason why contracts are important to us is that virtually all commercially insured patients are subject to some contract form. On average, more than 35 percent of the patients in hospitals in the United States are commercially insured patients. And being in the network gets you access to those patients; being out of the network doesn't necessarily deny you those, but ends up being much more complicated in terms of the likelihood that patients will be coming in.

In terms of the contracting practice, what I'd like to spend just one minute on, having spent a considerable amount of time both on the payor and the hospital side, one of the things that I have been struck by in the hospital industry as opposed to a number of other industries, is the

If you are looking at a contract that has a higher risk pool than one that has a lower risk pool, all else equal as an economist, I would expect hospitals to be charging or attempting to get different prices for those two pools. That's a cost-based difference in price, not a non-cost-based difference in price.

Something I won't spend a lot of time on, something that was prevalent in many hospital markets three or four years ago, was the presence of full-risk contracts, where hospitals were taking on, with their physicians, full risk of contracts. Many hospitals did very, very poorly with these kinds of contracts. They found that they had significantly underestimated the difficulty in managing these kinds of contracts, in understanding the patient basis, and in simply not having large enough volumes of experience across marketplaces to figure out how to price these well. And many essentially had to buy their way out of these contracts by trying to induce the payors to switch to very, very low priced HMO contracts temporarily until they could then, at renewal time, move into a more sustainable HMO pricing.

And as Tom mentioned, I won't spend any time on what was prevalent a while back was a lot of very significant volume commitments. Something also to think about in contracting is what both the hospital staff and the payors

are doing is (depending again on the hospital, on the hospital system, on the payor) is very sophisticated modeling of the break-even profitability of particular contracts. In principle, what both sides are trying to do is to get their best possible handle on what is the patient base that a particular payor could bring in a given metropolitan area to the hospital. What is the likely mix of services, that the frequency of use of those services, the kinds of costs that they are going to impose on the hospital, and as a result, to try to figure out exactly what sort of significance of risks are going to be brought to bear, what kinds of significant costs, and as a result, to try to model or estimate what the price-per-service should be.

And then in terms of ex post, there's a lot of assessment typically done about the time where contract renewal goes on to see how well did we do. Where this is particularly difficult is entering into a new contract with a new payor with whom the hospital has no experience, that they have to use other populations of people that they think are comparable, but ex post may not turn out to be.

So, what we're seeing in the marketplace as sophistication has increased, is a great deal of adjustment in pricing as people have come to understand what is sufficient to cover costs and what is not.

Trends, Tom has covered this. The one factor that

I want to mention is that I would agree completely that tiering of networks has proven to be the second easiest and most likely tool that payors are turning to, given that they no longer operate in a world where there are broad exclusivity options and where they are dealing with all-inclusive contracts. I would differ from Tom a little bit that there are, nonetheless, the standard steering mechanisms that are different from tiering that are in place.

Tiering is structured steering, where you're, again, either in the network or outnt trn5wcer fr9optplace.(301)8

there are two-hospital systems, there are five-hospital systems. There are even, depending on the classification, one-hospital systems.

So, system is a word that covers a whole array of structures and types. And, again, to understand why we see possible kinds of contracting I want to take a little bit broader perspective. I think Tom talked very well at one aspect of system-wide contracting. More broadly, what system-wide contracting is contracting on behalf of multiple hospitals at the same time. So, regardless of whether you get to the point where every hospital is in a particular payor's contract, recognize the task that the manager of a hospital system has to go through.

One of the things where you could have a business rationale and efficiency, which you see in many other industries, is if you could simply get a given payor, if not all of your payors, onto common timing of contracts. So, similar to having a fiscal year, you have all of your contracts for all of your hospitals, at least for a single payor, ending on December 31st of a given year. You could then start the process of renegotiation of a given payor all at one time, six months, three months in advance of that. And that is one of the things that I have seen both on the payor side and the hospital side as an important rationale for trying to have some form of standardization.

Now, the bondsman has been raised again to many

what are the abilities of payors to discipline pricing? Even though a hospital system may say, "I would like you to put all of my hospitals in a given contract," (A) it's not necessarily the case that patients end up at all of them and that steering has been denied, so the prices may be competitive for that reason.

Second, it may not be the case that the payor goes along with it, or if they go along with it, that they haven't gotten a great bargain. What I have seen in some practical cases is where a hospital said, "Take everything;" and the payor said back, "I really don't like this hospital and its quality particularly much. If it's really important to you for brand image, for system-wide image, then for me to have both of those in, you need to cut me a deal in the following ways." And overall, in order to accomplish a particular goal, the hospital system caves in.

So, I think those are important dynamics to look at. What are the tools, what are the compromises on both sides, not just on one? So, what's the bottom line? I think it's most important to look at why do we see particular contracting practices develop? Particularly in competitive markets and by systems with whom we have no concerns, what has the evolution been and how much of it is a logical response to marketing conditions? We need to look at both sides, but most importantly, in any competitive analysis that

we do we need to take into account what are the competitive constraints and the tool kits that are available to both parties -- to attempt to get the best possible contract on the hospital side, but very importantly, on the payor's side to assure themselves that they have been able to get the best possible deal and have continued to have the flexibility use other hospitals as a threat? We don't need to see the threat actually turn into an actual contract. In many cases in this industry, a threat alone is sufficient.

Thanks.

(Applause)l and s6ro3e nee133.5 -241D best

Change, which tracks a representative set of 12 markets across the country. And we've been following this issue of health plan/hospital contracting pretty closely. What I'd like to do is just share some of the findings that we have obtained from that set of site visits that we've been doing for a while now. Hopefully, this will provide some more context for all the things you've already been hearing about today.

So, throughout the course of this presentation, I'm going to discuss findings that relate to three main points. One is the reimbursement rates to providers have been growing at faster and faster annual rates for a number of years now. The second point is that a few years ago we observed a noticeable shift in the balance of power between health plans and hospitals. In particular, hospitals regained a significant amount of leverage over health plans, and that leverage has facilitated their ability to seek rate increases. I plan to take you through the shift and describe some of the strategies and contracting practices being used by plans and hospitals to gain the upper hand in negotiations.

The final point is -- maybe something sort of a very up-to-date finding that we have based on our most recent site visits -- is that we're now seeing some signs in our most recent round of visits, the last few of which actually

are still to be conducted, that the balance of power may actually be shifting back a little bit towards plans. This finding is preliminary, but I'll share with you some of the reasons why we think that might be the case.

Just a quick -- let me mention some things quickly about the Center. I just want to say that from our inception we've been funded exclusively by the Robert Wood Johnson Foundation. And our emphasis in our research is on health

interviews with leaders of the health care system in each market. And we triangulate the results, meaning we examine an issue from multiple perspectives. So, when hospitals tell us about their relationship with health plans, for example, we also hear about that relationship from the health plans. And we always do this before we say something about what's happening out there in the market.

This slide shows the 12 markets that we visit each year. You can see that they're pretty well dispersed across the country and really reflect where the population is.

So, with all that as background, let me jump into the findings. I'd like to start by showing you how hospital prices, which is -- that is, unit price, reimbursement rates have changed over the past eight years. What I have here is data from the Bureau of Labor Statistics, Producer Price Index for Hospitals. And please note that this excludes reimbursements from Medicare and Medicaid rates. So, what you're really seeing here is changes in prices for the privately insured, largely the privately insured.

As you can see, hospital prices grew 4 percent in 1994. Over the course of the next three years, the trend declined, first by a small amount in 1995 and then more substantially in 1996. And in 1997, hospital prices were growing by less than half the rate of 1994. '97 was, however, the last year of a decelerating hospital price

trend. Since that time, and continuing all the way into 2002, annual rates of growth have inclined steadily. And you can see that it really surged in 2002. Relative to the past, it grew by 5 percent, that's the fastest rate of growth since the BLS began tracking changes in reimbursement rates to hospitals in 1993.

I'm showing you this just to illustrate, quite simply, that something has changed out there in the marketplace that's led to significant increases in what hospitals get paid, and that's what I'll be talking about through the remainder of this presentation.

The change I'm alluding to pertains to the balance of market power and negotiating power between health plans or hospitals. It's important to recognize that the degree to

employer community, there was widespread expectation among hospitals that enrollment in HMOs would grow significantly and the tools of managed care would eventually become a normal part of their lives. As a result, many hospitals

communities that lack academic medical centers have premier institutions that are seen as highly desirable. The premier institutions, whether or not they're academic medical centers, are often the flagship hospitals in the multi-hospital systems.

Finally, hospitals moved to solidify their position in specific geographic sub-markets. This was another way to establish must-have status in plans' networks. It creates a situation where there are multiple hospitals or hospital systems in one market, but they're far enough apart that people in one part of the community tend to use the system they're closest to and not the system that's further away, unless the further away system has some highly desirable services, or is well regarded for some services.

All of these strategies helped hospitals to increase their leverage over plans, particularly when you consider some of the changes in the contracting environment that appeared around the turn of the decade.

Some of this has already been mentioned, but the environment did change in a number of important ways that really began to favor hospitals. The consumers became very disenchanted with the tools of managed care and that disenchantment coalesced into what has already been mentioned, the managed care backlash. Patients did not like the restrictions placed on them when they tried to access

care and they didn't like plans dictating what providers they could see and couldn't see.

As a result, managed care plans largely retreated from the use of these tools and began promoting less restrictive products with broad provider networks. This was a time when PPO products really started to become the largest type -- in terms of enrollment, the largest product out there in the market.

Also, the U.S. was experiencing unprecedented economic growth, which drove down the unemployment rate and caused labor markets to tighten significantly. And under such conditions, it was essential for employers to offer generous health benefits packages that appealed to employees' preferences for broad networks and less management of care if employers hoped to be successful in recruiting and retaining workers.

Finally, around this time, new capacity constraints did begin to emerge. We saw new capacity constraints emerging in our markets, making hospitals more willing to forego a contract with a health plan. This was the outcome of both some capacity being taken out of the system, in part due to some of the consolidation that went on, and it was also due to the retreat from tightly managed care, which led to increased demand for services.

Now, while all that was happening around the turn

of the decade, hospitals were certainly facing a number of pressures on their bottom line. First of all, hospitals' Medicare margins began to decline following the enactment of the Balance Budget Act of '97, which, among other things, cut Medicare provider payment rates. And this places significant financial pressure on hospitals.

Also, hospitals faced pressures on their finances from growth in their own operating costs. For example, there has been a severe labor shortage for a number of years now. And when nurses are in short supply, they're able to command higher wage rates from hospitals. And, actually, if you look at data on wage rates from the Bureau of Labor Statistics, you can see a really significant increase -- really significant acceleration in the growth in wage rates in just the last few years.

There are other pressures such as the rapidly rising cost of prescription drugs and hospitals in some markets face a number of pressures that are specific to their market. For example, hospitals in California face enormous seismic retrofitting costs, as mandated by state law, to make sure that their buildings can withstand an earthquake. These are just some examples of the pressures that hospitals are facing.

Now, all these forces I've been describing so far, the strategies of hospitals, the changes in the external

environment and the pressures that hospitals are facing coalesced to create a situation in which hospitals have aggressively pushed for better reimbursement rates and contract terms. Moreover, what we're seeing is that hospitals across many of our markets have enjoyed a great deal of success in securing better rates. And if you think back to that figure on the hospital prices that I showed you earlier, you can really see that borne out in that figure.

Hospitals are using a number of approaches during negotiation to secure better rates. One thing we've seen in many of our markets is a terminate-to-negotiate strategy. Fairly early on in negotiations hospitals announced that they wish to terminate their existing contract with a plan, or that they don't intend to renew their contract unless their request for higher rates and better terms is met. This helps to raise the stakes of the negotiation.

Hospitals are also leveraging their system status. In a few markets, for example, we've observed systems that contain a highly reputable and desirable flagship hospital, threatening to cut ties with the plan, unless the plan is willing to contract with and provide favorable rates to the other hospitals in the system, even if the other hospitals are less desirable to the plan. It sort of gets at the full-line forcing that Tom spoke about earlier in more detail.

We don't know if these less desirable hospitals in

the system are getting the same rates as the more desirable flagship hospital, but it does appear, from what we can tell, that they're getting better deals than they otherwise would have if they hadn't been in the system.

We've also observed hospital systems that have close ties to physicians using this solidarity in the negotiations with plans. Again, this is less prevalent across all markets than hospital-only systems, but where it does exist, plans face significant risk if they fail to come to terms with a hospital and also lose physicians in the process.

Finally, we've been seeing hospitals appeal for public support in many of our markets with contentious negotiations. This often goes hand-to-hand with the terminate-to-negotiate strategy. For example, a hospital may notify its patients that they'll no longer be able to accept their insurance if the plan doesn't come to an agreement with the hospital.

Negotiations also get played out via the local media, which further heightens the public's awareness of what's happening. Plans, of course, use this tactic, as well, but it appears that patients often identify with their physician or with their hospital before they identify with their insurance company.

The bottom line is that contentious contract

negotiations between hospitals and plans have become much more commonplace in markets across the country, and particularly the markets that we track. And this often threatens or even creates, in some cases, significant network instability for patients.

Now, health plans have been undertaking a number of strategies in response to the gains in negotiating leverage hospitals have achieved. Some of the -- Tom and Margaret both spoke a little bit about this already, but one response has been these tiered network products, and they're usually products where patients have to pay a different amount of cost sharing, depending on which hospital they use.

Now, we see these hospitals up and running, right now, in only three of our 12 markets: Orange County, Seattle and Boston. And they've reportedly caused some hospitals to agree to lower rates to get into the preferred tier. Nonetheless, we've also heard a fair amount of skepticism about their viability. For one, providers in many communities are clearly putting up resistance to these products. We've heard, for example, that a few hospitals that risk being in the high-cost tier have used their leverage to assure placement in the preferred tier, without agreeing to lower rates.

And in some communities that don't yet have tiering hospitals have sought contracting language

prohibiting it. They also have -- there's also data challenges to these products, not the least of which is figuring out how to measure quality so that it can be incorporated into the tiering criteria and we can certainly debate whether or not quality is an important thing to put in. If it is, there are a lot of barriers to getting that to work.

Now, if these products are to represent a significant challenge to a hospital's leverage, they'll need to gain the kind of acceptance from consumers that drives sy.5 -TD (signifi5 -24 mi5 cringns. 68.25 -24 sy.5n25 2nie1.25 -1

products typically have the more narrow provider network, but not the kind of utilization management restrictions that characterized HMOs. The viability of these products is, however, quite dependent on consumers' willingness to accept a limited network of providers again. And we've seen that for a while now they haven't been very accepting of that.

We've actually seen some recent situations in a few communities where exclusive relationships between plans and providers have fallen apart, or are showing signs of falling apart. So, it's really unclear right now if plans will have anything to gain from these EPO products.

As I mentioned earlier, the contracting environment is certainly not static. In fact, we're now seeing some developments that could send it back in favor of plans. All the evidence so far indicates that 2003 brought a third straight year of double-digit premium increases to employers and employees. Meanwhile, employers' profits and workers' wages are growing at a slower rate because the U.S. economy, which went into recession in 2001, is still sluggish and the combined effect here is that there's been significant increases in health insurance costs -- even though I would note that it's not quite as bad as it was during the recession of '91.

Moreover, employers are moving to increased patient cost-sharing. So, this really, you know, it effects

-- it shows the effects that are even larger than the combination of large premium increases and the sluggish economy would suggest. In this kind of environment, it's possible to imagine a situation in which both employers and employees become more receptive to products that offer, for example, a narrow provider network, if products are cheaper.

So, let me just wrap up with an assessment of where the balance of power between hospitals and plans stands today. As we proceeded through our most recent round of visits, we continue to see a willingness on the part of hospitals to take their negotiations to the brink and use some or all of the approaches I described earlier.

However, we've also seen some variation in the outcomes of the contract showdowns we've observed. In fact, there's been a few instances where health plans have been able to hold the line on hospital demands for increases. In the recent cases where the health plan had success in holding the line they were able to do so in part because they received greater support from the employer community for their tough stand.

The situation is markedly different from two years ago when employers choose to either stay out of these disputes or quietly pushed plans to settle to avoid network disruption. Now, this is, in part, a consequence of what I was just describing before and it may also signal that the

amount of leverage hospitals have is coming up against community norms.

Even if there isn't a renewed interest in narrow network providers among consumers, this development, if it continues, could be an important countervailing force on hospitals' leverage. Nevertheless, we're seeing fewer showdowns getting played out in the public, so it's more difficult to determine who, if anyone, is coming out ahead in these.

So, in closing, I think it remains to be seen whether or not the balance of power will shift back in favor of plans again in the near future and that's something we'll certainly be tracking. Such a shift would indicate that there continues to be countervailing pressures across the sectors driving healthy competition in local markets. One would expect such cycling to occur because the environment is constantly evolving and health plans are constantly adjusting their strategies in response to one another.

For policymakers concerned about competition policy, such shifts in the balance of power over time provide an important indicator of how markets are working and will be important to monitor going forward.

Thank you.

(Applause).

MR. COWIE: Art Lerner of Crowell & Moring.

MR. LERNER: I am just going to stay here. I first wanted to just make an observation about the minute-word ratio. Mike told me that I get 10 minutes, and Tom had 25. So, that's really stacked, since those of you who know me know that I can get in 40 percent more words in 10 minutes than Tom can get in 25 minutes, so Tom really has a complaint here, I think.

Coming to this today is sort of a back-to-the-future kind of thing for me. I just had a birthday last week, and my kids told me, with great subtlety, that I am now playing with a full deck, if you can calculate how many years that is, which then reminded me that the last conference that the FTC had that I remember on competition in health care was in 1976, when, if you do the numbers, I was at the FTC and was playing with half a deck, but anyway. . .

(Laughter).

MR. LERNER: I should mention that my comments today are my own and certainly I think most hospitals and most hospital systems behave in ways that are not even close to the edge and that are, you know obviously quite okay from an antitrust standpoint. But that's not very interesting. And, so, I'll be talking somewhat today about some of the more interesting types of conduct, which, while across the country we may see trends, as have been described in the last remarks by Brad, some of the instances I'm talking about may

be some of the ones that are more on the vanguard of some of these things, because those are the ones for which I get phone calls.

Let me just mention some of the kind of practices that I've heard about. Tom has mentioned some; Margaret has mentioned some of these. Hospital systems demanding that if you want the highly desirable hospital you have to agree to contract with the rest of the system. We've talked some about that, even if the other hospitals maybe aren't of the same quality and reputation, that if you want to get a contract with this hospital, you'll have to contract for physician services for physicians who practice at this hospital through a particular organization in which the physicians have become organized; you can't contract with physicians independently, and if you want to contract with this hospital, you'll also have to contract with the ambulatory surgery centers, DME suppliers or home-health agencies that we own or are affiliated with at prices higher than market prices for those services; that if you want to contract with our system, you have to include all of our hospitals in your highest benefit tier. And we've talked about this tiering idea.

And certainly I think it's legitimate for a hospital to say when I give you a discount, I want to know what I'm getting in return for that. I shouldn't be at the

most extreme giving you a discount for preferred provider status and then not be a preferred provider. I think that's common sense. The issue, I think, becomes more acute when a system says if you put any hospital in our system in the non-highest tier status, you will be picking a higher price for all of the hospitals. That's where I think the issue -- I think picking up on a little bit of what Tom was saying, I think becomes more acute.

Another practice is where otherwise independent hospitals, not part of a single holding company, form a network to adopt and pursue common clinical pathways, track their performance against those measures and pledge, for example, to give money to charity on an individual hospital basis if the hospital doesn't hit the targets, but then use this integration on a clinical front, as a basis upon which to insist that they can engage in price fixing to all comers. We'll talk more about that.

I've got a prepared statement that's outside that goes into more detail on some of this, but in the interest of time, we're going to skip through. One of the questions gone into here is the question Tom posed about well, assuming one has market power, and I thought it was an interesting -- this question of being able to charge more than variable cost but less than a monopoly price, when in that spectrum have you begun to have market power is an interesting question, but

I'm going to assume for purposes of discussion right now that somebody in the story has some kind of market power.

And I think it's appropriate to recognize that there are gradations of market power. It's not like market power is here and no market power is there. There are gradations, I think, in the real world that what you might see in some instances, and Brad, I think, gave you a flavor of this, is a hospital might see an advantage, even if it's a hospital that has some power already, in aligning a large proportion of the local physician community with that hospital by contract or by ownership. There may be very legitimate vertical integration and quality improvement advantages from this, but in some instances, it could have anticompetitive effects.

Health plans often depend on physician behavior to discipline exploitation of market power by hospitals. If a health plan has a risk arrangement with the doctors under which the doctors are partially at risk for the cost of hospital services, the health plans can enlist physician cooperation in admitting patients to less expensive hospitals. However, if a hospital takes over the managed care contracting function for a large proportion of the community's physicians, then that aspect of the dynamic between the managed care and those doctors can disappear. The hospital might structure the doctors' reimbursement

arrangement so that they are insulated from the cost of the hospital services, and they can also work with the physicians to try to forestall more informal efforts by the health plan to encourage utilization of other institutions.

When the number of physicians involved is low, of course, this is not a problem. This becomes a problem only as a matter of degree, as the number of physicians gets much larger. In some cases, and this is where it gets even more interesting, the hospital might be willing to use some of its leverage as a hospital to get the health plans to get more money to the doctors. This gets at this whole question of using up your monopoly chips in one place and how are you going to use them? You might conceivably see a hospital use some power to convince a managed care plan to pay doctors more, even if in some theoretical way it means that the hospital might make less. But in a sense, what the hospital might be doing is buying insurance, that it won't have to reduce its prices even more if the doctors truly become agents of competition, shopping around for and using their ability to influence physician admitting patterns.

In some cases, you see the situation that was also talked about where the hospital might insist on the managed care plan including other hospitals, maybe elsewhere, or other types of providers in the network at prices higher than those institutions could otherwise command. And there might

be some of the legitimate business reasons that Margaret was describing why this may be going on.

But it also may be that the health plans are, in fact, being required to pay more in town B and higher than competitive price in town A. In other words, the situation that Tom was describing, where you could conceivably have a situation where the net overall cost is more than if the hospital simply charged a high price in the first town would have some market power.

Why might this be the case? I don't know exactly. It may be that it's the case because by transferring the cost of these services to consumers in another town, you basically get a different demand response. In other words, if one town your costs are already very, very high, further price increases may risk the employer community buying cheaper, lousier health insurance packages and more small employers not buying health insurance. But if you shift the costs to another town, you basically are not as far along on the demand curve in the other town. But I'm not an economist, but I've talked to a bunch of them, and what I got back was two of them saying, "Yeah, that sounds pretty good;" two of them saying, "Gee, I'm not really sure." So, I think there's further study that's needed on this one.

Well, what should the antitrust enforcement agencies be doing about this? First, I think there's a

couple of basic things that need to be remembered. One is the per se rules have value. Number one. Number two, the rule of reason would not be the marketplace equivalent of a hall pass. And by a hall pass I mean that you're still stuck in school but you're out of the teacher's reach. And too often we're stuck in situations where you sort of have clients that feel that well, gee, I'm in a rule of reason, I guess that means they really can't get me. And I think

some of the more informal steering techniques by basically prohibiting it by contract.

And there may be a price tag associated with doing that. So, I think tiering is a useful tool, but it's not by itself a solution to a market power problem. I would be very concerned, though, about hospital systems that basically use the threat, not of taking hospital “A” and charging a higher price if it's going to be in a lower tier, but of basically saying we're going to give you higher prices across the entire system if you put any of our hospitals in the lower tier.

In terms of legal analysis, I think tie-in analysis is a useful point of reference. I think you do run into the economic theory question about, you know, whatever monopolists only being able to extract their monopoly rents once. And we run into situations where health plans perceive that they're paying more, hospitals believe that they're getting more, but the agencies are trying to figure out as a matter of theory how and why this could be so and seeking empirical data to prove that it's true.

I think we need to figure this out fast, and if it is true, we maybe shouldn't spend too much time trying to figure out why it's true. But if we find that it is true, we should probably stop that harmful conduct if we can.

Some of this I've already talked about. Tie-in

analysis isn't the only screen. I think monopolization and agreement and restraint of trade doctrines, of course, are also highly instructive and all of you may not have yet had a chance to read in full or even at all the Third Circuit Court of Appeals en banc decision this week in Lepage's v. 3M involving the market -- very analogous to health care -- of Scotch tape. In any event, the critical aspect of that case that I think one would want to look at is the Court confirming that bundling price terms and bundling discounts across different products to the same class of purchasers can, at least on the facts in that case, be anticompetitive and monopolistic. Even where the seller had not charged below cost on the one hand or threatened an outright refusal to do business on the other.

The other comment in terms of merger enforcement I'd make -- in terms of enforcement is of course merger enforcement. If we stop in the incipiency, mergers before they create a market power situation, with sensitivity and recognition of efficiencies and other benefits and also recognition that market dynamics may shift again, but if we stop anticompetitive mergers, then we don't have to deal sometimes with trying to -- how to cope with market power after it's already there.

And there are, of course, two sides to every story, and I sort of had my role today to pitch one side, so

that's made up of over 31 health plans ranging from large, national health plans such as Aetna, Oxford, Cigna, to medium-sized regional plans to smaller plans that serve primarily Medicaid and Child Health Plus, and we even include managed long-term care plans, so we have the full gamut.

As you might imagine, these plans, health plans, often don't agree on much, but if there's one thing they do agree on, it's the tremendous concern they all share over what they perceive to be anti-competitive conduct on the part of many hospitals and hospital systems in the state. The practices the health plans have experienced run the gamut, including many of the ones already mentioned. To take a step back to the most basic problem, we see naked price fixing. I'm not just throwing that out as a provocative thought because fortunately we have the court decision in the Vasser Hospital/St. Francis Hospital case that many of you may know about, which granted summary judgment and reflected a fairly naked example of price fixing done under the excuse of "well, the government said it was okay."

We also have more subtle examples of price fixing done through virtual or pseudo-networks, including a fairly common tactic of what's been talked about before, that you must include every hospital in the system. That's not the exception; I think that's the rule in New York. We have pseudo-networks where there are virtually no operating

I didn't bring any overheads, not to leave any evidence of being here.

(Laughter).

MR. SCICCHITANO: I'm the Senior Vice President of Vytra Health Plans, which is a Long Island Health Plan. I joined Vytra in 1992 and have negotiated all of the hospital contracts for the organization. Vytra is a not-for-profit health plan with about a little over 200,000 members, 130,000 insured and 70,000 self-insured primarily in Nassau and Sufolk Counties on Long Island.

My remarks today will focus on two ways that hospital practices are adversely affecting Long Island consumers and employers. First, the current system of contracting has a negative impact on the percentage of Long Islanders that are able to purchase affordable health care. And, second, Long Islanders are paying higher rates to support more hospitals than the marketplace needs.

On Long Island and across the region, we've experienced four consecutive years of double-digit increases. The cost of health insurance has risen at a rate several times higher than the rate of inflation. For the past two years, hospital increase alone have risen at a rate more than three times the general inflation rate.

In order to fully understand the implications, I need to spend a little time quickly just discussing the Long

I apologize, I don't have a map, but I'll leave it up here afterwards to see. But there's North Shore LIJ Health System, which the Department has had some interactions with in the past. They are predominantly on the western end of Nassau and Suffolk. Then there's the LI8, which is made up of eight hospitals. Then there's LIHN, which has some hospitals on the western end of Nassau/Suffolk but really controls the center of Long Island. And then there are three hospitals on the east end of Long Island that control that entire market.

There are only four independent hospitals remaining on Long Island. As you will see from the map,

requires that we contract with all of their hospitals except one. And the one that we don't have to contract with is in the northernmost part of Nassau County. There's nothing else around; it's impossible to get to.

If you can't use that hospital, it's possible to get around, so they've allowed us not to contract with that hospital, which will only do discount off charges, for the most part. So, it's not practical. We need the hospital in our network. It's very honorable, but we can't really -- there's not much of an opportunity for the health plan to leave the hospital out of the system.

The second system requires that we contract with all the hospitals but won't let us contract with one of them. It's a specialty hospital that has an occupancy rate over 100 percent and it feels no need to give discounts; however, they're part of the health system. What happens is the physicians send members to that hospital through the emergency room. So, we're paying full charges for all of the activity at the hospital.

And third health system, on the east end, notified a local paper that Vytra -- well, they had terminated its relationship with Vytra, which was not true. This initiated calls from the Department of Health and other regulators, asking how we were going to meet our access standards in the region. In fact, it was not true, but, however, it did

initiate negotiations and resulted in increases in the rates, which was off-cycle.

The reality is to compete effectively on Long Island a health plan needs all three systems in its network to meet the service and access standards, as well as customer demands. If we don't contract with a particular system, the plan will be unable to serve the significant portion of the population. This dynamic affects consumers, employers and health plans by severely limiting competitive pricing opportunities that are normally available, such as requests for proposals, carve-out agreements and provider agreements -- and preferred provider agreements.

It also limits efforts to improve the quality of care members receive by preventing health plans from making greater use of centers of excellence. From this advantaged position, the hospitals are proposing even more unreasonable terms designed to bolster their positions. Let me give you a couple of examples that I'll read exactly -- straight from a contract that I have on my desk. "Vytra or Vytra's agents shall not restrict by co-pay, deductible, pre-authorization network design, plan design or any other method to prevent access to the hospitals." Obviously, this is precluding any kind of tiering arrangement, as well as other kind of arrangements that may drive business from one hospital to another.

The second clause, "If, as a result of any significant change to any hospital's operating cost, the hospital may propose a renegotiation of the rates." What's the point of a contract if that's the case?

Third clause, "There shall be no carve-out of services to subcontractors during the term of this agreement." Now, that links all the ancillary services or other services that we could go elsewhere. Physical therapy, go outside of, get an arrangement, a capitated arrangement with a physical therapy network, that would be beneficial both from a quality and a cost perspective, we can't do that.

And the last, which I find the most interesting, is, "During the course of the agreement, Vytra shall not implement any policy, rule or procedure that reduces the hospital's income." I don't know what that means, but I'm sure it doesn't benefit the consumers.

(Laughter).

MR. SCICCHITANO: The impact of imposing these conditions is that Long Islanders are paying higher rates to

from a systems approach to the delivery of services. There's been no measurable reduction in length of stay, while cost for admission continues to rise at rates far greater than overall medical inflation. And, now -- these are all assurances that health plans had heard when these so called mergers and acquisitions and alliances were formed. By inflating the cost of health care, the current system of hospital contracting does ultimately have a negative impact on the percentage of Long Islanders that are able to purchase affordable health insurance.

Thank you again for the opportunity.

(Applause).

MR. ISELIN: I just want to add one additional point as a sort of New York State focus conclusion, and just to show that we were listening. When Tom put up his last slide, I wish we had it here again and could put it up. I was trying to write the points down as I went, but as he went through the points as to in the last slide of why we care or when is it a problem, I forget what it was called, but every single point that you listed is something that we have present in New York.

We do believe that we have health systems with substantial market power. I know that's probably a discussion for later or another time. It's a complicated discussion, but we think we could show it. We have enormous

barriers to entry. We do have a vigorous CON process, applicable not only to in-patient but out-patient surgery. There's a moratorium on out-patient surgery centers, for example.

New York does not allow publicly traded entities to enter those markets, so you have a very restricted form of ownership structure that you'd have to adopt to get into the market at all. Whatever is going on is not payor-driven. I can't remember all the points, but I was checking it off, and, again, we do have an across-the-board refusal to allow tiering.

So, trying to tie what we're seeing in the real world with your maybe 30,000-foot overview of what are danger signs, if you will, we think they match up well. And I just couldn't resist sort of tying back what we're seeing with what you presented in a maybe theoretical way.

So, with that, thank you.

MR. COWIE: Next is Debra Holt, an economist at the FTC.

MS. HOLT: Thank you. The contracting practices that are under discussion in this session, or at least a lot of them, bear some resemblance to models of full-line forcing, tying and bundling. I'm going to discuss the ways in which these models do and do not apply to the contracting practices. I will also briefly discuss a bargaining power

model and some implications of a restriction on payors' ability to steer patients to lower-cost or higher-efficiency providers.

I'll start with the full-line forcing. Recent economic analyses of full-line forcing focus on its use as a vertical restraint to reduce a retailer to set the efficient price when a monopolist produces multiple differentiated products. In the single-product case, and with a monopoly retailer, the efficient outcome is obtained when the manufacturer charges the retailer a fixed fee and then sets the wholesale price equal to the marginal cost of production; however, when the monopolist is producing multiple differentiated products, this instrument is insufficient. However, a two-part price, combined with full-line forcing is sufficient to obtain the efficient outcome.

Okay, so this take, this most recent take, on full-line forcing has limited relevance to modeling the potential anticompetitive effects of the contracting practices that are commonly referred to as full-line forcing. In the model, the manufacturer or provider has a monopoly in both products. The goods in question are substitutes, and the practice results in lower prices and higher efficiency.

However, there is one conclusion coming from these models that is quite relevant to a consideration of remedies. Namely, brand discounts, which could be interpreted as

market share or competitiveness, because the intermediaries have an incentive to offer consumers an optimal variety of products.

So, the applicability to the full-line forcing type contracting practices is limited since the tied products in her model are perfect complements and the bundling requirement is passed on through to final consumers. It may possibly apply to some of the hospital-physician ties that were referred to earlier.

Okay, the fourth thing I want to discuss briefly, a bargaining power model. A model of bargaining power may be relevant to the analysis of these contracting practices, as has been alluded to. In a model by Chipty and Snyder, cable franchises in discreet geographic markets negotiate with programming suppliers over the terms at which programming will be supplied. The result of that model is that under certain conditions on the surplus function of the supplier, a merger between the two cable -- between two of the cable franchises can increase their bargaining power and thus their profits.

hospital's bargaining power. The result is a change in the division of surplus between the payors and hospitals and consumers are not necessarily affected.

Finally, I want to discuss sort of informational issues. If the payors have better information than consumers regarding the quality and cost of hospitals, then some of these contracting practices may reduce the amount of information available to consumers. And if so, you know, there may be a loss of wealth there. There are certain questions in this area that we need to get answers to; for instance, what sources of information do consumers use in choosing hospitals? Would a reduction in the ability of payors to steer lead to overall higher health costs for consumers; if so, through what mechanism? Would a reduction in the amount of steering lead to less competition among hospitals; and if so, through what mechanism?

Okay, so, just to summarize, we have existing economic models of anticompetitive harm due to tying, bundling or full-line forcing are of limited relevance. Not only are the tied or bundled goods, hospitals in this case,

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not the final consumers. The consumers are getting, as a result of these contracting practices, a larger number of choices, along with possibly higher premiums. Can it be shown that these changes harm consumers, given that the change in price is accompanied by a change in the product offering?

As I noted, the contracting prices are consistent with the model in which the ownership of hospitals in multiple geographic markets is used to increase bargaining power and negotiations with payors. It is not at all clear that such a shift in bargaining power would harm consumers. If payors' coverage tiers are the only or primary mechanism by which consumers learn about the desirability of a hospital, then the restrictions on multiple tiering for hospitals within a chain may reduce consumer welfare.

And, finally, assuming some anticompetitive effects were found, the effects achieved through these explicit contracting practices can most likely also be achieved through various pricing schedules, including volume discounts and aggregate rebates. Therefore, a remedy which prohibits the explicit practices will probably not be effective. On the other hand, a remedy that invovles scrutiny of possibly equivalent pricing practices would be problematic, given the number of efficiency justifications for the pricing practices that might substitute for the

explicit contract terms.

(Applause).

MR. COWIE: Why don't we take a 10-minute break and we'll conclude with questions.

(Whereupon, a brief recess was taken.)

MS. LEE: I have a question for the panelists. Well, I have a couple of questions for the panelists to begin. The first one is how has increased bargaining power of hospital and hospital systems changed contracts? I mean, we've talked about -- several people have mentioned that, well, hospitals are now getting more money. But my question is, well, how are they getting more money? Are they changing from per diems to discount off charges? Are they now putting MFNs into their contracts? How is it that these hospital systems are getting more money?

MR. SCICCHITANO: All the ways you mentioned, but basically it's just leverage that doesn't allow -- it's really not a negotiation anymore. It's really here's what we need. And they tend to be -- starting point, upwards of around 15 to 20 percent, and you may negotiate certain services off of that, but really when it gets down to the fact that you can't exclude a system because you're dealing -- at least on Long Island you're dealing with a whole system.

We can't exclude a system from our network without losing some competitive advantage or at least staying with

the competition. It's basically take it or leave it in a lot of situations. And they know -- when it was an individual hospital you were dealing with, you could make decisions to leave a hospital out of your network.

Yes, there were some implications to that, but they weren't as dramatic as leaving out an entire geographic area when you look at Long Island, saying we don't have a contract there. The Department of Health in New York would say, well, you can't -- you don't meet your service area requirements. So, the hospitals know that, as well. They know we can't terminate or allow a termination.

And then it runs -- you know, there is an example on Long Island where Blue Cross came to a termination with one of the health systems. It wound up in the newspaper, battling back and forth. They finally settled, but it was really more towards the hospital end of the negotiations.

MS. LEE: But do you see any trends? I mean, you talked about in Long Island how there were three hospital systems. I mean, do they tend to favor a certain type of reimbursement or certain contract clauses, aside from the full-line forcing that's been --

MR. SCICCHITANO: There weren't per diems. There aren't per diems now, most of the situations, but they would prefer to get the case rates, and then if there's any savings

they reflect a shift which, at the end of the year, ends up being more cost to the health plan.

MS. LEE: Meg.

MS. GUERIN-CALVERT: I think -- two points, because I think these contract terms are useful. First, one of the things may be appro po, the two comments that were just made, but particularly about the discussion we've all had. One of the things that I think is really important to understand is that one of the reasons why we are seeing price increases across the board, if you look at, and I've done and others here have done a very substantial amount of research. Brad talked about some of it; Tom, I know, has done a lot. If you look in every market in the country, costs are rising at hospitals in substantially above the rate of inflation. And as a result, it's not all surprising across the board in every single market, at virtually every single hospital we would see pressure to raise reimbursement rates, particularly for commercial insurance, particularly in a world where Medicare and Medicaid reimbursements, relative to costs, have not quite kept pace.

And, so, if you look at studies of margins, a greater proportion of hospitals are operating in negative margins than were earlier and margins across the hospital industries have declined in the last three years even though reimbursements have gone up.

And I think the same thing is true of the contracting practices. If you look, as managed care evolved, there has been a movement as markets have matured from case rates and simple discounts. New York has relatively recently deregulated and moved first to just percent-off charges, then moved to per diems. Some of the most advanced payors themselves welcomed and encouraged case rates in Long Island first. And, so, you see this evolution.

And just echoing Art's point, I have seen some of the smallest hospitals attempt to renegotiate their contracts

between a hospital system becoming more profitable and an anticompetitive harm.

And you have to trip -- the trip wire is some measure of a monopoly price, and we can talk a lot about how you might identify that, but the point I really want to make is that it is not at all surprising that hospital rates have gone up, particularly in New York, as Meg notes. New York came off of regulation not that long ago. There was some very unsophisticated negotiation that was going on for a while. I think, if Rochester was any measure, I've done some work in Rochester and in Buffalo, if they're any measures, there was a scramble to try to figure out how you could make sure you're going to keep the volume that you used to get under the knife from the rate-regulated programs.

So, I think really what's going on now, I think even nationwide, much less Long Island or New York, is that the insurers and the hospitals are having to move toward a new equilibrium. And I'm of the belief in general that

certainly on Long Island are losing money. Part of that, the inherent reason of that, is that there is an over-abundance of beds on Long Island, and beyond the beds, there's an over-abundance of services. You see two hospitals not far apart from each other both adding PET scanners. Do you need two PET scanners within two miles of each other? The supply keeps increasing while the demand isn't there for it.

So, inherent in those increases they need, they have to subsidize services that there's no demand for, at least at this point in time. And it's not just with PET scanners, it's with numerous other services that we see. And that's where the inefficiencies that exist perhaps in the systems, we're not dealing with the over-supply that exists.

MR. MCCARTHY: One real quick follow-up, Vince, and that is that could be taken as competition. In other words, when two hospitals buy PET scanners, it's because they want to compete on some range of services.

MR. LERNER: Even when they're part of the same alleged system.

MR. MCCARTHY: Well, I don't know the facts.

MR. LERNER: That's what he's talking about.

MR. MCCARTHY: Well, and the answer is yes. Even within a system, two hospitals do continue to compete. I

where we pinched the supply pipeline in the hopes that that would control prices, and it didn't do much good. I don't think there's a study I've ever seen out of many, many studies that finds that certificate of need works. When I was at the Federal Trade Commission, I did a study on certificate of need and I found all it did was keep out the for-profit hospitals. If you treated the passage of a CON law as indigenous, meaning that why did we pass one anyway, the answer has a lot to do with the for-profits -- I'm sorry, the not-for-profits in the state at the time trying to block the entry of for-profits.

MS. GUERIN-CALVERT: I also think that the presence of that kind of whether we call it over-capacity or excess capacity relative to demand is something that, as Tom mentioned, as you move toward a new equilibrium, is something that players in the marketplace can make use of, because in a circumstance where you have excess capacity and the desire to fill it up, it makes the entity that has the excess capacity either more vulnerable and more willing to cave in on various terms and conditions or sets up more opportunities where volumes can be diverted to an entity with excess capacity.

MR. ISELIN: But doesn't that assume that they're not acting in tandem? If they were independent, that would be true. But if they're all acting in tandem in one large system, as you have on Long Island, how does that remain

true?

MS. GUERIN-CALVERT: I guess in part if what you had was a circumstance where for whatever reasons you had all of the hospitals in an area, in a marketplace, in a single system, then you'd have Tom's, you know, monopolist that you'd need to worry about. Where you have two or more competing systems, where you have unilateral action, you have games that can be played both within a system, across systems, and also making use of other hospitals. If you have something the size of Stonybrook, which is a full-service tertiary facility located right in the center, you know, that's a fourth independent player that one could look at. You also have potentially the hospitals in Queens or even in Manhattan for some services. But, again, you know, I think in each case we have to put it in the market context as to whether there are competing systems and whether there's somehow concerns, which I haven't heard talked about, of collusion among systems.

MR. LERNER: We'd need to debate this one case, but I think that what the health plans in New York on Long Island would say is that you cannot have a network without both the two large systems. You have to have both of them. Once you have both of them, you can't -- since each of them know that you need both of them, you can't really play the one off against the other. That's a factual premise; it may

or may not be true, but that's the perception.

MS. GUERIN-CALVERT: And I think that's why I'm kind of going back to Tom's point, is it that that's the problem that has been faced in every marketplace; is it that if you can no longer drop somebody, if you have to must-have, what tools do you have available to you? Long Island is one of the few places where folks have actually testified that they've been able to drop must-have hospitals. But, again, that was a while back, it may no longer be prevalent. But I think it is where you have to look at, even if you have to have people in, are you able to negotiate good rates?

MS. LEE: I also had a question about tiering. I mean, we've heard from on this afternoon's panel that this has become a more common practice. It's no longer just in network and out of network, but there are gradations of these tiers. But we've also heard that there's a difference between having a contract and usage. So, my question is, how successful is tiering? That is, how successfully have health plans managed to divert their enrollees to lower cost hospitals and to follow up on that, how anticompetitive has full-line forcing been?

So, you know, we've again heard that full-line forcing has been a problem. Health plans are forced to take these perhaps lower quality hospitals at these higher rates; but if, in fact, enrollees don't go to those hospitals, you

know, my question is, what has the anticompetitive effect been?

MR. LERNER: My only comment is I think that the tiering thing in most of the marketplaces where I have clients that are experiencing it, it's just too new. There's very little experience with it so far. Some of that

County, California, which is one of the most advanced managed care markets in the entire country. And it certainly is probably one of the most advanced markets in terms of plans pursuing these tiered network products.

And, you know, we spoke to health plans executives and they just say, you know, that these really are brand new, we're not -- we haven't seen huge savings from them yet, but it is, you know, too early to tell. The plan that was the

you mentioned. A long time ago, Blue Cross went to the whole state and said to all the hospitals in the state, you can either be on tier one or tier two, before it was really even called tiering.

And just as Brad said, virtually everybody signed up for tier one, but what that meant was that in order to get that status was a discount. So, in effect, if you as an insurer can get everybody to sign up for a discount, then you've got both a broad system and a low price. And usually that doesn't sustain because of -- you want that channeling of the volume that you're giving the discount for.

It is very new. There's been some legitimate concern by the hospitals about whether the tiering is measured properly, and I really think that that's something that should be hammered out in the negotiation.

They're worried, as I said earlier, about we're high quality, how come we're put on the high tier. That doesn't bother me so much as, you know, we do a high case mix, so we have a different cost structure.

MR. COWIE: Tom McCarthy addressed the economic theory covering a situation where the flagship hospital tries to force payors to use the less desirable hospital. And I understood your comments, there are al. sital. And I

situation where the flagship hospital tries to force payors to use, say, the ambulatory services or the out-patient services? In other words, the flagship hospital is trying to restrict competition from an out-patient facility or a boutique hospital, something in the same geographic area.

MR. MCCARTHY: Debra would be much more up on the literature that would apply there, because I thought her treatment of the literature was pretty comprehensive. My basic answer is it applies the same way. What is raised by the literature that Debra cites is whether these are -- whether in some ways some of the goods that are tied together at the local level are somehow not independent and are complements and you get maybe a different prediction.

MR. COWIE: Why is that?

MS. HOLT: Because you're talking about the same consumer looking at the two products, say, rehabilitation services the week that you're released and the hospitalization itself as, you know, a bundle of services, and that's exactly where, for instance, the Whinston sort of model of time does apply. You know, you have a monopoly power, say, in the hospital, but you have some competition but imperfect competition in the provision of rehabilitation services.

MR. LERNER: And I think one thing that I'd like to explore that I think may be worth some further discussion when we're on it, we don't have to do it today, it's the question of why or whether the literature would support or wouldn't support looking at the bundling at the level of the health plan. We could view the health plan as being in a sense an independent consumer, who's then reselling a rather

MS. HOLT: Well, thanks for asking that question. I would like to just clarify that what I was trying -- the point I was making is that the models that we sort of reflexively look to when we hear this, you know, superficially this set of facts don't fit nearly as well as one would think initially.

I'm not saying that there isn't a model out there that would show that these things are deeply anticompetitive and harmful to consumers, just that we really need to think, you know, more deeply about it and think about the ways in which these practices and these exact institutions and environments can lead to the anticompetitive outcome.

MR. ISELIN: Just to follow up again, maybe a bit less theoretical, but possibly something to think through as a good example would be the tying of in-patient and home care. I mean, home care is, in my mind, a relatively fungible type service. I mean, people don't generally say I want this home care agency. I mean, they don't really care who's giving it to them as long as they're getting some home care. And yet, so if you took sort of a fact pattern, where you had an in-patient facility and, for the sake of argument, said it had market power, and they then said to the health plan, in a situation where the consumer, ultimate consumer really doesn't care much, well, we're going to -- you must use our home care and the rates for that home care are three

times what you'd have to pay to somebody else, again, for a service that's sort of relatively fungible and not consumer-driven. I mean, you know, again, I don't know how all the literature analyzes that, but I throw that out as a real world example that may sort of outline the kind of question you were asking and maybe just ask everyone, okay, how do you work through that?

MR. LERNER: Have you got one, Harold? Have you got one?

that, unless you can steer, and I agree.

MR. ISELIN: What also happens, though, is --

MR. MCCARTHY: You can't as a no-steering privilege.

MR. SCICCHITANO: Just the nature of that situation, though, the hospital is very influential on a member who just had orthopedic surgery and the hospital staff is in there telling the patient -- or somebody's in there telling the discharge planning is this is the best place to go, and this is something that just happened yesterday. I was notified that one of the hospital systems told every health plan on Long Island, with the exception of Vytra, maybe they knew I was coming here -- that they no longer are allowed to have on-site nurses in the hospital. Now, I haven't heard that because we were the ones excluded from that, and I'm not sure what the reason is, why we were excluded and why that happened, but they control a lot of the discharge planning that influences that situation to get more business in their direction at three times the cost.

MR. ISELIN: In other words, they effectively block steering, and we can debate all the different ways that that happens, but if you take the analysis with all the facts and add in effective blocking through contract provisions or utilization review or discharge planning or whatever, effective blocking of any steering and almost total absence

of effective consumer choice, given that someone's in the hospital being discharged and somebody's making home care arrangements for them and the consumer isn't out there going, "Well, I think I'm going to shop around for which home care agency I'm going to get." You know, walk that all the way through, and again, I'd sort of just be curious whether that gets over the line for anybody or not.

MS. GUERIN-CALVERT: I guess part -- I mean, one of the things is this has been -- the issues that you raised have been a perennial issue, and one of the areas that I know the FTC and other agencies, state agencies in particular, have spent some time on is really trying to beef up disclosure and conflict of interest regulations. And I know that some plans have also tried to do that to provide as much information to consumers as possible, that they do not need to necessarily stay with the hospital system in order to have quality of care. They can choose to do so, but to inform them of their options, and in some cases, hospitals and the discharge planners are required to let people know about alternatives.

MR. LERNER: Just a final comment is a long, long time ago, one of the things that made people think that there was a breakdown in market forces in health care was that if consumers were left to shop for health care, we would not get a very market -- a very sound market result, for a variety of

reasons, including lack of information, and including the fact that the time when the decisions were made is a time in some cases when it's all fraught with emotion and other distractions and the fact that the existence of insurance means that for every, you know, dollar of health care that's being spent, you know, only six cents or 10 cents or 12 cents is coming out of the consumer's pocket.

So, for all of those reasons, there was a move away, as Tom explained, from the indemnity, the classic indemnity, health insurance model to a more managed care model based on the premise, supported by antitrust thinking, that the managed care plans, to some degree, become a proxy for the consumer in the purchasing decision, or become a level where they make the competitive choice in the marketplace and avail themselves of the information and competition and price competition, and then sell competing health plan products to consumers.

If you structure the hospital services market or the medical services market or any other market in such a way that the health plans cannot really avail themselves of competition effectively and then say, "Oh, but that's okay, because we still have consumers who will still make competitive choice." I think we're back in the problem that we were at in the late '60s and early '70s.

I don't think you want a model where you don't

have competition between the hospitals and their dealings with the health plans. There is certainly the case being made for some reforms in health care that would go to, you know, whole models of health care, where consumers go out and buy their own health insurance on their own with a bucket of money from their employer, without going through their employer, where people have, you know, IRAs for health. There's all sorts of other models that might completely change the economic dynamic of how consumers function.

But right now, most people are still enrolled in health plans where most of the dollars are being paid out by the health plan and the consumer's exposure to cost differences from one provider to another are relatively modest, plus they have information gaps, plus they have emotional issues that separate them from the decision.

So, I think it's still very important to focus on whether or not there is vigorous and effective competition at the provider level for participation in the health plans, and not depend on the health plan's ability to tinker with co-pays and tinker with referral mechanisms as a way to reinstall competition after they've already had to include everybody at prices that weren't competitive at the front end. End of speech.

MR. MCCARTHY: Art, you're slipping into health care policy, which is a bait I often take. But let me --

I'll try to keep it narrower than that. We came from a place where there was a lot -- or basically everything was done by co-insurance. And what ended up happening in the sort of '60s into the '70s was that that co-insurance kept getting lower and lower and lower, so that we had what we all called first-dollar coverage or near first-dollar coverage. And that's one place where the insurance really broke down.

Now, having said that, consumers have rejected, to a large degree, the restrictive nature of gatekeeping and the restrictive networks. Now, I think they're going to come back to it. I'm fully agreeing with Brad as to where this may go next. But, right now, what you have, the only way you can deal with consumers in making decisions, if they truly were to reject the whole managed care model, it hasn't gone that far, but if they truly were to reject it is you're back to co-payments. You're back to co-insurance.

And there was even -- I mean, one of Meg's colleagues in the Dubuque case found evidence of co-insurance differences causing people to go quite a distance. Rightly or wrongly, co-insurance can move people around. But, you know, it does matter how big that co-payment is.

MR. LERNER: All I'm saying is -- I agree. I agree with you. I'm just saying I don't want to put all my eggs in any basket.

MR. MCCARTHY: I would prefer to have them shop,

too, the insurers.

MS. GUERIN-CALVERT: I think one other basket that I've seen some insurers develop very substantially is use of the internet to do the information provisions to their enrollees as to what their options are and also behind the scenes to be encouraging physicians to be choosing particular options. And, so, that's one of the things that has helped people have a little bit better understanding of which ambulatory surgical centers are in the plan that they could choose from, just by going on the website.

MR. ISELIN: I guess that's prompting me to make a comment, which Art has cautioned about the -- my level of concern about publicly funded programs, Medicaid managed care in particular, but, you know, it's nice to talk about the internet, but now you go to Medicaid managed care and Child Health Plus and networks like that, where the notion of full disclosure and consumer shopping. I mean, you don't even have co-payments or co-insurance.

And, you know, I'm not saying there isn't access to the internet, but the notion of sophisticated consumer shopping around and looking at quality data and everything like that translated into Medicare managed care market where you are still, as a health plan, expected and challenged to negotiate aggressively for good prices to benefit the state and the federal government and the ultimate payor there, you

know? I mean, there's kind of disconnect in my mind as to how those theories really work when you get into some of those different product markets.

MS. LEE: To shift gears a little bit, several of my colleagues have talked about various economic theories of tying and bundling, in terms of analyzing full-line forcing. And I was wondering if we could just take a simpler approach. I know that hospital merger cases have very much focused on local and geographic markets, and in those matters, we've been very much focused on patient demand in terms of defining the geographic market. What is true, however, is that both employers and health plans, while acting as agents for their patients also have a need for greater geographic coverage. I'm sure that Vinnie would say that he needs greater geographic coverage in order to be marketable to larger employers. So, when we think about full-line forcing and any potential anti-competitive effects it may have, can we think that maybe a network would have hold-up power when an individual hospital would not and just look at it in a simpler framework?

MS. HOLT: That was the framework I had in mind. I believe that was the framework they had in mind, as well.

MR. MCCARTHY: That sounded like portfolio theory.

MS. LEE: A little bit, but it just seemed like there was a lot of focus on tying and bundling, and while I

think that the analysis, certainly what you laid out at the end, Tom, in terms of, you know, there has to be market power somewhere and things like that, all of that would apply. I mean, would this be a harder way to go than, you know, looking at it as tying or bundling or --

MR. MCCARTHY: The problem I have with portfolio theory, and most of us would say this sort of thing, the problem is that if you're going to argue that what creates the market power is the whole set of services or locations or products, whatever it is, all bundled together, you sort of have to say, why is somebody forced into consuming that whole set as opposed to something less than that, and then that requires some sort of initial market power to trigger it, which means, I think we're right back to tying as the underlying mechanism. And, so, you could have a portfolio that does have market power, but it's not due to a portfolio effect, it's due to having some market power in some market to start with.

MR. LERNER: I agree with everything you said, June, but then I lost track, so the only comment I would make is if what you were saying is -- I had it in my prepared remarks, but I didn't go through, is that --

MS. LEE: Right.

MR. LERNER: If you were, and to use our community here, if you were to say to an employer, "I'm going to not

have" -- if you were going to tell me as a consumer, you're going to have a hospitalization, do you need to go to a hospital in Maryland?" Okay, I live in an area where if you told me that if I got sick, short of going to the emergency room, but for some sort of planned surgery, I couldn't go to a hospital in Maryland, I'd say, all right, can I go to Georgetown, or can I go to Washington Hospital Center, can I go to Fairfax, and you said yes, I'd say, you know, I'm not going to die over this, okay?

MS. LEE: Mm-hmm.

MR. LERNER: But if you, and I might be willing, if my doctor said I want to take you to Virginia, or I want you to go down to Washington Hospital Center from Maryland, I would go, and my family has gone. But if you were to offer a health plan in Virginia, this is my sense of what the reality faced by the plans is, and whether it's portfolio effect or what we sometimes call network effect, I don't know what you call it, but if you'll go to a health plan and say all of the hospitals in Northern Virginia have just merged, all of them, not just most, not just the big Inova system, but they've all merged, okay? By some of our traditional geographic measures, you'd say, well, I don't really care because people can cross the Potomac River and people can go to D.C. and people can travel. But if you tried to sell, in a benefit plan to an employer, a major employer in this community that

had no hospitals in Northern Virginia, you wouldn't sell it to anyone. That's a fact. Now, I suppose at some price difference, you could, okay? At what level, how big that price difference would be, but it would be a lot -- but that merged system in Northern Virginia that has every hospital, I would bet, be able to raise their price more than 10 percent before you'd see health plans starting to sell products with no hospitals in Northern Virginia.

So, I think the whole geographic market issue in those hospital merger cases, I don't know if that's the same thing you're talking about or not, but I think there's something.

MS. GUERIN-CALVERT: I think Art has teed it up exactly right, and Tom may disagree, in the sense that if what you have is a circumstance, just hypothetically, where every single hospital in Virginia, in suburban Virginia is a single network, at most what you have is the circumstance as you laid it out, which is it would be difficult for health plans probably to not include it in. It's a completely

Georgetown, Washington Hospital Center, GW, Sibley, Suburban, Shady Grove, Johns Hopkins, fill in the blank, so as to make a price increase unprofitable, then even though they're in the network, the contract terms that they would have to offer would be competitive ones. And that's the dynamics that you need to analyze.

MR. LERNER: I agree with that question completely, but the problem is when you look at statistics, which would show you that 24 percent of all the people in Northern Virginia come into the District to get their health care, or whatever it would be. That's not a very good statistic to measure what percentage of the patients who are going to those hospitals now, could an HMO faced with a no-steering clause actually get to leave?

MS. GUERIN-CALVERT: I think what you would have to look at is how is it that the 24 percent are already going, what happens in this area, very substantial number of physicians in this area --

MR. LERNER: Sure.

MS. GUERIN-CALVERT: -- have privileges in D.C., Maryland and Virginia. There have been huge shifts from people that were in D.C. moving out to Reston to have half their practice there, have another -- so, again, it's very fact-specific.

MR. MCCARTHY: I would agree with all of that. I

could be a very competitive response or an anti-competitive response, and the border between the two is obviously debatable.

But you see sometimes "alleged" "coercion" of primary care physicians not to refer patients to the surgeons who are at the ambulatory surgery center, alleged allegations of pricing strategies with managed care plans to secure exclusive status, which could be viewed as a competitive response, or I suppose depending on the facts, anti-competitive. But there have been at least two cases recently of that that I'm familiar with, one of which in Louisiana the plaintiff lost because they failed to adequately plead it, adequately establish the geographic market. Their economists apparently didn't cut the mustard. And then in the other case, the court ruled let it go to trial. There are two of those that I'm familiar with. I'm not familiar with much more than that, though I'm sure there are.

MR. ISELIN: There's a third I'm familiar with in New York, very similar to what Art described. It's actually a fairly rural community, Rome, New York.

MR. LERNER: That was one of the two I was talking about.

MR. ISELIN: Okay. And it's moving forward, it's still in discovery, but that exact fact pattern where the hospital, some physicians got approval to open up an

ambulatory surgery center. The allegation is that the hospital said to the plans, we will give you favorable in-patient rates if you refuse to contract with the ambulatory surgery center.

MR. LERNER: And I should mention a Pennsylvania one, not familiar with litigation -- there are a number of hospitals I'm familiar with in Pennsylvania that have adopted a strategy that says before you can get hospital privileges, we will screen your application, and on your application we will determine if you have a "conflict of interest." And a conflict of interest would include, apparently, an ownership interest in something that competes with the hospital. And they also say, if it turns out that at some future point in time your answers to any of these questions would be different, your privileges are thereby void. So, there are a number of -- I'm not familiar with litigation around it, but that is a practice I know a number of hospitals are using. In fact, it's included in the hospital advice manual that a popular law firm gives out to hospitals to tell them how to cope with these outbreaks by doctors.

MR. COWIE: Thank you very much for your patience. I believe the hearings resume tomorrow at 9:15.

MS. MATHIAS: Actually, I did want to affirm that they do start at 9:15 tomorrow morning. We will be discussing issues in litigating hospital mergers. We hope

that everybody can attend.

We also wanted to note that, as is evident, we unfortunately did not have a hospital on the panel today, and we think that would have added to this discussion. However, we do hope that hospitals and other entities will feel free to send in written comments. The method for doing that is described within our every press releases. And you can -- if you haven't seen one of our press releases, they can be found at www.ftc.gov.

Tomorrow is only a morning session. We will start

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: MARCH 27, 2003

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

DATED: APRIL 4, 2003

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