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5 DEPARTMENT OF JUSTICE
6 ANTITRUST DIVISION
7 PRESENT:
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11 HEARINGS ON
12 HEALTH CARE AND
13 COMPETITION LAW AND POLICY
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I N D E X

PRESENTATION:	PAGE:
BY MR. HURLEY	5
BY MR. BURGESS	29
BY MR. TOWN	55
BY MR. BURNS	67
ROUNDTABLE DISCUSSION	84

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

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3 MR. HYMAN: Good afternoon. We're going to get
4 started with our mid-April set of hearings on Health
5 Care and Competition Law and Policy. These hearings are
6 jointly sponsored by the Federal Trade Commission and
7 the Department of Justice, and sitting next to me is
8 Scott Thomson from the Department of Justice Antitrust
9 Division. We're going to be co-moderating this
10 afternoon's panel.
11 Today we're going to talk about hospitals and
12 specifically horizontal networks and vertical
13 arrangements, and we're lucky enough to have four
14 speakers, two of whom are talking about horizontal
15 arrangements and two of whom are talking about vertical
16 arrangements. So, the symmetry will hopefully work out
17 well.
18 The four speakers for today, consistent with our
19 general framework of abbreviated introductions so
20 everybody can talk longer, are to my far left, Bob
21 Hurley from Virginia Commonwealth University, who is
22 speaking on behalf of the Center for Studying Health
23 System Change. Sitting next to him, Jim Burgess from
24 the Boston University School of Public Health. Seated
25 to my right is Bob Town, from the University of

1 Minnesota. Is that public health or economics?

2 MR. TOWN: Public health.

3 MR. HYMAN: And then the empty chair to his

1 a call-in for each of those days as well, and following
2 our wrap of that session on April the 11th, we will
3 reconvene about two weeks later to start working on
4 insurance and insurance companies and we'll have
5 sessions continuing through April, May, and June. And
6 our expectation is that we will complete all of these
7 hearings by September, assuming all goes well. Perhaps,
8 I'm careful to say September at the moment.
9 So, with that, let me turn it over and I think
10 showing my lack of imagination, I am going to go left to
11 right in order, so, Bob, if you could start off, we
12 would appreciate that.
13 Let me just add one other remark for the people
14 who are listening, which is that the PowerPoint
15 presentations that are being shown should be posted on
16 our website within about a week and transcripts of this
17 session should be posted within about a month. It takes
18 that long to turn them around. If you look at the
19 hearing's websites, which there is an FTC one, as well
20 as a Department of Justice one, you will find a broad
21 range of materials that weigh into the hearings, past
22 sessions, PowerPoints, transcripts and so on.
23 Thank you.
24 MR. HURLEY: Thanks, my pleasure to be with you
25 today, and I actually am going to talk about vertical

1 and horizontal both, so I'm not sure who the other
2 person is who is splitting the topics with me. I'm
3 going to talk about the vertical and horizontal
4 integrations in the community tracking studies in these
5 markets. I'm sure some markets you've probably heard
6 about, and some of my colleagues have presented to you
7 previously, in terms of these markets around the country
8 that we study very closely and carefully on a biannual
9 basis, and when we see the map when it comes up, you
10 will actually see where these markets are.
11 What I will be talking about briefly is provider
12 integration that is observed in these markets,
13 horizontal and vertical integration illustrations of
14 what we see, and then I want to focus in on a couple of
15 very specific illustrations of this hospital health plan
16 sponsorship and then some of the evolving developments
17 in hospital/physician relationships. And then draw just
18 a few conclusions at the end. So, that's the kind of
19 preview or the road map for what I'll be doing.
20 The Center for Studying Health System Change, if
21 there's anyone in the world who doesn't yet know who we
22 are, because we do a lot of these presentations, is a
23 center founded in the mid-1990s fully funded by the
24 Robert Wood Johnson Foundation. Our goal is to do
25 objective, independent research on how private markets

1 are changing across the country, how these changes
2 affect people, consumers, and what the implications are
3 for policy makers. And you can see our website here.
4 The community tracking study, as you're probably
5 aware, there are actually two components to the Health
6 System Change work. We do surveys in 60 markets across
7 the country, and in 12 markets, the community tracking
8 studies are markets in which we do in-depth biannual
9 site visits to these markets. We have been following
10 them since 1996 and we are in the process of completing
11 our 12 markets for the fourth round here right now.
12 The markets are selected as a representative
13 sample, you'll see that in a moment. They speak to
14 national trends, I think reasonably well. There's some
15 geographic maldistribution, perhaps, but they are
16 stratified into kind of mega markets, large markets and
17 then smaller metropolitan areas. And they ostensibly
18 represent the average health care markets.
19 In the course of these site visits, we will do
20 70 to 100 interviews in each of the sites on this
21 two-year cycle. We do a broad cross-section of
22 interviews with health care executives and stakeholders.
23 We say we triangulate the results, we actually
24 quadrangulate them because we really interview in four
25 sectors, we interview on the health plan side, and the

1 provider side, and the purchaser community and then the
2 policy makers with respect to state and local
3 governments in these communities.
4 These are the sites, and I'll be drawing a lot
5 of my examples, of course, from the identified sites in
6 this -- on this map. The white marks on here represent
7 the 48 other markets in which we do surveys, the
8 physician and consumer, household and purchaser surveys,
9 and then the 12 markets that are listed are the ones
10 that we've been -- we are in the process of visiting
11 them. We just went to Phoenix, Arizona, last week, and
12 I think some of my colleagues are in Miami this week and
13 Boston in a couple of more weeks and that will complete
14 the fourth round of visits in these markets.
15 So, what have we seen as far as the evidence of
16 vertical integration and horizontal integration in the
17 community tracking sites? Well, let me just sort of
18 give you some big bullet items and then we will drill
19 down through these. Integration is quite extensive, as
20 you'll see, in these markets. It's been undertaken for
21 multiple purposes through various forms of arrangements.
22 We've been doing these market visits since 1996, so we
23 have actually seen a bit of a cyclical pattern with
24 respect to this integration activity, and I'll try to
25 dwell on that a little bit.

1 Horizontal integration has increased and then it
2 has slowed over the course of our site visits, largely
3 because of the consolidation that's occurred in the
4 market. We are sort of reaching the limiting point in a
5 number of our markets where consolidation is simply
6 maxed out.
7 Vertical integration itself has had an
8 interesting life cycle to it as well. Vertical
9 integration activities were much more apparent in the
10 earlier rounds of our visits, they have slowed, and in
11 some instances have reversed, and we'll describe some of
12 the rationale for this and the reasons for this as we've
13 observed them in the market.
14 Today the vertical integration activities that
15 we're observing are much more targeted in their
16 strategic age. The earlier ones one could say were
17 almost mimetic, they were imitative of other people sort
18 of taking the responsibility to make changes as observed
19 in other markets that are much more selective and
20 purposeful today.
21 And I think a central point of my entire remarks
22 will be the changing market conditions have influenced
23 the value of integration, both for these health systems
24 that are engaged in it and also the markets in which
25 it's occurring.

1 Just a picture to kind of give you a sense of
2 how we'll be presenting this, the horizontal obviously
3 of the flagship hospital with its affiliated hospitals
4 is the most common form we observe in our markets. And
5 we have some markets, such as Orange County, California,
6 where we have a single health system that owns ten
7 hospitals. That happens to be the Tenet system. In
8 other markets, these are more smaller scale of
9 horizontal integration.
10 And then the vertical integration represents a
11 wide range of activities, of related activities that
12 have been undertaken by this same focal institution or
13 typically the focal institution, many of which are going
14 to be characterized as ownership kinds of activities,
15 the dotted line with respect to these affiliated
16 physician networks is something I want to dwell on
17 because I think we have seen a transition, a
18 transformation really in the nature of the
19 physician/hospital relationships that is emerging in a
20 number of markets, and moved away from the spell of time
21 in the mid-nineties when practices were being purchased
22 extensively by hospitals.
23 Provider horizontal integration, again, several
24 markets in which this is evidenced, I only highlight the
25 Cleveland, Phoenix and Orange County because this is

1 where it's very evident and very widespread in terms of
2 a several multihospital system is evident in these
3 markets.
4 With respect to the aims, why are the
5 institutions in these, why are they undertaking this as
6 based on what they're telling us and what other
7 observers in the community have told us. They're
8 enumerated here in several points, again, which will
9 resonate with your general understanding of the
10 rationale and motivation for horizontal integration.
11 Improved operating efficiency is certainly a
12 frequently espoused and touted rationale for engaging in
13 these, achieving degrees of economies of scale
14 associated with operating multiple facilities in a

1 health plans and insurance companies here doing business
2 in these markets.
3 With respect to some of the yields from this
4 horizontal integration, let me just highlight a few of
5 these that are evident from our interviews. And again,
6 reflecting the fact that our qualitative information has
7 limitations in terms of

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1 certainty with respect to the high end kinds of
2 services.
3 There are fewer independent facilities in the
4 markets, and I would like to go to the next point as
5 well, the markedly enhanced negotiating leverage with
6 the plans has, in fact, contributed to that, if you
7 will, the idea of fewer independent facilities, given
8 the negotiating positions that horizontally integrated
9 systems enjoy, it is difficult for independent
10 facilities to be able to garner the same kinds of
11 contractual terms and opportunities that the system-
12 affiliated institutions can, unless they have a
13 particular market niche of some kind or geographic
14 advantage.
15 So, what we have seen is kind of a snowballing
16 effect of independent facilities joining these markets,
17 and having been back to these markets now on four
18 different occasions, we can see that kind of centripetal
19 force, I guess, pulling in rather than spinning out
20 amongst these institutions.
21 The potential to pursue exclusive affiliations
22 with selected plans is also enhanced through this
23 horizontal integration, particularly for those
24 facilities that have been able to achieve broad market
25 coverage, geographic coverage. They are now able to

1 present, for those health plans who are interested in
2 exclusive affiliations, are able to present a health
3 system that with a single signature can actually be
4 delivered -- a hospital system that can deliver
5 facilities across an entire market. And again, that's
6 an aim for some of these systems to achieve that level
7 of market scope.
8 And the last point I make is the one I just
9 qualified by suggesting that our level of detail in
10 terms of our understanding and the source of our
11 information is unable to assess the impact on
12 operational efficiency. Again, we're dealing with some
13 assertions in this case in terms of the ability of
14 organizations to contend that they are able to achieve
15 certain economies of scale. On the other hand, we're
16 not in a position to be able to validate that.
17 Now, let's shift to the vertical integration, if
18 we could, for a moment, in terms of looking at the kinds
19 of activities that are under way. Some of thei argjert
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1 are the ones that have the vertical and horizontal
2 activities.
3 With respect to the aims of vertical
4 integration, we've seen and heard extensive interest in
5 pursuing these for the purpose of controlling patient
6 flow, locking in market share. Whether it's
7 affiliations with individual practitioners or
8 acquisition of practices, as we saw five or six or seven
9 years ago, or whether it's just alliances and structural
10 arrangements that create a kind of forced loyalty, we've
11 seen those kinds of activities and the yield from those,
12 I think, has been significant in a number of instances.
13 We've also seen this ability to solidify
14 relationships, to move beyond just the tacit
15 understanding of referrals to owning practices and
16 requiring the referrals to be made to selected
17 facilities. Again, that's a purposeful yield from these
18 efforts.
19 Certainly, again and again in some respects,
20 this almost seems like ancient history today as we think
21 about over six and seven years ago. As we saw the
22 ascendancy of capitation, the expectation that
23 capitation becoming the predominant form, the prevailing
24 form of payment, the position to receive and to
25 distribute capitation dollars was a powerful motivator

1 in the mid-1990s for these delivery systems to pursue
2 vertical arrangements that would essentially allow them
3 to control those premium flows into essentially -- make
4 allocation decisions of those dollars.
5 Related to that, and of course if you think of
6 capitation as being the physiology of these
7 organizational entities, putting them together was kind
8 of the anatomy, if you will, of these integrated
9 systems. Pursuing seamlessness across the continuum of
10 care, then became very important to be able to
11 distribute those dollars and to distribute that care at
12 the most efficient and effective site.
13 We've also seen the opportunity of using
14 vertical integration to offer alternative distribution
15 and contracting options, and I'll come back to that in a
16 moment, because we've seen a number of health plans or
17 we saw a number of health plans sponsored by health care
18 systems as a way of generating additional competition to
19 some of the traditional insurance companies.
20 And finally, although this is a diversification
21 argument, it also is a means by which a vertical
22 integration was a way to generate revenue flows from
23 other sources and other types of payers, rather than
24 just the conventional payers for inpatient and
25 outpatient care.

1 A few comments about the yields from vertical
2 integration. What we've seen is that clearly the
3 positioning associated with building vertical systems
4 does expand control over premium dollar flows. It does
5 allow an organization to have influence on where those
6 dollars that are going for outpatient care, as well as
7 for inpatient care, are going. Whether those dollars
8 are going for physician care versus hospital care are
9 going in terms of being able to create a system.
10 Vertical integration has clearly yielded better
11 contract terms with managed care plans, again, in terms
12 of whether it's getting higher payment rates, more
13 favorable terms in terms of duration of contracts,
14 prohibition and exclusions of certain kinds of
15 undesirable kinds of payment methods, such as for
16 outpatient care and so forth, the ability to mobilize
17 that leverage as a result of having a system of care in
18 place has been -- has yielded significant gains for
19 systems that can pull that off.
20 We have also seen a number of hospital systems
21 develop managed care products, and another slide or two
22 down the way I'm going to show you that we actually have
23 seen that peak -- certainly we all in this room know
24 that this has peaked out some time ago, but we still
25 find in a number of our markets, we do have hospital-

1 sponsored plans, at least in three or four of our 12
2 markets, there are still hospital-sponsored health plans
3 that are playing a distinct role in those markets, and
4 actually expanding the availability of product offerings
5 above what would be available just from the insurance
6 companies and the health plans.
7 Physician affiliations have been enhanced,
8 although they've gone through a very tumultuous time
9 over the years, and I will come back to that in a
10 moment, too. We've seen success in decentralizing
11 delivery sites of being able to follow the populations
12 in community with ambulatory care, surgery centers and
13 imaging centers as a vehicle that the hospitals can
14 maintain these relationships and can maintain these
15 relationships with their customers in locations closer
16 to where the customers are moving.
17 And finally the continuum of care to the extent
18 that the systems have been able to put this in place and
19 keep it in place, a challenging issue, particularly in
20 the wake of the BBA of '97, the extent to which it's
21 been kept in place does, in fact, improve the patient
22 flow across the integrated systems.
23 But we have, as I was alluding to a moment ago,
24 seen diminished enthusiasm for vertical integration in
25 virtually every one of our markets over the last two

1 rounds, really. We saw more of this in 2000, it's
2 continued into 2002.
3 We've seen systems struggle with the ability to
4 achieve the expected returns from their vertical
5 integration efforts. We've seen and heard systems admit
6 their lack of proficiency in the diversification
7 efforts, of discovering that the advantage in other
8 lines of business were more challenging and were
9 different enough from their hospital management in which
10 they're not so sure of success.
11 Obviously we've seen conflicting goals in
12 competing businesses. This, of course, is the classic
13 problem of the health -- the hospitals owning health
14 plans, and we'll hear a little bit more about this in
15 another slide, but this, in fact, has been a very
16 challenging issue, and those of you who are veterans of
17 the health care industry know we've been through
18 essentially two waves of this. In fact it used to be
19 called Humana 101 at the beginning of the nineties, and
20 some people suggested that we went through the Humana
21 102 in the late nineties when hospitals began their own
22 health plans and subsequently have sold those off.
23 We've seen a decline, a substantial decline, in
24 capitation payments, and so the loss of those capitation
25 payments or the failure of capitation payments to

1 mobilize or to be sustained has undermined one of the
2 important rationales for building vertical systems. So,
3 many systems that have been dismantled were dismantled
4 because the capitation dollars never came, or if they
5 came, they came in such a small fraction of the overall
6 revenue picture that they didn't really change the
7 philosophy.
8 We've also seen increased demands of the core
9 business. Running a hospital, of course, is much more
10 challenging today than it has been in the past, because
11 of various pressures. Financial pressures, in
12 particular, that the hospitals are under and the ability
13 to devote their resources to sustaining their core
14 business as deflected from their ability to engage in
15 other activities.
16 Probably the most prominent change has been in
17 the payer environment, this came out of the balanced
18 budget act of 1997. We did a site visit from MedPAC in
19 1999 or 2000. We visited a high profile integrated
20 system in the southeast and the CEO proceeded to tell us
21 how in the last 18 months he had sold off all the
22 physician practices he had bought, he had discontinued
23 his HMO that he had started, he had spun off the nursing
24 home that he had developed. And he was in the process
25 of shutting down the home health agency that he had

1 developed, and then he said that when we're finished
2 doing all of those things, we're going to go out and
3 find the consultants who told us to do this and we're
4 going to kill them. And it was sort of reflected this
5 kind of at the end of this whole process, the
6 environment had changed fundamentally in terms of the
7 payer environment in terms of the suitability for doing
8 vertical integration.
9 And a last point, an evident point again
10 somewhat related to the effects of the BBA was the
11 reduced resources for investment in these other
12 enterprises.
13 So, a couple of areas where we still see
14 activity I would like to kind of highlight for you and
15 we've seen a significant change in terms of vertical
16 activities related to hospital-sponsored plans and then
17 we'll talk about the hospital and physician
18 relationships.
19 Interestingly, these health plans actually
20 peaked some time ago now. These products rarely
21 achieved substantial scale. They were generally
22 unprofitable for the hospitals, although it's difficult
23 to render a very definitive judgment because typically
24 the hospital was contracting with itself, if you will,
25 for the substantial portion of the hospital care in the

1 networks that they were creating, so it was all
2 difficult to assess from a single site how profitable
3 the hospital sponsored HMOs may have been.
4 There were clear internal conflicts associated
5 with the tensions between promoting cost minimalization
6 in a prepaid health plan and revenue maximization in a

1 I'm sure some of you will be discussing this somewhat
2 tomorrow, that that really obviates the need to have a
3 health plan sponsored by providers, if, in fact, they
4 are moved into a kind of hand and glove relationship
5 with the dominant health system.
6 The physician/hospital linkage evolution is very
7 interesting, I think very important, and probably
8 underappreciated at this point in terms of the longer
9 term implications of it. We know a lot of it from what
10 happened in the nineties, but I think we're still in the
11 process of discovering where this is leading us.
12 We saw a decline in risk-based payments and that
13 led to the abandonment of many of these formal
14 structures, these physician/hospital organizations, PHOs
15 that were in vogue in the mid-1990s. Surprisingly, in
16 some of our markets we still see physician/hospital
17 organizations in place. Even in the absence of
18 capitation in some instances, the health systems have
19 continued to finance or subsidize them, physicians have
20 continued to maintain affiliations with them.
21 In some instances, such as Indianapolis, this is
22 a vehicle for distributing capitation by the
23 hospital-sponsored HMOs, the HMO that dominates that --
24 that's the major competitor for the Blue Cross plan.
25 In other cases, the health system affiliation

1 with the PHO is a way of improving negotiating leverage
2 for the physicians by essentially moving in tandem with
3 the health system in terms of its negotiations. Health
4 plans have significant ambivalence about dealing with
5 these PHOs in many markets. The plans vary in their
6 responses to them, they essentially are playing the
7 so-called messenger model role, of carrying the offers
8 from the health plans to the providers and the providers
9 then maintain the opportunity to choose to participate
10 or not.
11 Some health plans prefer this as a means of
12 contracting, a kind of turnkey arrangement to be able to
13 get a single network but dealing exclusively with the
14 PHO in a local market. Other plans refuse to deal with
15 them and actually have threatened legal action against
16 them if they attempt to play too prominent a role.
17 It's unclear, again, from our vantage point of
18 our sort of 500,000 foot view, it's unclear whether PHOs
19 result in higher physician payments, but the assertion
20 is made that they stay in place because the physicians
21 believe that by having this affiliation, it somehow
22 enhances their negotiation leverage.
23 Today what we're observing, and this is a
24 qualification I want to put on the overall development,
25 if you will, the more targeted purpose and purposeful

1 nature of vertical integration than we're observing now.
2 Health systems are facing significant challenges from
3 specialty physicians. I believe that in some of your
4 earlier hearings you've had some discussion of specialty
5 hospitals and single specialty hospitals rising.
6 Vertical integration for some health systems
7 today is an initiative that may preempt or co-op
8 physician maneuvering. To preempt the physicians from
9 going off and making a deal with an investor-owned or an
10 entrepreneurial group that is going to come to town and
11 build a facility for them or to perhaps build a facility
12 themselves with their own capital.
13 We see this in markets like Syracuse and
14 Lansing, the sponsorship of ambulatory surgery centers
15 and imaging centers has been a controversy in which the
16 full-service hospitals have argued this is a threat to
17 our vitality if, in fact, this bundling is permitted to
18 go through by those who would draw these services out of
19 the hospital.
20 In other markets like Indianapolis, Phoenix and
21 Little Rock, it's actually been a much higher level of
22 activity, because of the growth of specialty or the
23 boutique hospitals. Indianapolis is a city that has a
24 number of freestanding heart hospitals under way,
25 freestanding orthopedic hospitals. Phoenix has already

1 had a number of those already built. These are markets
2 where specialty facilities are up and running, and in
3 some cases, representing a significant challenge to the
4 full-service facilities.
5 In these cases, in these kinds of markets, you
6 can see integration, vertical integration talk and
7 thought and strategy is still very important in terms of
8 how do the full-service hospitals respond to the threats
9 represented by these. So, these activities may include
10 building or buying or joint venturing to try to assert
11 some hospital influence and control on these markets.
12 Just a word about integration and regulation.
13 There are some elements in place in a number of states
14 to influence the degree of integration, although they
15 are not avowedly intending to focus on the activities of
16 integration.
17 Existing state regulations, as I say here, are
18 uneven. Horizontal integration may be subject to
19 special scrutiny, particularly if it involves an
20 acquisition of a facility that's going to require a
21 conversion from not-for-profit or for-profit status.
22 In other states, Certificate of Need is still an
23 active instrument, if you will, in trying to influence
24 the shape of the market. It addresses vertical
25 integration somewhat obliquely in terms of affecting

1 capital expenditures or acquisition or even in some
2 cases actually the divestiture of certain kinds of
3 services.
4 In states that don't have Certificate of Need,
5 hospitals, in particular, are feeling vulnerable to
6 these entrepreneurial unbundling and dismantling
7 activities that I was referring to earlier, and are
8 actually trying to use the Certificate of Need vehicle
9 as the means to try to slow that process. And clearly,
10 payer policies have both encouraged and discouraged
11 integration efforts in this realm.
12 Just to close, I would like to say that
13 integration is a means to modify the organization's
14 boundaries and functions in the face of a changing
15 market environment. Over this eight-year period that
16 we've been watching the markets, it's clear that the
17 hospitals have had to go through some very significant
18 contortions to try to respond to the very mixed messages
19 in the environments that we deliver it.
20 Integration does enable health systems to pursue
21 both their missions and their margins in a very clear
22 fashion, a very purposeful fashion, but it's also true
23 that integration activities have reduced competition in
24 some markets and probably contributes to higher costs
25 for consumers as a result in terms of success,

1 particularly in the horizontal integration front.
2 Whether integration activities primarily serve
3 institutional or community needs varies a great deal
4 across our 12 markets, and certainly continues to be a
5 subject to dispute. That's probably why you're talking
6 about it today. Shall I stop there?
7 Thank you.
8 (Applause.)
9 MR. BURGESS: I would like to thank David and
10 Scott for inviting me to be here today to talk about
11 this issue. I'm also really glad that although David
12 claimed that it was a random order that I did get to go
13 after Bob Hurley, because Bob, I think, gave a really
14 good overview issue around various kinds of both
15 vertical and horizontal integration issues. And I'm
16 going to talk in a much more micro level on one specific
17 issue within the issue of horizontal integration, and so
18 as a result, I think it was really helpful to have some
19 overall background.
20 This is joint work with Kathleen Carrie and Gary
21 Young, all of us from Boston University, and it's
22 partially funded by a Robert Wood Johnson Foundation
23 grant. Gary Young will be here tomorrow to talk in more
24 detail about not-for-profit versus for-profit issues in
25 some of these same areas, and this is part of an ongoing

1 research agenda that the group of us have in looking at
2 some of these issues.
3 I'm going to focus in, in particular, on issues
4 of collaboration that may not be ownership-based, so
5 that the issues, if you think about the relationships
6 between hospitals, those hospital relationships can
7 entail an ownership relationship, or a system
8 relationship. Or they can also be formed in various
9 kinds of collaborations, and these collaborations have
10 been becoming more and more common in the health care
11 industry.
12 And not actually just at the hospital level, but
13 also at some of the other levels, at the purchaser
14 level, at the health plan level, and also at the
15 physician level. So, at many of the different levels
16 these things have been happening.
17 Just for some context, I will try to make a
18 couple of relationships there, and describe some of the
19 differences about why hospital collaborative
20 arrangements are special.
21 And I want to relate that, in particular, to the
22 issue that I think, again, from an antitrust
23 perspective, people might be interested in, which is
24 focusing in on the hospital pricing behavior, and the
25 history of looking at hospital pricing behavior has been

1 to this, on how we look at hospital competition, how we
2 look at inpatient prices, which again is only a piece of
3 what hospitals do, and then I'll describe some further
4 questions and issues.
5 First, a definition of networks. Networks, and
6 I'm just going to use that term, that one term, are
7 non-ownership collaborative relationships, between
8 hospitals. They also go by a variety of names. You'll
9 hear them called strategic alliances, joint ventures,
10 collaboratives, and other names, associations, various
11 other names. And I'm going to just refer to them
12 generically as networks.
13 And it's important to stop here for a second and
14 talk about some of the activities that these networks
15 do. Sometimes the networks are formed for very, very
16 specific things. Such as sharing capital issues, which
17 might involve a mobile MRI machine, or something like
18 that, that moves around between the hospitals, or even
19 out into the community.
20 It might be pooling specialized resources,
21 especially with contractual arrangements with physician
22 groups, or specific physician specialties that might
23 then allow those specialized resources to move around
24 between the hospitals.
25 It also might be purchasing collaboratives.

1 There's a lot of emphasis sort of on looking at
2 pharmaceutical markets there, and purchasing drugs, but
3 also in very mundane things like purchasing joint
4 laundry services and things like that to get greater
5 efficiencies.
6 And then perhaps most importantly, or especially
7 of interest, I think, might be outpatient outreach
8 centers, where they'll collaborate together to form and
9 develop outpatient outreach centers in the suburbs.
10 This is especially common with urban hospitals, who in
11 order to compete with suburban hospitals develop
12 outreach centers. It's a location issue, suburban
13 hospitals may be closer located to a payer mix that's
14 very attractive to the hospital in terms of the
15 insurance coverage of suburban patients, and the
16 hospital in the inner city may be overwhelmed with
17 Medicaid patients and non-paying patients.
18 And the outpatient outreach centers may be an
19 arrangement where a number of urban hospitals can get
20 together, form an outpatient outreach center in the
21 suburbs where patients can come in as a collection
22 point, have outpatient visits, pre-op and post-op
23 visits, and then try to attract them down to the
24 hospital and compete with the hospital in that suburban
25 area that might be the local hospital.

1 So, and there are many other kinds of activities
2 as well. Sometimes those activities are not so
3 specifically defined, but are -- take on maybe all of
4 these arrangements, or just pick up on opportunities
5 that are identified by the network.
6 It's also important to note that this can be a
7 precursor to ownership system relationships, where
8 networks may be formed, and then may develop into an
9 ownership system relationship. Or they can be a
10 substitute for it, where hospitals are choosing a
11 collaborative network relationship in place of more of
12 an ownership relationship.
13 I also want to stop here a second and talk a
14 little bit about some of the networking that happens at
15 other levels. It's also true that health plans, for
16 example, form networks of this type, between each other.
17 And what health plans have been doing mostly is forming
18 these networks as quality collaboratives. And they do
19 that, actually, to, you know, bypassing hospitals, they
20 tend to do that and focus on physicians, trying to go
21 down and work with physicians and collaborate, and
22 they're also now starting to go out and pay those
23 physicians for performance and quality and outcomes and
24 things.
25 So, these relationships that are non-ownership

1 relationships can be very important at all levels of the
2 health care system. Of course they're also purchasing
3 collaboratives by the purchasing arrangements that
4 employers get together and will make arrangements and
5 form networks to purchase.
6 So, these non-ownership activities are becoming
7 more and more important in health care. And it's
8 important to look at them, I think, and that's why we're
9 focusing on them today in terms of hospitals, but I
10 think it's important to see it as a general relationship
11 that's happening in the industry.
12 Let me briefly talk a little bit about some of
13 the literature in this area, I don't have the full
14 references here, but I've provided them to David and we
15 certainly can make those available if you can't track it
16 down. There has been recent focus in the literature in
17 the area that I'm talking about focusing on
18 profit/nonprofit comparison, which is indeed the subject
19 of tomorrow's discussion. And I briefly list out here a
20 number of the articles in this area.
21 I won't go through those, since that's really
22 going to be a subject for tomorrow, but I do want to
23 call attention to two things: One is that the Keeler,
24 Melnick and Zwanziger paper also looks at the California
25 market and looks at it covering up to 1994, and the data

1 that we've been looking at and the opportunity that
2 we've identified to look at some specific changes in
3 these network relationships also picks up in 1994. And
4 we use very similar methodology in trying to look at
5 that as a way of trying to extend those results and move
6 it forward through the rest of the nineties.
7 And I know Jack Zwanziger testified I think last

1 And she has a number of papers, including some
2 joint work with Steve Shortell, where they've looked at
3 in a broad sense, looking at the performance of the --
4 of network and system hospitals and comparing them to
5 each other.
6 In a conceptual way, the other important
7 touchstone to the work we're doing is the Larry Casalino
8 and Jamie Robinson work from the mid-nineties looking
9 specifically at the California markets and comparing the
10 environment at that time, not just at the hospital
11 level, but also at the physician group level and health
12 plan level, and making decisions about ownership versus
13 contractual relationships. And some of the choices that
14 were being made, and that's an important touchstone as
15 well.
16 And then lastly, in terms of a market area
17 calculation methodology, we're going to argue that
18 especially if you're looking at network activities
19 where, as I described, a lot of times the purpose of the
20 network is to expand the scope of a hospital to move, to
21 maybe work with other hospitals and to attract patients
22 from outside of their traditional market areas.

1 Zwanziger, Melnick and Mann article is really the one
2 that describes in detail. That methodology is a zip
3 code-based methodology, and I'll talk more about that in
4 a minute.
5 Let's sort of step back and talk a little bit
6 about the potential FTC or DOJ interest in these network
7 activities. First of all, of course, is that there is
8 this session today, looking at networks and vertical
9 arrangements and the horizontal arrangements as well.
10 The DOJ and FTC jointly, in 2000, issued guidelines on
11 provider collaborative arrangements, which are focused
12 on the question around how to balance pro-consumer
13 benefits and potential problems.
14 And as we think through some of the potential
15 pro-consumer benefits, we might think about things like
16 better information flows, efficiencies that might be to
17 lower prices for health plans and consumers, quality
18 improvements, economies of scale, or perhaps more likely
19 scope economies, and also outpatient outreach centers
20 that I just described might also give better access to a
21 teaching hospital specialist.
22 Because most of these urban hospitals that are
23 reaching out into these outpatient outreach communities
24 are specialists that are from the teaching hospitals and
25 may mean improved access for consumers to get to those

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1 resources.

2 On the other hand, there are also some potential

1 exemptions to form these kind of contractual
2 relationships. States have generally been pretty open
3 about giving them a lot of leeway to form these kinds of
4 contractual relationships. And Fred Hellinger's 1998
5 article describes a little bit more about some of those
6 state activities.
7 Now, let's step back and then talk a little bit
8 about some of the theoretical issues, economic issues,
9 about how we might think about these issues, these
10 concerns. Health care is a fundamentally multiproduct
11 good that's also produced by a complex firm or set of
12 firms. And there's a lot of actually internal dynamics.
13 It's important not to think about a hospital as
14 a unified entity. A hospital is actually a complex
15 organization with lots of inter-incentives running
16 through it between different kinds of specialty areas
17 like physicians, nurses, managers, and other types of
18 people.
19 And that there's a -- in economics, there are
20 two classic theoretical frameworks that people use,
21 which are both probably good extremes to think about,
22 but probably not -- neither probably really describes
23 the nature of this. One is the classic Mark Pauly
24 physician workshop idea, where hospital placement
25 physicians engage in activity managing it as a workshop,

1 and the second being the Joe Newhouse hospital manager
2 model which gives them more of a view as the hospital
3 manager as coordinating resources to provide health care
4 to patients.
5 And in each case I think it misses the fact that
6 hospitals have become very complex. In fact I'm only
7 going to be talking about the inpatient side of them,
8 the coordination between inpatient and outpatient is in
9 itself complex, as well as the way it interacts with
10 other entities. So, I think keeping those ideas in mind
11 is important.
12 The second thing is that the standard sort of
13 economic theories that you might bring to bear on this
14 tend to be developed based on single product
15 definitions, which don't apply very well. And a number
16 of new theories have been developed in health care to
17 try to explain behavior across horizontal and vertical
18 integration and arrangements activities. One of those
19 is David Dranove's theory of option demand which says
20 that health plans might want to set up contracts with a
21 hospital or patients may want to contract with a health
22 plan which gives them access to particular resources,
23 not knowing whether they are going to actually use those
24 services, because most of us don't know what health
25 conditions we're going to face in the upcoming year, or

1 two or three, and instead we're valuing in some sense
2 the option to be able to get those services. And that
3 can affect the pricing, the nature of the way the
4 negotiation occurs, the form, the various kinds of
5 health plan provider networks, and how those things fit
6 together also on the hospital side.
7 But even these theories are generally
8 incomplete. Health economics has not developed a good
9 overall view to try to explain how to view these
10 relationships between purchasers, employers and
11 government health plans and providers, hospitals and
12 patients. And as someone who has been trying to work on
13 those questions, I thought it was a lot easier than when
14 I started. I've been working on some complex
15 theoretical models, and it's actually proving to be a
16 lot harder than I thought it was.
17 So, as a result, this is still primarily an
18 empirical field, where people are primarily looking at
19 data and trying to make assessments from it.
20 Let me talk a little bit about the sample and
21 data sources of what we've been looking at, and we
22 identified the area of California to look at because the
23 market growth in these network activities was extremely
24 large in the period following 1994. 1994 was the first
25 year that the American Hospital Association started

1 systematically collecting information on these network
2 arrangements. And those network arrangements in
3 California started out at a particularly significant
4 level, and increased quite a lot during the period
5 following 1994.
6 Another thing that we found out after really
7 looking at the data is really how different rural areas
8 were from MSA level data, and so I think it's important
9 when we're trying to look at these questions to kind of
10 separate questions with respect to how they affect rural
11 hospitals and MSAs.
12 And what we have been looking at is a sample
13 size for California -- 1,493 hospitals. I am going to
14 show you just a little bit of summary data, and that's
15 based on that sample of 308 separate entities over that
16 five-year period. Of course there are mergers during
17 that period that happened, so that some of the actual
18 hospital entities actually disappear.
19 And we're using AHA data plus this special AHA
20 data on networks which provides some detailed
21 information on network activity and when they're formed,
22 how they're formed, how they're based and a little bit
23 about what they do. And also patient level data.
24 With respect to networks and market competition,
25 as I mentioned, we really believe pretty strongly in

1 particular, that's, as I said, been done before, but
2 what we want to do is to focus in on the relationship
3 between system relationships between hospitals, or
4 ownership relationships and contractual or network
5 relationships.
6 So, as a result, we're going to compute four
7 HHIs for each hospital. Hospital systems represent
8 ownership relationships and networks represent
9 contractual relationships. And some of the usual
10 approach has been to treat the systems as though they're
11 a single hospital in calculating this market competition
12 measure. But what hasn't really been done is looking at
13 the network activity.
14 And so what we do is actually calculate four
15 different HHIs, one that doesn't account for systems or
16 networks, counting for each locality, hospital, places,
17 as an individual. One that accounts for systems, which
18 is that HHI-S is the one that is most used in the
19 literature. But then also look at one that just
20 accounts for network relationships, and then one that
21 accounts for systems and networks together. And it
22 would help, I think, to just visualize that, because we
23 go through briefly an example, so I am thinking about a
24 particular zip code, just one zip code that has five
25 hospitals in it, A, B, C, D and E. And hospital A has a

1 50 percent market share, hospital B has a 30 percent
2 market share, hospital C is a 10 percent market share,
3 and D and E each have five percent market share.
4 And if we imagine that hospitals A and D are
5 consistent with that hospital ownership together, and
6 then hospitals A and B and hospital A and E separately
7 exist in a network relationship. And we set this
8 particular example out here because it represents the
9 extreme level of what actually happens in the market in
10 California.
11 So, you do actually see these relationships
12 where you'll have a hospital existing in a system with
13 one set of hospitals, in two separate networks, each
14 with different hospitals, some of which don't actually
15 include the hospital that they're in an ownership system
16 relationship with.
17 In doing that, then, this just outlines how
18 calculating the four separate HHIs. One, the one in the
19 upper left, that assumes that all five hospitals are
20 individual entities. Then the one next to that on the
21 right is the one where HHI and the network relationship,
22 what we do is we chain these together so we allow
23 hospitals A and B and E to all be chained together
24 essentially in a relationship, some kind of relationship
25 together, and calculate an HHI from that, and then in

1 the lower left is looking at it as a system, where we
2 just look at A and D as emerged, and then looking at
3 systems and network activity together, chaining all of
4 these things together, where actually hospitals A, B, D
5 and E are all viewed as one entity, and only C is
6 sitting apart. And getting an HHI there of 0.82.
7 So, that just gives a sense of what we were
8 trying to do. And then the second piece of that is how
9 to look at inpatient prices and how to do that. The
10 methodology we've been using is the one that comes from
11 Keeler, Melnick and Zwanziger, which is an adaptation of
12 Bill Lynk's model that came before that, which
13 formulates a price index for ten specific DRGs.
14 Hospitals have these complex systems, and what we want
15 to do is in some sense, each individual patient is their
16 own output, but we have a methodology with DRGs that
17 allows us to group those, which again has strengths and
18 weaknesses, but then within that, there's going to be a
19 service mix difference between hospitals, and to try to
20 identify something that's consistent. The ten DRGs were
21 chosen originally by Lynk to try to come up with a set
22 of common DRGs that most hospitals would have activity
23 in that might be possibly complicated, so it's the idea
24 to try to come up with DRGs that aren't just simple
25 cases, but have some potential complexity to them.

1 And there's a little bit of debate in the
2 literature. We followed the Keeler, Melnick and
3 Zwanziger approach which excluded the Medicare space,
4 and then calculating average net prices from net
5 approach charges, and then followed a regression
6 methodology to model log net price for each DRG and then
7 build that into a price index.
8 The ten DRGs are here, I'm not going to focus on
9 that, I just wanted to keep that in the slide. And then
10 there's also a slide here looking at the details of the
11 price index calculation, and I wanted to keep that on
12 there to go into the record, but I'm not going to go
13 through that list in detail, but basically intuitively
14 what it does, it just takes that price and it tries to
15 explain all the differences that we know might affect
16 price that would be other than things that would be
17 negotiated. So that what you have left over is
18 essentially a price index that will wind up, as
19 designed, could line up well against a hospital
20 competition measure to identify things well.
21 And we do find that this procedure works pretty
22 well, and we were actually fairly surprised, not having
23 done this work this way previously, at how well this
24 process works at purging out the variation that you
25 don't want to pay attention to, and leaves the variation

1 that you do want.

2 This is just a picture to just describe what

3 happens in this California market over this period, and

4 it's actually we're still in the middle of doing the

5 analysis here, so I don't really have results that I

6 would like to present as complete, but I think I can

7 tell a story from here that gives a sense of what was

8 going on in California, and a little bit of sense of the

9 direction of some of the results.

10 I've mixed onto the same graph two different

11 concepts, one being HHI means, and also the percent of

12 the hospitals in the California market that are members

13 of the network, so the top line there that starts out

14 around 25 percent in 1994 is the percent of hospitals

15 that were involved in at least one network.

16 That rises very sharply for 1994 to 1996 from

17 that 25 percent to over 40 percent. Then it levels off

18 and then actually comes back down a little bit in 1998.

19 And if you look at the HHIs and the comparison between

20 those, you will actually see a little bit what's

21 happening in this issue of substitutability, versus

22 using a network as a way of generating an ownership

23 relationship you can see illustrated here.

24 The HHI not accounting for systems or networks

25 is fairly flat, although it drives just a little bit in

1 the last two years. The HHI for the network, which is
2 the next one up, rises in the first year and the second
3 year, quite a bit, while the percent of possibilities
4 getting involved in networks is increasing. And then it
5 really levels off. Whereas the HHI looking at system

1 relationship, versus a case where what's really
2 happening is the networks form, and that's a precursor
3 to system formation.
4 So, we're now trying by identifying those
5 hospitals relationships where the network turns into a
6 system, that's helping us to try to identify things a
7 little bit better, but we're still working on that.
8 So, as I mentioned, some collaborative networks
9 become ownership systems. And I should also note,
10 though, that some recent data reverses that trend, where
11 it seems that although what happened is you had network

1 what's going to be talked about tomorrow, that we do
2 see. There's a significant difference between the
3 nonprofit effect on prices and the for-profit effect on
4 prices. And as I mentioned, that effect doesn't seem to
5 be multicollinear with any of the effects on HHI or
6 hospital competition.
7 And we do get a slightly higher for-profit
8 effect on prices in the '94 to '98 period than Keeler,
9 Melnick and Zwanziger found in the 1994 and before
10 period.
11 And most other results, though, were very, very
12 similar to theirs. In fact, the government ownership,
13 which is a negative effect, that they have a lesser
14 effect on prices than not-for-profits or for-profits.
15 We get exactly the same coefficient as Keeler, Melnick
16 and Zwanziger does in all of our specifications. So,
17 that stability is a very strong point how we like to do
18 things.
19 And let me finish by just citing a couple of
20 things that we're continuing to look at or that might be
21 interesting for others who are interested in trying to
22 study these questions that we are looking at. Obviously
23 California has unique market properties with these high
24 levels and then increases in network activity. The AHA
25 data covering these networks and explaining them

1 actually also covers the whole country, so it could be
2 interesting to start looking at other markets as well.
3 Second is to look at the relationships with
4 who's actually operating the network. The data that AHA
5 collects actually also tells you who the operating
6 officer is for the network and where it's located. This
7 could also give a sense for what's going on, in
8 particular, many of the networks are operated by the
9 chief of purchasing, in which case it's really obviously
10 a purchasing network. Others are operated by the chief
11 of managed care, which really is a managed care
12 relationship to work with the health plans, yet others
13 are operated by the CFO. And also some are operated by
14 the clinical director, the chief of clinical services.
15 So, there's a variety of variation in here, and
16 we haven't to date taken, tried to account for the
17 differences in networks. And also I think we could look
18 at some more detailed work at the profit/nonprofit issue
19 where there's been recent concerns about aggressive
20 pricing practices that could spill over into higher
21 payments from other payers. And in particular,
22 Medicare, for example, now is thinking or is working on
23 revising their way of paying for outlier payments, based
24 on worrying about those kind of spillover effects.
25 So, that's the end of my presentation today, but

1 I would be happy or be pleased to talk about some other
2 issues on the topics afterwards in the general
3 discussion.
4 (Applause.)
5 MR. TOWN: I am Bob Town, I am from the
6 University of Minnesota, and I am very happy to be here.
7 And I get a chance to talk about my thoughts about
8 hospital mergers. I am going to take a slightly
9 different tack than the previous two speakers in that I
10 am going to talk about -- less about recent research but
11 mostly about kind of how I would like to argue that or I
12 am going to argue about how we should think about
13 hospital mergers. And so that's what I am going to
14 focus my talk. Although a lot of what I am going to say
15 is based on research that I have done.
16 And I think the thing that -- well, there's
17 several things about hospitals that make them unique
18 when you talk about merger analysis, but one of the
19 things that I think is particularly interesting, is that
20 hospitals are forming networks, and I'm using the term
21 networks here in the sense that Jim was using systems,
22 that there are ownership linkages between these physical
23 structures. But these -- so they're forming these
24 networks and they're competing against within HMO
25 networks.

1 And that makes the analysis very difficult and
2 different than almost any other industry that I can
3 think of. And so I'm going to talk a little bit about
4 that.
5 So, I wanted to -- so, when I talk to it, I want
6 to articulate a method for analyzing hospital mergers.
7 And this is kind of -- this method for thinking about
8 them is not just my own, it's come from synthesizing
9 conversations with colleagues at the Department of
10 Justice when I was there, from HMO contracting people,
11 from hospital administrators, from my own research.
12 So, this is not unique to me, and it didn't come
13 from me. And, in fact, I think various enforcement
14 agencies have made this argument that I'm going to make
15 here on various cases. However, I think the courts have
16 been less receptive to this argument, and I would like
17 to argue that they should be more receptive to it.
18 I'm going to primarily focus on pricing impacts
19 of a hospital merger. However, I think, you know,
20 economists like to talk about prices because it's
21 something we can measure very easily, but ultimately the
22 bigger concern may be in the quality demand, and there's
23 not very much work done in that area. In fact, I
24 think -- I know of two papers that -- they're up there,
25 that have done some work, and actually, there's a

1 broader list, if you were interested, and I could send
2 it to you, but there's very little work done on what
3 mergers do to hospital quality. The Kessler and
4 McClellan paper is in the quarterly Journal of
5 Economics, it's actually a very nice paper and the paper
6 I have with Gowrashankan, it's in the Journal of Health
7 waiting to be accepted and published. And I am happy to
8 send that to anybody who is interested.
9 Now, hopefully my talk will have some potential
10 pitfalls, I think the courts have fallen into when
11 thinking about hospital mergers. You know, to keep from
12 being specific about what cases those pitfalls occurred
13 in. So, in any merger, whether it's hospitals or any
14 industry, I think the organizing principle is, you know,
15 who are the buyers, what are they buying, and who are
16 they buying it from?
17 So, in the case of hospitals, who are the
18 buyers? Well, there's kind of three of the kind of big
19 buyers, there's going to be Medicare and Medicaid, which
20 we generally aren't too concerned about on the pricing
21 side, since they set prices, for the most case.
22 And then there's managed care. I am including
23 in managed care those self-employed insurers who are
24 contracting with hospitals. I'm lumping them in there.
25 And I think it's useful to think about exactly what do

1 do that in order to justify the expenditure, and also
2 allows the HMO to exclude those hospitals that they
3 think are low quality.
4 And there is some evidence, although it's
5 limited, that HMO enrollees go to better hospitals.
6 Mike Chernew and colleagues have a paper on that and
7 Kersey [phonetic] and colleagues have a paper on that.
8 Now, the utilization management component is
9 actually relatively important, because it's the HMOs
10 making these investments in the particular hospital.
11 And those might not be recoverable if they decide to
12 drop that hospital from the network.
13 So, I think the best way to kind of highlight --
14 or at least highlight how I would like to have people
15 think about hospital mergers is to kind of go through a
16 hypothetical hospital merger. So, I have up here my
17 little medium-sized hypothetical city, in which there
18 are hospitals, which are given by the different letters,
19 A through I. The numbers in the hospitals represent
20 market share of the managed care enrollees in that city.
21 With any luck, they add up to one. Or add up to 100, in
22 this case.
23 The color of the hospital represents which HMO
24 they've contracted with. So, here, HMO 1, which I have
25 in green, they're contracted with hospital A, C, and E,

1 and F. HMO 2 has contracted with hospital D, B, and
2 also F. So, hospital F is contracted with both HMOs.
3 So, if you were doing kind of what I would call
4 an Elzinga-Hogarty kind of analysis that this kind of
5 constitutes a city where, you know, the patient flows
6 are relatively constant within the circumference of the
7 city, and there was going to be a hospital between -- to
8 add a little animation here, there it is, a hospital
9 merger between E and F, you get the initial HHI would be
10 1450, and the change in the HHI would be 200. Which
11 would be sort of below the official guideline radar, but
12 certainly in practice would be below the guideline
13 radar.
14 But this analysis, that kind of analysis ignores
15 several things. One, it ignores the nature of the
16 contracting networks that are in place; it ignores the
17 differentiation that's occurring here. Both
18 product-wise, geographic-wise, perhaps quality-wise,
19 which is an important component of product
20 differentiation. And those things can affect, I think,
21 greatly, how you analyze the merger.
22 So, how should we think about this one? And I
23 think here's the kind of the city down below here in
24 this little corner. And I think the best way to start
25 to analyze the impact of the merger is to think about

1 how prices are set prior to the merger. And those
2 prices are going to be set via negotiation between the
3 HMO and the hospital, and that bargaining negotiation is
4 going to be reflected in the value that a particular
5 hospital brings to the HMO's network.
6 If a hospital brings a lot of value to that
7 network, presumably you get a little higher price for
8 the HMO sending their patients there. So that the
9 value, in this case, of hospital F to HMO 1 is going to
10 be the value of the network that HMO 1, which is the
11 green guys, has from the network of A, B, E and F. But
12 the threat that the HMO has to the hospital is to drop
13 it from the network. And say, you know, we can't come
14 to a good agreement on the reasonable price, but we're
15 going to drop you from the network, and that is going to
16 be the value to the HMO hospital, A, B, E, and suppose
17 that I was the next best alternative to F and they
18 include I in the network.
19 Post-merger, that bargaining -- the bargaining
20 position has changed. And it's changed because now the
21 threat of hospital F, as they've moved to merge with
22 hospital E, is that they can drop both hospitals from
23 their network. Which means that if they can't reach an
24 agreement on the premium, then the value to the network,
25 to the HMO, is the value of A plus B plus I; in other

1 words, they lost E in this circumstance.
2 So, the net change in price due to the merger
3 will be the difference between the price up here and the
4 price down here, which will be a function of the change
5 in the value of the next best alternative to the HMO.
6 And I think that's pretty intuitive and I think
7 it's kind of hard to argue that, but where the issues
8 get sticky, and there are a couple of sticky issues, and
9 they're twofold: One is how do you estimate the value
10 of alternative networks? You know, there's two
11 associated problems in that. One is what's the right
12 metric for valuing the network? There's many players
13 here. Unlike cereal, where the consumers of the cereal
14 are paying for it, in hospital markets, that's generally
15 not the case. Consumers are not paying directly out of
16 their pockets for the services.
17 They're paying the HMO, or the firm, more
18 accurately, that they work for is paying the HMO, to
19 contract with all these hospitals.
20 So, understanding from whose perspective the
21 value of the network is not entirely obvious. The
22 second is what are the other possible alternative
23 networks? Here I included I as the alternative to E and
24 F, but it easily could be without I, it could be I and G
25 and H, all right, so there's different network

1 configurations that serve as the next best alternative
2 to the current network.
3 Now, in the paper in the Journal of Health
4 Economics, we use consumer surplus of inpatients, and we
5 attempted to measure that. But that's not necessarily
6 the best alternative. It could be the value to the
7 buyers. And probably best, if we could measure it, but
8 it's very difficult to do so, is what's the -- what are
9 the HMO profits from various network configurations?
10 The next big problem is what's the function F?
11 Now, if you remember, F is the thing that translates
12 these changes in the value of the networks into prices.
13 You may be able to form a measure of the value of
14 different alternative networks, quite easily, or maybe
15 with some effort, but still it's unclear how you
16 translate those things into prices.
17 For the economists in the crowd, the next bullet
18 point will make sense, for probably everybody else, it
19 won't. And I think ideally, you would like to have F
20 come out of some equilibrium bargaining model that
21 you've solved. That's difficult, and no one's done it.
22 At least in this kind of context.
23 So, the alternative, there's a couple of
24 alternatives. One is you can look for statistical
25 relationships, which is what we did in our Journal of

1 Health Economics paper, or another possibility is you
2 can use the current pricing data to make inferences
3 about what that F function looks like. And talking to
4 HMO contracting personnel can actually tell you a lot
5 about what that F function looks like. And I think it's
6 hard to discount the importance of knowing what that F
7 function looks like and the help that the contracting
8 people can give you on what exactly it does look like.
9 So, this is the kind of typical non-guideline,
10 and the reason I put that non-guideline there, is
11 because I think the method that I'm outlining here if
12 you think about it is perfectly consistent with the
13 horizontal guideline method.
14 So, the Elzinga-Hogarty kind of analysis
15 suggests little harm from the merger. However, I took
16 those -- I took some kind of simulated data, and given

1 California, and we said, geez, you know, let's run some
2 hypothetical mergers. So, we said for each hospital, we
3 picked their next best, their closest substitute
4 hospital, assumed there was a merger from that, and then
5 recalculated the value that they would bring to the
6 network, or actually more exactly, the loss that they
7 would bring to the HMO network if they were excluded
8 from that network.
9 And given our estimates that we did earlier,
10 about 15 percent of the hospitals that we did this for
11 had price increase -- expected price increases of
12 greater than five percent. And LA is a very -- well,
13 there's a lot of hospitals in an intense urban area and
14 a lot of hospital competition. So, if this could happen
15 in LA, it could happen in a lot of places.
16 And the reason it's happening in LA is the role
17 of product differentiation and geographic
18 differentiation are very important in determining
19 hospital prices. And we know that in any market where
20 differentiation is important that even if there are a
21 lot of competing firms, that if the right competing
22 firms merge, you can get big price increases.

1 differentiation can account for those explicitly in your
2 analysis. I think in any kind of pricing regression,
3 you have to have that incorporated in there somehow.
4 Restricted HMO networks are the important
5 mechanisms by which insurers maintain lower provider
6 payments. So, it's this ability to exclude hospitals is
7 what gives HMOs bargaining leverage, versus hospital, or
8 vice -- kind of the flip side of that is that what gives
9 hospitals bargaining power is their ability to be
10 essential for a network.
11 And then a point that I really didn't get a
12 chance to highlight here, but I think is also important,
13 is that actual patient flows may not have a direct and
14 obvious relationship to market power. And you can think
15 of a hypothetical case where two hospitals are right
16 next to each other, right, but one HMO sends all their
17 patients to one hospital, another HMO sends all their
18 patients to another hospital, it looks like, geez,
19 they're pretty much very concentrated places, right, but
20 it would be easy for each HMO to kind of start moving
21 patients to other places.
22 So, the actual flows may not represent kind of
23 market power issues, but it's what you have to take into
24 account is what could happen if the networks were
25 reconfigured.

1 And my last point is that -- or I should say the
2 actual patient flows may actually represent market
3 power, so just because -- just because they can't
4 doesn't mean they don't.
5 And finally, the given networks that are in
6 place will play an important role in determining what
7 the price impacts of the merger are. So that in
8 analyzing the merger, you have to take into account
9 exactly what the network configuration is going to be.
10 I should say, and the last point, one of the
11 reasons I think this view has not been adopted is that
12 in a lot of economic analysis, this kind of analysis is
13 not done because the data is not available to do it. I
14 don't think it's because economists think it's a wrong
15 way to think about it, it's just that the data to do
16 this is not available publicly. However, in a merger it
17 certainly is available, and there's no reason why it
18 couldn't be done in a merger. In fact, it is done. And
19 I think I'll stop there.
20 (Applause.)
21 MR. BURNS: Well, I agree with everything that's
22 been said.
23 So much for my spelling.
24 I'm here to talk about hospital vertical
25 arrangements, the rationale and performance. Before I

1 start, let me just apologize for coming in so late, I
2 had class at noon at Penn and it's kind of hard to get
3 down here when you're teaching at noon.
4 We were asked to address a number of questions,
5 some of which are relevant for hospital vertical
6 arrangements. Just quickly to describe for people what
7 the vertical arrangements are that have emerged in the
8 U.S. market, what are the key drivers of performing
9 these vertical arrangements between hospitals and other
10 players, how they affect cost and quality, how do they
11 affect bargaining power and other competitive dynamics
12 between hospitals and payers, and finally, do consumers,
13 employers or insurers prefer these arrangements. I'll
14 try to go through this pretty quickly. I think the
15 evidence is pretty clear.
16 First, what are the vertical arrangements that
17 have emerged in the market? I have categorized them
18 into three types: One, partnerships with physicians
19 that hospitals have formed, and I'll go through those a
20 second; second, managed care vehicles where hospitals
21 have gotten into the HMO and PPO business; and finally
22 the whole continuum of care inpatient and outpatient.
23 First, hospital integration into input and
24 output markets. Here you have the core hospital, it can
25 vertically integrate into ambulatory care getting into

1 physician offices and ambulatory surgery centers,
2 various kinds of outpatient care, and then towards the
3 extended care, post-acute care, skilled nursing care
4 continuum.
5 Hospitals can also integrate into insurance
6 vehicles, as I said, becoming a buyer as well as a
7 supplier of hospital services, and then finally,
8 hospitals can develop the full continuum of care from
9 primary care, specialty care, outpatient care, acute
10 care, home health care and skilled nursing facility
11 care.
12 This slide came from the advisory board, you may
13 recognize it at the bottom. This is one of their chief
14 marketing initiatives when they tried to get hospitals
15 to think that they could actually do all of these
16 things.
17 Now, let me just delve down a little bit into
18 the hospital partnerships with physicians. This is the
19 alphabet soup we faced in the early to mid 1990s where
20 the hospital organized an IPA around its medical staff,
21 physician/hospital organization, which was really
22 nothing but a joint venture between the hospital and its
23 medical staff, typically including some sort of
24 contracting unit to go to the market with managed care.
25 Management services organization, a group practice

1 without walls, or what we really called a wall without a
2 group practice inside of it. A foundation model. And
3 then the primary care physician acquisition and salaried
4 model.
5 Now, there actually are data on these, more than
6 the others, and here's what's happened with the hospital
7 partnerships vertically with their physicians, over
8 time, for all those six models, you can see that they
9 really peaked in 1996, and then they trailed off after
10 that. So, 1996 was the peak. 1996 was also the peak
11 for hospital mergers and acquisitions, according to the
12 American Hospital Association's data.
13 The other thing you see here is that the single
14 most prominent type of vertical integration arrangement
15 with physicians was a PHO. Thirty-three percent of
16 hospitals had a vertical arrangement with a PHO, and a
17 PHO was nothing other than a joint venture with
18 hospitals and physicians to get a managed care contract.
19 That is not what I call integrated health care. That's
20 just forming a bargaining unit to go to the market with
21 managed care.
22 The other thing you should note is you should
23 not add all those up, you know, in a column to figure
24 out how many hospitals are doing something, because
25 hospitals typically had a menu of these things that they

1 were offering their physicians, integration light up
2 here and integration heavy down here, and they typically
3 offered two or more of these initiatives.
4 Second, what are the key drivers of this
5 behavior? The way I've chosen to answer this question
6 is to contrast the theory versus the real motives behind
7 this. Last summer Mark Pauly and I published an article
8 in Health Affairs which summarizes what I'm about to
9 show you. If you want more information, we published it
10 in the July/August issue last year of Health Affairs.
11 Basically what you do is if you take what the
12 practitioners argued for why they were doing vertical
13 integration, and then you compared it with the
14 theoretical arguments for vertical integration from the
15 literatures of management, industrial organization
16 economics strategy. You'll find essentially a
17 disconnect between what providers were saying they were
18 doing and what economists and other people say you ought
19 to be doing vertical integration for.
20 There's a little overlap between these two, but
21 not a great deal. Basically the providers were putting
22 these things together to prepare for and accept global
23 capitation, go on to form large patient pools and
24 provider networks to handle the risks. They said wanted
25 to assume responsibility for the health status of the

1 population, but they didn't really know what that meant.
2 They wanted to integrate care and financing, offer the
3 seamless continuum of care, whatever that means, have a
4 future platform for physician partnerships, maybe
5 improve physician recruitment to these fully integrated
6 systems, expand into new markets, and reduce transaction
7 costs. Then there are a whole series of private agendas
8 that hospitals were pursuing at this time, which had
9 nothing to do with what they were actually saying. What
10 they really wanted to do was control referrals. They

1 the literature, and perhaps I shouldn't blame them for
2 not knowing the literature because we don't write it for
3 them. It's fairly obtuse literature. They probably
4 haven't taken a course in the last 20 years in
5 industrial organization economics. But also because we
6 probably haven't been very good at getting in front of
7 them and telling them here's what the academic and the
8 research literature suggests about the strategies
9 they're doing.
10 It is not surprising because the practitioners
11 tend to jump on bandwagons. They'll listen to what the
12 consultants say, they'll listen to what the advisory
13 board says and they'll jump on to these, fad after fad
14 after fad, in the health care industry. Vertical
15 integration was one of those fads, and the providers
16 jumped on that fad blindly.
17 And if you look at the diffusion of vertical
18 integration arrangements, it has the perfect shaped S
19 diffusion curve, and there wasn't a whole lot of
20 research evidence, either in industry or health care, to
21 back up why they were doing it.
22 Now, there were ten assumptions behind
23 integration. This is my Dave Letterman top ten for why
24 hospitals were getting into the vertical integration
25 business. First, California here you come.

1 Essentially, a California model of capitated health care
2 was going to come to the east coast. That never
3 happened.
4 Second, there were four stages that your market
5 was inextricably going to march through. Remember the
6 four-stage market model that APM and the University
7 Health System Consortium were touting, you know,
8 hospitals were running around saying, I'm a stage two
9 market, hospitals were going around, I'm a stage three
10 market, as if that meant something. That whole thing
11 turned out to be totally bogus.
12 Third, scale economies, the never-ending belief
13 that scale economies exist in the provider side of the
14 health care industry and it turned out to be the Helen
15 of Troy of integrated health care. You know, the face
16 that launched a thousand integrated delivery venture
17 efforts.
18 Fourth, desperately seeking synergy, okay?
19 Hospitals throw around the words economies of scale and
20 synergy as if these things exist and as if they know
21 what they mean and more importantly as if they know how
22 to get them. But they are looking for synergy and they
23 don't even know what the word means.
24 Five, they thought by buying primary care
25 physicians they could get the managed care contracts and

1 the covered lives. That turned out not to be true.
2 Six, you can control referrals from the primary
3 care physicians you buy. That also turned out not to be
4 true. We learned this the hard way in Philadelphia and
5 Pittsburgh where we had the Allegheny bankruptcy. In
6 Allegheny, a health plan bought 552 primary care
7 physicians, overpaid for the practices and then said,
8 we'll make it up on the referrals. Okay, they didn't
9 get the referrals, okay? They thought they were going
10 to get 75 percent of the referrals from the doctors they
11 bought. They ended up getting 25, 30 percent, and not
12 much of a jump after they acquired them.
13 Seven, you can partner with physicians. Okay,
14 this is one of the key assumptions that underlies this
15 literature and I'll show you some data why it's not
16 true.
17 Eight, HMOs want to partner with integrated
18 delivery networks. That was also an assumption that was
19 not true. You know, the HMOs are just dying to deal
20 with a provider cartel.
21 Number nine, integrated delivery networks can
22 leverage HMOs. During the nineties when this trend was
23 taking place, that was not true. It may be more true
24 today, which is one of the issues why we're here, but it
25 was not true during the mid-1990s.

1 And number ten, the Clinton Health Plan. The
2 Clinton Health Plan helped to launch integrated delivery
3 networks, along with enabling legislation in Minnesota
4 and Washington, both of which were repealed three years
5 later. That didn't matter. And the Clinton Health Plan
6 was never even passed and it launched all of these
7 things. You know, if Bill and Hillary were smart, in
8 1993 when they floated the Clinton Health Plan, they
9 should have just backed off and not done anything else
10 and they would have been declared a success, rather than
11 having to go through the defeat they suffered in the
12 next year in Congress.
13 Third, how do these arrangements affect cost and
14 quality? I'm going to quickly summarize the literature.
15 Here again, most of this is summarized in the article I
16 did with Mark Pauly. Now, I'll go through it, different
17 arrangement by different arrangement.
18 In terms of acquiring primary care physicians.
19 It turned out when you did that, you only got a small
20 number of capitated lives from the managed care
21 companies. You suffered heavy financial losses for
22 every acquired primary care physician. You got
23 estimates up to $100,000 per primary care physician per
24 year, and Allegheny had 552 of those, so do the math and
25 you can see that they had $50 million of debt just from

1 that alone.

2 Small increase in physician loyalty, very small
3 increase. Failure to capture the majority of the
4 referrals that I mentioned, and one study found that
5 acquired primary care physicians had lower willingness
6 to cooperate with the system's practice guidelines,
7 compared to free physicians or independent physicians.
8 Very surprising.

9 Secondly, when you turn to the physician
10 hospital alliances, the alphabet soup, the IPAs, the
11 PHOs, the MSOs, they also failed to attract covered
12 lives, they had little or no infrastructure to manage
13 any of the capitated risk lives they did get, they
14 failed to increase physician loyalty, they failed to
15 improve hospital efficiency measured in terms of cost
16 per day, they failed to impact hospital quality,
17 measured in any number of ways, no economies of scope,
18 and they actually declined in prevalence post 1996 as I
19 showed above.

20 Then you turn to hospitals that got into the HMO
21 business. These things were a sorry failure.
22 Hospitals, they were sorely undercapitalized, they had
23 an inability to sufficiently grow and then compete with
24 the larger HMOs which had already consolidated and
25 gotten big. They sustained huge financial losses in the

1 early years, huge medical loss ratios, sometimes over
2 100 percent, no actuarial or marketing expertise, and
3 imagine having an HMO in-house when you have a physician
4 division and a hospital division. Guess who wants the
5 money? Everybody else except the HMO. And so they
6 conflicted over where to spend the money in-house.
7 And finally the hospital continuum of care
8 efforts. Those efforts were all derailed by the
9 Balanced Budget Act which really cut the rug out from
10 long-term care. So hospitals that got into that, lost
11 their shirt after the Balanced Budget Act. They were
12 also smaller markets with relatively low revenues.
13 There was no IT technology capability in these hospital
14 systems to link the disbursed alternate sites and no
15 economies of scope in combining outpatient and inpatient
16 care.
17 Fourth, how do these arrangements affect
18 bargaining power and other competitive dynamics between
19 hospitals and payers? This is where it gets
20 interesting, especially in the last couple of years.
21 First, there have been no empirical tests of
22 these dynamics to date. One study is about to get under
23 way, I believe, between Bob Town and myself and some of
24 his colleagues at Minnesota. There has been one
25 recently published study from The Community Tracking

1 Study. It's in the February issue of Health Services
2 Research. It's based on field interviews in the 12
3 sites of CTS, and it suggests that physician hospital
4 integration can leverage managed care firms.
5 Now, having studied this literature for a long
6 time, I have two problems with this research finding.
7 First, vertical integration is empirically confounded
8 with horizontal integration. Hospitals got into the
9 vertical integration business the same year that they
10 got into the horizontal integration business, and you
11 can't -- no researcher has empirically separated those
12 two effects. I believe the horizontal integration
13 impact on competitive bargaining with HMOs is much
14 bigger than the vertical integration effect.
15 Secondly, with this research finding, the reason
16 the researchers, who are all good researchers, assume
17 that vertical integration, vertical integration can

1 Let me show you what data we have so far that
2 discounts this. This is unpublished data, it's from a
3 national survey of 12 integrated delivery systems around
4 the country where we surveyed all of their physicians
5 who were in these aligned relationships, you know, the
6 PHOs and the MSOs, those are the physicians who are in
7 integrated salary models, who are part of the hospital
8 hierarchy, that's the bar on the right.
9 The physicians who are in the network or
10 alliance models like the PHOs or MSOs, those are in the
11 middle. And finally, the physicians who are rank and
12 file medical staff members who are not affiliated with
13 the hospital in any way are what we call the market
14 arrangements.
15 Now, this was probably the best study of these
16 different types of physicians, because we had a
17 stratified random sample of these and we had the
18 population of these, and then we gave them, you know, a
19 40-question survey, asking them how affiliated are you
20 with your hospital, how loyal, how committed, how happy,
21 how autonomous, et cetera, there were 12 different
22 survey dimensions, and it was on a Likert five point
23 scale.
24 One means not at all, two means no, three means
25 I'm not sure, four means yeah, I'm sort of aligned with

1 you, and five means yes, I'm on the same page with you.
2 Now, look across, the average score is three.
3 Now, three on the Likert scale is a question mark.
4 That's essentially you're asking the physician, are you
5 loyal to this hospital? The physician goes [shrugging
6 shoulders]. Are you committed to working with this
7 hospital? [Shrugging shoulders.] Are you ready to
8 invest in developing new ventures with this hospital?
9 [Shrugging shoulders.] It's a shrug factor. Physician
10 says, I don't know, and perhaps I don't care.
11 Then you compare, well, we're buying up all
12 these physicians in the hierarchial arrangements and
13 we're setting up all these strategical alliances in the
14 network arrangement, do we get better performance out of
15 those than the rank and file physicians on the medical
16 staff? What do you see? Not much.
17 Now, we had a huge sample here, almost 2,000
18 physicians. Some of these little deltas in here are
19 statistically significant, with a huge sample. But the
20 question is, are they substantively significant, and are
21 they worth spending all that money on? I don't think
22 so. And I don't think those deltas are substantively
23 significant.
24 Now, I can imagine one scenario where a hospital
25 physician integration might have some leverage over

1 managed care. If the hospital partner is the dominant
2 player in the local market, a large hospital system, the
3 must-have hospital and an insurer network, and the
4 hospital has a very large network of primary care
5 physicians which are both owned and contracted, then the
6 insurer may be afraid it will get locked out of the
7 doctor market if it doesn't do business with the
8 hospital partner. And that, in fact, is what the CEO of
9 Tufts Health Plans said to the FTC a few months ago in
10 their dealings with Partners Health.
11 Now, I think that is an isolated instance,
12 because how many hospitals in a local market have the
13 clout and the prestige and the must-have status of
14 Partners Health Care? And how many hospitals in a local e sta

1 the additional margins, they wanted to pay themselves
2 more money, I don't know where that money was going to
3 come from, but they thought, we'll cut out the managed
4 care margin and just pay ourselves higher rates. They
5 wanted to get experience with risk contracting and
6 position themselves as the ill-fated provider sponsored
7 organizations from the Balanced Budget Act.
8 The problems as I have mentioned before were
9 numerous. I counted up at least 30 or 40 different
10 problems these hospital-sponsored health plans had, any
11 one of which would have sunk these things.
12 Now, finally, do consumers prefer these
13 arrangements and do employers or insurers prefer these
14 arrangements? Let me ask you the first question first.
15 Do consumers prefer these arrangements? Well, when was
16 the last time you went into a doctor and asked for
17 integrated health care? It's a dumb question. There
18 are only a small percentage of the population that needs
19 to have the coordinated continuum of care, typically for
20 chronic conditions that persist over some point in time.
21 So, for the vast majority of patients, typically
22 those under 65, integrated health care is a nonstarter.
23 And secondly, what about everybody else? Well,
24 consumers don't really know integrated health care firms
25 exist, thus they don't demand them. Some employers like

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1 BCAG [phonetic] view them as wasteful and duplicative,
2 especially when they establish the same type of
3 organizations and infrastructure. Insurers view them as
4 contracting cartels that seek to extract higher prices
5 in exchange for no value added. And I said there are no
6 performance results and so I challenged the providers to
7 make the case that they indeed add any value.
8 Thanks.
9 (Applause.)
10 MR. HYMAN: Okay, we're going to take about a
11 ten-minute break, and then we'll reconvene at 4:00 for
12 some roundtable discussion. Thank you.
13 (Whereupon, there was a brief recess in the
14 proceedings.)
15 MR. HYMAN: We have some time for a roundtable
16 involving all of the panelists, and Scott and I have a
17 number of questions that will hopefully kick off the
18 discussion, but before we do that, we wanted to sort of
19 give some time to each of the panelists, if they wanted
20 to ask questions of any of the other participants or
21 sort of frame a subject for discussion, since you all
22 are certainly experts in your respective fields and
23 we're just official interlopers. So, why don't we start
24 again at the far left and just ask Bob if there's
25 anything he heard that he would like to ask questions

1 about, or whatever.
2 MR. HURLEY: I guess I just wanted to mention,
3 and I mentioned this to Rob during the break. I think
4 that there are some exceptions to the nobody's
5 integrated and nobody's made it successful. I think --
6 in fairness to the mother of all integrated systems,
7 Kaiser California -- is an example of a system that does
8 achieve integration that gives that name respectability.
9 And I think when it actually registers with consumers; I
10 know in our visits to California in looking at the
11 Kaiser experience, it really is a sense of one-shop
12 shopping and does offer a credible continuum of care.
13 So, I think, rather than suggesting that this is
14 an impossibility, I think it's a rarity rather than an
15 impossibility.
16 MR. BURNS: Full agreement.
17 MR. HYMAN: Well, let me just follow up on that,
18 why is it a rarity as opposed to a nonexistent
19 possibility? I mean, what are the conditions in
20 California and elsewhere that justify its, you know, its
21 continuation in this marketplace?
22 MR. HURLEY: Well, I think particularly Kaiser
23 has 60 years of history, which is hard to discount when
24 it comes to its capacity to do this. I think it also
25 does have a unique "compact" I guess is the phrase they

1 use to describe the relationship that they've been able
2 to really meld between physicians and the health system
3 that goes back almost 50 years itself, and that
4 relationship has matured and ewiy iemer time.

1 by very many other people.

2 The others that are like Kaiser around the
3 country are Geisinger, which is in beautiful Danville,
4 Pennsylvania, the next time you're on route 80 in the
5 center of the state; Carle Clinic, which is Champaign/
6 Urbana, Illinois; Scott and White in beautiful Temple,
7 Texas; the Marshfield Clinic, perhaps; Oxner Clinic,
8 perhaps. You can count them on one hand, at most two
9 hands. They all have a core set of characteristics
10 which distinguish them and give them strategic
11 advantage.

12 Typically, they are located in rural areas,
13 hardly any other competitors. They launched -- they
14 were launched on the basis of a large multispecialty
15 group practice in the twenties or the thirties, and so
16 over the last 70 years, they've all developed a
17 physician-centric collegial culture, which you won't
18 find anywhere else. And on top of that physician
19 multispecialty practice, they built a hospital or
20 hospitals, and then they all got into the managed care
21 business around the 1970s, long before anybody ever did.
22 And, thus, the physicians have had 20 to 30 years of
23 experience and comfort working with managed care, became
24 more managed care friendly, and they have a captive HMO
25 and a captive market where they could get the HMO out

1 there and penetrate the market with no competitors on
2 either the Blue side or the for-profit commercial
3 insurers.

1 Kaiser, is at the health plan level, they're the ones
2 that are explicitly out of the kinds of collaborative
3 relationships that are forming at the health plan level
4 in like California.
5 So, one of the other things you see is that when
6 an organization like Kaiser forms and does what it does,
7 it also tends to go it alone in other ways, in
8 contractual ways as well. So, I think that's an

1 actually work and how we actually get patient health
2 care out of them.
3 I guess, the question I would like to ask is a
4 little bit of Bob Town and some of what he was saying.
5 I really liked his model. I wanted to make one
6 connection point is that when he was talking about that
7 equilibrium bargaining model, that was the same thing
8 that I was talking about when I also referred to a
9 theoretical model that wasn't out there. That was the
10 exact same model I was thinking of.
11 And as someone who spent the last year trying to
12 build such an equilibrium bargaining model off and on, I
13 think it's really important, but really hard to really
14 understand in a conceptual way what's really going on is
15 health plans and providers are competing with each
16 other.
17 And again, it's an area we really don't
18 understand, but it's really crucial to really get a
19 sense of what the key friction point in the markets are.
20 And I think most of us would probably agree that that's
21 a key friction point, but not about how it actually
22 works. And I guess the question I wanted to ask Bob was
23 about when you were talking about the -- it's sort of a
24 question about the ex post view about the patient flows.
25 Your little picture that you put up there was sort of an

1 ex post, I mean here's the realized levels of where
2 patients end up in these hospitals.
3 And it's also, and I know you're familiar with
4 it, but the ideas of the option of demand ideas that,
5 you know, it's sort of more of the case when the network
6 is setting things up, they're trying to set up the
7 options to use things, and we don't really know -- the
8 patients going in don't always know what services
9 they're going to need, and similarly the HMO in setting
10 up its network doesn't know exactly which patients are
11 going to need things.
12 Do you think there's any usefulness in thinking
13 about those conceptions from an ex ante point of view or
14 do you think the ex post view is better?
15 MR. TOWN: Well, I think on the option demand
16 side, a lot of large numbers kicks in, so that in the
17 aggregate that's not an issue, that you don't have to
18 worry about it. The HMO doesn't have to worry about
19 option value because it knows it's going to have the 35
20 bursts. So, I think at a meaningful level, I think
21 that's not -- it doesn't contribute to the analysis.
22 So, and I think the ex ante versus ex post, it's
23 hard to get to know the ex post, when you're ex ante.
24 So, I think that's the big problem.
25 MR. BURGESS: Okay.

1 MR. HYMAN: Bob?

2 MR. TOWN: My question is actually more of a

3 magnitude question, one for Jim and then one for the

4 other members of the panel. And the one for Jim is I

5 was curious as to what kind of magnitudes you were

6 getting on price effects and what it would say about

7 various types of vertical or vertical and horizontal

8 arrangements, I guess more horizontal arrangements, that

9 we should be concerned about and which ones we shouldn't

10 be concerned about. And then the question for the other

11 two panelists would be what sort of magnitudes do you

12 see of price effects from vertical arrangements in the

13 literature of the stuff you've done?

1 there who are not actually using any substantial amount
2 of hospital services for substantial periods of time and
3 yet are paying money into the system through their
4 health care premiums. These may be quite desirable from
5 the point of view of the HMO customers that were the
6 primary focus in the discussion, and I think implicitly
7 the other discussions as well, and yet they don't show
8 up in patient flow data at all.
9 So, if you could comment on if there's any way
10 to get them in somehow.
11 MR. TOWN: Well, the answer is there's always a
12 way to get them in. It's whether you can get them in in
13 a way that you're happy with. I haven't spent a lot of
14 time thinking about these option demand issues, mostly
15 because I tend to view that, you know, if you're talking
16 about populations of 100,000, in a particular HMO in a
17 particular city, you're going to have the whole variety
18 of the average outcome is a pretty good proxy for what
19 you should be worried about.
20 But I might be wrong in that, and I just haven't
21 really thought it through as carefully as I should to
22 give a good answer.
23 MR. BURGESS: Let me give you my
24 counterargument, I guess it would be. What I think the
25 issue is is that even in an empirical basis, we haven't

1 really been looking at the problem simultaneously on
2 multilevels, and I'm as guilty of that on what I've been
3 doing as anybody, but it's the issue that if you
4 really -- and part of this problem, of course, is having
5 good data. Historically we've had much better data on
6 hospitals and haven't had very good data on health
7 plans, and where health plan people are located.
8 One of the things, I think, if we're really
9 going to look at health plan mergers, which is another
10 aspect of stuff or things that are going on, I think one
11 of the things that kinds of data that should be
12 collected by the courts and things in trying to look at
13 that is to really understand where the patient -- where
14 the patients that are enrolled in the HMOs actually
15 live, and then looking and relating that to, you know,
16 where they go and seek primary health care, where they
17 go and seek specialty health care, where they go and
18 seek home health care, you know, the whole continuum.
19 And then try to get a sense for those complexities.
20 But I guess more directly to the question, I
21 think it's the option demand issue builds in once you
22 are really trying to understand how the health plan and
23 the hospitals are competing with each other as, you
24 know, for their various market shares. Where health
25 plans are trying to gain revenue from enrollment of

1 patients and providers are trying to gain revenue from
2 services or perhaps from capitation. Meaning how
3 they're paid.

1 of redundancies are usually high on the list of the
2 things that are offered in justification of what's
3 sometimes a quite problematic merger, and I guess the
4 question is in light of what we've heard about
5 predictions of people putting their hard-earned money
6 into both horizontal and vertical arrangements, and
7 actual consequences. How much credence should we give
8 ex ante predictions of efficiencies captured and
9 redundancies eliminated given the record of horizontal
10 and vertical integration?
11 MR. HURLEY: Well, I guess the short answer is
12 not very much, based on what we've seen. Again, I think
13 Rob is sort of posing that people are saying they're
14 doing this more relative to the theoretical arguments, I
15 think illustrates the fact that some of this is clearly,
16 I mean, it's a public assumption. And I think there
17 also is an element that the expectation that
18 acquisitions in a horizontal sense would, in fact, be
19 achieving this, we find that a number of these systems
20 that have done acquisitions have difficulty in achieving
21 and rationalizing that they've intended.
22 So, the motivation for a weaker facility or a
23 smaller facility to affiliate is often for bolstering
24 and they may actually enter this transaction with a
25 different set of expectations than the acquiring

1 facility. And I think many of these facilities have
2 discovered the, you know, the competing heart problem
3 for the hospitals is a very hard thing to still, and so
4 consequently they've ended up making an investment.

1 whatever. Typically, there's a conflict between that
2 goal and another goal that they always espouse, and that
3 is: We want to expand our service delivery network.
4 Now, if you're really going to get serious about closing
5 down beds or maybe closing down excess capacity, what
6 you're going to do is you're going to take capacity out
7 of some portion of the geographic market, but then that
8 opens up a hole in that geographic market and you've
9 just shot yourself in the foot in terms of expanding
10 your service capacity.
11 So, those two goals are in conflict with one
12 another, and when push comes to shove, they maintain the
13 service capacity. One, because that's their goal, and
14 second, if they remove the service capacity, someone
15 else will move in and take away some of their market
16 share. And so, no system wants to do that. So, that's
17 one of the problems.
18 The second bigger thing is with regard to these
19 justifications, or these hypotheses, that these
20 executives have. I'm convinced, and I've said a lot of
21 strident things here, I'm going to say a couple more. I
22 don't believe executives know what they're saying when
23 they say we're going to achieve economies of scale. And
24 I don't believe they know how economies of scale are
25 actually achieved, and just how limited they are in

1 labor-intensive industries.

2 The second thing is that they'll say other
3 things like synergies and other magic words which they
4 pick up from consultants and gurus and even academics.
5 And I don't think they understand what those terms mean
6 either, but more importantly, they don't understand how
7 you actually achieve them and then how big the savings
8 from those things are.

9 So, I don't believe anything that they say up
10 front because I don't think they know what they're
11 talking about.

12 MR. HYMAN: Tell us what you really think.

13 MR. THOMPSON: I guess I had a question for Bob,
14 in terms of the implications of your theory for how we
15 ought to think about market definition. Obviously
16 you're down on Elzinga-Hogarty, but it wasn't from --
17 and you feel that your theory is consistent with
18 standard merger guidelines market definition ideas, but
19 it occurred to me in thinking about the examples that
20 you put forward that I would have to define a separate
21 market for each HMO. In contrast, I believe, if I were
22 to use Jim's HHI, it would be a different market
23 possibility to use either one necessarily completely
24 consistent with existing guidelines as I see it, unless
25 we define each HMO as its own market, for example, as

1 the center of some market.
2 MR. TOWN: I think on the guidelines side, I
3 think -- boy, it's been a while since I studied it, but
4 I believe there's -- I mean, there's a lot of price
5 discrimination going on on the hospital side. So, I
6 think there's part of the guidelines that talks about
7 how you define markets when there is price
8 discrimination going on. I think that it allows you to
9 do it at kind of the customer level. So I think that's
10 kind of part of the guidelines that kicks in. But I
11 think using guideline analysis in what I did, you know,
12 the two hospitals that merged would have been a market.
13 And the problem with Elzinga-Hogarty is that
14 there's -- it's defining markets on the basis of flows,
15 but it has no relationship to prices at all, which is
16 the basis by which you would like to define markets.
17 And that's the fundamental problem with Elzinga-Hogarty.
18 I think conceptually it's fine, as far as you want to
19 identify markets on the basis of where people are going,
20 or where they would go under different scenarios, but it
21 doesn't incorporate the price dimensions, which is
22 critical for understanding where market boundaries are.
23 Does that answer your question?
24 MR. THOMPSON: I think so.
25 MR. BURGESS: Well, I guess I would just add to

1 that, I mean, I would agree mostly with what Bob Town
2 said in his answer, I guess I would add to that that
3 it's the same issue of the challenge is it's kind of
4 like how do you -- I don't think we know yet how to
5 simultaneously, and I don't know how to do it,
6 simultaneously sort of look at the network at the health
7 plan's market share and its market, and then also be
8 looking at the hospital's market. And in some sense, if
9 we believe that a lot of the things that are happening
10 in health care that are important are contractual
11 relationships, that may not be ownership relationships,
12 then it does matter if I'm looking at a -- Let's flip it
13 back to the health plan merger, if I'm looking at a
14 health plan merger, it doesn't matter what network of
15 providers they've contracted with. What multispecialty
16 or single specialty group practices, what hospitals, in
17 what markets, and what the nature of the competition of
18 those hospitals and physician groups in their markets
19 is, also impacts how you want to view the health plan
20 merger.
21 I mean, and those two things interact. I think

1 also talking, you know, at health plan level, I think
2 there is more of an importance to look at the provider
3 networks. And if you're looking at a provider network
4 relationship, you might to see, you know, how it

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1 HealthSouth was doing was taking over the chronic rehab
2 or acute rehab market and they developed that. Then you
3 add MedCath taking the heart thing and trying to
4 integrate that across all the different kinds of heart
5 services. So, if there's an opportunity there, the
6 niche firms can arise and exploit that and HealthSouth
7 did quite well for some time. MedCath is still out
8 there and doing well.
9 So, there's a market out there. But I don't
10 think everybody hospital in every community needs to be
11 developing an IDM to serve that niche.
12 MR. HURLEY: I was going to, I guess I would
13 plug it just a little differently. I think there are
14 certainly risks associated with becoming very good at
15 caring for very sick people. And I think in the absence
16 of a risk adjustment at the private payer level is that
17 there's a significant concern shared by integrated
18 systems like Kaiser that it behooves them to be worried
19 about that.
20 I think I wanted to mention something that
21 relates perhaps to several of these questions is that I
22 think we have to recognize that when you use the term
23 health plan, and when you use the term HMO we really
24 mean health plan, and when we say health plan we really
25 mean multiproduct firms today, and multidiverse networks

1 associated with this multiproduct networks, because I
2 think that this issue of the degree to which plans are
3 selling more heterogenous products today is very
4 significant.
5 I know in California today there's a serious
6 concern for a plan like Kaiser to be the last
7 comprehensive benefit package in the market, as
8 everybody else is moving toward bundled and lower cost
9 products. So, I think this idea of becoming very
10 proficient at caring for needy persons carries with it
11 added risk as we go to more fee to user based designs on
12 our products.
13 We're seeing this in terms of the way networks
14 are being contracted now, and as you look out and look
15 at more of these consumer-driven variant products coming
16 along or tiered networks and arrangements, you're seeing
17 plans develop really finely articulated relationships
18 with provider networks that are built around the
19 suspected risk dynamics associated with this. And I
20 think it's going to complicate the ability to understand
21 these relationships between health plans and providers,
22 in important ways, but that seems inevitable at this
23 juncture. The HMO is in most of our markets, and our 12
24 markets is a dead product in probably 10 of them or 11
25 of them, there's nobody buying it anymore, everybody has

1 moved on to something else.
2 MR. HYMAN: Let me follow up that, which was the
3 next question that I was going to ask. How it changes,
4 and I think some of this has been discussed already, the
5 demise of capitation has obviously sort of a baseline
6 tradition where it's dramatically transformed who the
7 providers are and what they look like. And I guess I
8 would like to invite each of the panelists to talk
9 briefly about the extent to which the rise in point of
10 service options, consumer directed health care, and
11 whatever is the next thing coming down the line might
12 change the dynamics of the marketplace.
13 Bob, you've actually already talked a little bit
14 about that.
15 MR. HURLEY: I think I would go a little bit
16 further in saying that we're looking at kind of
17 gradations of membership, almost, in terms of network at
18 this time among providers. And part of that is these
19 other products, other than the HMO, have less steering
20 associated with it and therefore bring less value, less
21 certainty of value to the plan -- to the provider
22 networks, and therefore the provider networks expect to
23 be able to relinquish some of the discounts that they've
24 been getting.
25 So, understanding that and appreciating how the

1 claim or control that a health plan has on providers as
2 a result of contracting for less certainty prepared will
3 actually dilute the relationship that exists among
4 plans, and also corresponding to that is more cost
5 participation by the individual consumer, then puts
6 them, that makes them a more influential player in
7 actually the relationship that the delivery systems are
8 going to be having with the health plan. So, I think
9 it's sort of a two-pronged approach: A weakening of the
10 linkage between the plans and the systems; and possibly,
11 it depends on whether the information flow supports
12 decision making by consumers. But I think consumers
13 will, in fact, play a more prominent role in the sites
14 of care and the pursuit of care than they have under
15 this past decade of comprehensive health plans.
16 MR. BURGESS: Well, I think one thing to note, I
17 mean, this is not a unique view, I think pretty much
18 most of the panel probably shares it, is that the
19 incentives under capitation were, in some sense, doomed
20 to fail from the beginning, just as the incentives in
21 the fee for service were destined to fail. And the
22 problem, of course, is that the incentives in capitation
23 push you toward too little care and the fee for service
24 pushes you toward too much care. And economists have
25 been arguing at least since the eighties, but probably

1 longer back than that, that you wanted some kind of
2 mixed system that balances those incentives.
3 And a lot of it -- there's been a lot of
4 theoretical talk about how you would actually take and
5 use risk adjustment and other methods like that to try
6 to come up with a good mix system model for how you
7 would pay -- how you would pay for health care. And
8 fundamentally, I think, again, that runs into the
9 problem that you need to understand better how to deal
10 with all the multiproduct aspects that have been hard to
11 deal with.
12 So, I think when you talk down the road about
13 looking at consumers getting more involved, I think most
14 all economists view consumers getting more involved in
15 making choices that we can then look at so to understand
16 how they made choices is generally a good thing. And
17 then how we move from that to how we can get the health
18 plans to balance into that I think is the challenge.
19 And that is, you know, the direction to go is to then
20 start thinking about how to balance capitation and fee
21 for service incentives in some way so that you can get
22 more efficient care.
23 MR. TOWN: I just have a couple of thoughts.
24 One is that as HMOs, I guess that's the code word, but
25 since they're dead, health plans, as they move to more

1 diffuse networks, the role of competition will probably
2 because heightened, because the value that you have --
3 that a particular provider brings to the network
4 increases, because you're loath to exclude them.
5 And so, given kind of the simple model I put up,
6 I think you would imply that the plan would be even more
7 vigilant about maintaining competition in a provider
8 market. The second thing is that one of the reasons
9 that capitation failed was not because it was such a bad
10 idea, or mixed capitation failed, it just got too
11 confusing because every health plan was doing a
12 different form of it. Physicians had, you know, ten
13 different contracts with ten different forms of
14 capitation, which, you know, they couldn't make sense
15 of. And so it was not so much that the capitation was
16 providing the wrong incentives or couldn't be workable,
17 it was not workable given the complexity of the contract
18 and the environment.
19 MR. BURNS: The only thing I would add is sort
20 of from a more global perspective, is the impact of the
21 economy in employment, on whether or not people go into
22 HMOs versus PPOs and POS, that's a definite
23 relationship. The other thing, and I just noticed this,
24 is that the semblance of HMOs by the mid-1990s, I think
25 the HMO model peaked in popularity around '95, '96, if

1 I'm wrong. That also happens to have the trough in the

1 point that the patient -- the patient is not part of the
2 equation with either horizontal or vertical integration.
3 I mean, CEOs talk a game about seamless continuum and
4 we're assuming responsibility for health status, but at
5 the end of the day, these things are put together for
6 market power to attract physicians or something else.
7 The patients are secondary.
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1 effect. I don't know.

2 MR. THOMPSON: Before I ask my other question,

3 does anybody else want to respond?

4 MR. HURLEY: I wanted to use just the example of

5 the PHOs, because Rob you didn't hear me say this

6 earlier, but there are some lesser markets where we're

7 finding PPOs extant. And I didn't mention the specific

8 areas, but there are some examples where PPOs are the

9 entree; the bigger plans are basically ignoring the

10 protestations of the PHOs and saying we want individual

11 contracts. And so basically these organizations may

12 ostensibly be vertically integrated, but from the plans

13 that don't agree to deal with them, they are not

14 integrated, so they can see right through the argument.

15 MR. TOWN: I know one large health plan will

16 contract directly with physicians, only with physicians

17 within a medical group; they won't even contract with

18 the medical group. They will bypass the group and

19 contract with physicians. So, there really is a drive

20 by health plans to bypass these kind of vertical

21 arrangements.

22 MR. BURGESS: I might just add maybe a question

23 for Bob, one of the things that you didn't really talk

24 about when you just went through that example was the

25 role of the teaching hospitals and the academic medicine

1 PHO model. In the PHOs you're looking at, did you see
2 any tendency for the PHOs to persist in academic medical
3 centers versus nonacademic medical centers?
4 MR. HURLEY: Well, whether you think of the
5 faculty practice plan as being PHO or whether it's
6 actually meant as a group, the one at least that comes
7 to mind is the organized medical group. They actually
8 do negotiate as a group and they're recognized as a
9 group per se, not even as an IPA, but as an organized
10 medical group.
11 I can't think of any. There may be some
12 instances where they're structured as a PHO but for all
13 intents and purposes at least the core faculty are
14 presented as a group rather than an organized entity and
15 something that can be ignored.
16 MR. BURGESS: And then in those group practices
17 like that, are they -- are they falling apart anymore or
18 less than the other?
19 MR. HURLEY: The academic medical centers? No,
20 I think that -- I think what Bob was saying earlier is
21 that I think that it is true that plans in some cases
22 would prefer to have individual contracts if they could,
23 but our experience is that most plans, if it's an
24 organized group, organized literally as a multispecialty
25 or even a single specialty -- well, particularly

1 multispecialty group, most of the plans are okay in
2 recognizing them as an organized entity, it's the --
3 it's the weaker, looser negotiating front that they're
4 opposed to. And that, I think, is problematic.
5 MR. THOMPSON: A second question has to do with
6 the assertions you made about the economies of scale and
7 scope. As an economist, I try to transcend that when I
8 moved into cost functions, and in particular the
9 standard simple model of constant marginal cost that we
10 often use.
11 Is it your perception that they simply don't
12 know what they're talking about, they don't know whether
13 or not these economies are achievable or that they
14 really are not able to get them, they're not there to be
15 achieved?
16 MR. BURNS: Before I answer your question, let
17 me just say, I'm probably the only token behavioral
18 scientist up here, I'm not a card-carrying economist. I
19 do like the use the term economies of scale and I do
20 think I understand what it means. I think the answer to
21 your question is both. I don't think they know what
22 these terms mean; I don't think they know very well the
23 different ways that you can achieve economies of scale;
24 and I don't think they know just how big or how small
25 the economies are through the various ways you can

1 achieve them. But secondly, even if they do, the -- you
2 know, let's assume that the benchmark is 85 percent of
3 your costs around the clinical side. Well, to really
4 cut costs and achieve some economies of scale, you have
5 to do the real clinical integration of merging some
6 clinical operations across sites. Now we all know from
7 the CTS studies and other studies that that is hazardous
8 to your tenure as CEO, and you typically get fired if
9 you try to pull that off and it doesn't work. Because
10 it's very hard. And the only times you can actually do
11 that clinical integration that's physical consolidation
12 is where the two hospitals, let's say two hospitals, are
13 close together, so you don't disrupt the patient and the
14 physician travel patterns. And secondly, there's got to
15 be like a burning platform, in other words, the thing is
16 going to go under, so you can use that as leverage over
17 the physicians to do this sort of consolidation.
18 And there are going to have to be some other

1 I could be wrong, you can ask the other three.

2 MR. BURGESS: Well, I'll jump in on that sort of
3 cost function, the economic cost function idea. When
4 you estimate hospital cost functions, I think there's a
5 number of issues and factors that come into play that I
6 think even establishing or questioning -- I think I
7 would question the idea. I mean, I've done, I've tried
8 to do it, so I know, I mean, I know what you're getting
9 at, but if you're trying to sort of think about what the
10 marginal cost actually measuring it, and then making the
11 assumptions that you're making, start to get really
12 problematic. And just to cite one example, one of the
13 papers that I've done in that area looks at trying to
14 incorporate quality, and in an expansive way tries to
15 say, okay, what happens when you try to add quality to
16 cost function and figure out what happens.

17 Well, it turns out that the -- you can show
18 pretty clearly once you go through it is that the
19 quality is really measuring unmeasured case mix.
20 However much case mix you measure, that you didn't
21 measure enough case mix, then the quality measure is
22 just again more case mix. And apart from that there's
23 probably even more case mix that you didn't measure.

24 So, the problem is that even trying to
25 understand from that perspective, and we all understand,

1 you know, all of us economists like to think we can
2 simplify the world enough to still be able to figure out
3 a marginal cost, it makes it really hard to relate that.
4 So, I guess, that would be my, you know, I think
5 if you're going to do that, be real sure you're
6 measuring quality, at least in what you're doing, and of
7 course the hospitals themselves are struggling to figure
8 out how to measure quality. So, they don't really --
9 because they don't really understand their own case mix
10 I guess is what it gets back to.
11 MR. TOWN: I think it's unclear why they need
12 the merger to achieve a lot of these economies of scale,
13 there are other vehicles to achieve it that you don't
14 necessarily have to have full integration of facilities
15 to do it. So, again, that would be on a case-by-case
16 basis, but even if they were there to be had, it's not
17 clear that the merger is the right way -- is the
18 necessary way to go to get them.
19 MR. HYMAN: Let me actually follow up on Jim's
20 point and ask on quality and ask Bob Town a question
21 about quality. When you were talking about how to do
22 the analysis, you said you have to explicitly account
23 for quality differentiation, if I heard you correctly.
24 And, you know, quality is very hard to measure. There
25 are different measures one can use, there are

1 aggregation problems, there are risk adjustment
2 problems.
3 What sorts of measures are you thinking about
4 and how should they be factored into the analysis? Are
5 we talking about process measures or outcome measures or
6 organizational measures?
7 MR. TOWN: Well, I was actually having in mind,
8 the most simple measure, and that is how are -- how do
9 patients view hospitals? How desirable are hospitals to
10 patients? So, how are they determining which hospitals
11 they would prefer to go to? Which is for those who have
12 an unferreted access to any hospital, which ones are
13 they choosing and why.
14 So, that's the sense that I had, because that
15 will ultimately determine the value a particular
16 hospital brings to an HMO network.
17 Now, that being said, once, you know, if we had
18 the ability to measure hospital quality well, which we
19 don't, and given that we could do that, insofar as that
20 would affect patients' views of the hospitals, then that
21 kind of analysis probably would have to be done. But
22 because hospital quality is so difficult to measure, and
23 I've spent some time working on that problem, and it's
24 very difficult to measure in just the simplest cases.
25 It's even more difficult in the complex cases which

1 who is really sick.
2 And we don't organize our data in that way, as a
3 health system, yet. I think we're heading in that
4 direction, but we don't have that yet. So, I agree with
5 Bob, too, that if going in that direction, if you're
6 going to do that, we want to try to just set up the data
7 in that way.
8 MR. HURLEY: I was just going to say, to
9 appreciate just what a swamp this is, really, to follow
10 the issue, take a look at what happened in California
11 just about a year ago when the first of the tiered
12 networks were rolled out. Blue Cross/Blue Shield was
13 first out and Pacific Air and Blue Cross have them all
14 now. It's extraordinary after all the years of effort
15 that has gone into measuring quality and reporting
16 systems and report cards, as soon as anything was done
17 to even attempt to differentiate only on cost. The
18 plans were just clobbered with this argument that you
19 have to have quality information, and then they were
20 clobbered further with the fact of the inadequacy of the
21 quality of information.
22 So, it's a year later, the metrics that are for
23 quality are things like, are you reporting to Leapfrog
24 your levels of utilization for certain high volume
25 services, or are you completing the satisfaction survey

1 that might produce the results that then could be used
2 for differentiation in order to qualify you for the
3 higher tier. It's really extraordinary just how once we
4 attempt to put our money where our mouth is on quality,
5 how quickly people retreat from that. It's very
6 disturbing.
7 MR. BURGESS: Just to make a point, that's a
8 purchaser group. So, it's the question that you have a
9 purchaser group is the one who wants it in that form and
10 that's what they want to know. So, that's what they're
11 asking for. So, that, again, my point is that that's
12 not really a focus to the patients, it's focused at what
13 the purchaser group wants to know.
14 MR. HYMAN: Scott? I guess I've got one or two
15 more. This is for Bob Hurley, you said when we were
16 talking about integration that there's often a conflict
17 between serving institutional or community needs, or
18 maybe it's just how you express the goals. I mean, I
19 thought that was interesting, because community needs
20 is itself, at least from an agency perspective, a
21 peculiar way to articulate what you're about, is
22 consumer preference as opposed to community needs
23 would be the way that I think the agencies would
24 think about this.
25 So, I guess the question that I have, and maybe

1 this is just is health care special question in yet
2 another guise, is why is it that it's framed in terms of
3 community needs? Is that simply a cultural phenomena
4 within hospital administrator training, and how
5 frequently is it sort of do consumer preferences get
6 even mentioned?
7 MR. HURLEY: I think that's a really good
8 question, because I do think that there are -- and
9 again, I'm going to be cynical about this or skeptical
10 about this, but I think there are hospital executives
11 who believe that, in fact, they are expressing community
12 needs when they're talking about broader issues that go
13 beyond their own individual instances. But the reason
14 why I was using that phrase earlier was partly to kind
15 of emphasize the point that I was raising about the kind
16 of contemporary efforts at vertical integration that
17 we're observing in several of our markets are really
18 preemptive to keep the full-service hospital from being
19 unbundled by these entrepreneurial spasms, if you will,
20 in the market.
21 And, you know, again, you can argue whether
22 or not you think that the hospital, and you may have
23 said this earlier, oneain,qrtheof ohe mtalkid bo ku

1 for thinking about what constitutes this. But I
2 think we have, you know, a significant challenge today
3 in terms of establishing where are those boundaries
4 going to be drawn as we see the unbundling occurring
5 and the centrifugal forces that are pulling these
6 services off from the institution and the degree to
7 which individual physicians or groups of physicians'
8 interest run counter to the maintenance of the
9 full-service institution.
10 Now, whether the institution is better
11 articulating community needs, I probably would bank
12 a little more on them than I would on the group of
13 cardiovascular surgeons who have got to have the
14 Medcath facility in the suburbs. I think that's the
15 kind of issues that we need in community -- it seems to
16 me in communities today, we have a gap in terms of
17 identifying who are the statesmen who talk about
18 community needs and can articulate community needs, in
19 the absence of any other kind of forums to be able to
20 achieve that.
21 Certainly it's fallacious to think that the
22 every hospital administrator who dons the mantel of
23 speaking for community needs should be believed, but I
24 think there are some transcending issues that the
25 institution that the institutional history and heritage

1 of the hospital still commands that, you know, in the
2 center of the health care universe.
3 MR. BURNS: Yeah, I agree totally with that.
4 That's one of the key undebated issues is the validity
5 of these niche firms coming in and stripping these
6 things off from hospitals. And how hospitals are
7 responding to that also needs to be addressed. There
8 ought to be some public discussion of that and more
9 research on these things.
10 I know that Medcath has released its second
11 report on how well their hospitals are doing in terms of
12 quality and efficiency, but that needs to be, you know,
13 analyzed in the wider scope of things. But clearly what
14 the providers are doing is what Bob's saying. They're
15 setting up their own, quote "Centers of excellence,"
16 unquote to retain physicians so that they don't bolt
17 from Medcath.
18 MR. HYMAN: I'll just ask whether anybody wants
19 to say anything else? No? Okay. Well, I'm pleased to
20 announce that we are not only finishing ahead of time,
21 but we have addressed the key issue already, which was
22 single specialty hospitals we did two weeks ago. So,
23 we're just slightly ahead of our time as the ad likes to
24 say. And can you join me in a round of applause for our
25 panelists.

1 (Applause.)

2 (Whereupon, at 5:00 p.m., the workshop was

3 concluded.)

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3 DOCKET/FILE NUMBER: P022106

4 WORKSHOP TITLE: HEALTH CARE AND COMPETITION LAW POLICY

5 HEARING DATE: APRIL 9, 2003

6

7 I HEREBY CERTIFY that the transcript contained

8 herein is a full and accurate transcript of the notes

9 taken by me at the hearing on the above cause before the

10 FEDERAL TRADE COMMISSION to the best of my knowledge and

11 belief.

12

13 DATED: 4/9/03

14

15

16 Sally Jo Bowling

17

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

19

20 I HEREBY CERTIFY that I proofread the transcript

21 for accuracy in spelling, hyphenation, punctuation and

22 format.

23

24

25 Sara J. Vance