1 FEDERAL TRADE COMMISSION

FEDERAL TRADE COMMISSION

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P R O C E E D I N G S

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MS. MATHIAS: Good morning and welcome. We are here today to look at hospitals and the non-profit status. This is the 9:15 to 12:30 session that we'll be having this morning. I don't think I said, but welcome to the FTC and Department of Justice Hearings on Health Care and Competition Law and Policy.

Just as a note to all the speakers, because we have the air on and because we do have a conference call listening in, it helps if you make a real effort to speak into the microphones so that the court reporter can get it and so that the people on the phone can also hear.

My name is Sara Mathias, I'm with the Federal Trade Commission. My other moderator is Ed Eliasberg and he is with the Department of Justice.

Non-profit hospitals, it's my understanding, equal about 60 percent of the community hospitals that are operating in the United States today, and so, it's an important issue to both the Department of Justice and Federal Trade Commission.

In Kenneth Arrow's 1963 essay, Uncertainty and the Welfare Economics of Medical Care, he focused on the issue of trust and agency and his analysis stated that as a signal to the patient, that the physician was acting on

the patient or the consumer's behalf, that the physician would avoid the stigma of profit maximizing. We have seen, in recent years, the beginning of growth of for-profit hospitals, and the question becomes, do for-profits and non-profits act the same, are there differences, what should we be taking into account when we look at the different hospitals and how they act and don't act.

We have an esteemed set of panelists here and I'm very pleased that they were all about to modify their schedules and come. It does take a lot of work to prepare for this kind of session, to put together their talk, their PowerPoints, look at their research, look at other people's research and we are very deeply grateful that all of you could make it here today.

Now, as far as how we work, we do like to make sure that everybody gets their due credit for all their history, but we like to spend more time talking than on introductions. So, I will give a very brief introduction, but we do have a handout that has the biographies of everyone included in it and we hope that you will grab that from the table outside so that you can see the full value that all of our participants add to our table today.

On my far right is Bill Lynk. He is Senior

Vice President and Senior Economist at Lexecon, which is an economics firm in Chicago. Bill heads up Lexecon's health care and antitrust practice. Actually, it's health care antitrust practice.

To Bill's left is Tony Fay, who is Vice President of Government Affairs at Province Healthcare Company in Brentwood, Tennessee.

Gary Young, to my immediate right, is an Associate Professor of Health Services at the Boston University School of Public Health and Co-Director of the School of Public Health's Program on Health Policy and Management. Gary is also a senior researcher at the Management Decision and Research Center, which is a research and consulting component of the Veterans Affairs Health Services Research and Development Service.

Cory Capps, who is on Ed's left, holds a Ph.D. in Economics from Northwestern University and is currently a Research Assistant Professor at the Department of Management and Strategy at the University's Kellogg School of Management, and actually from 2001-2002, Cory was also working at the Department of Justice. We always like to see our alums.

Frank Sloan, who is on Cory's left, has been the J. Alexander McMahon Professor of Health Policy and Management and a Professor of Economics at Duke

University since 1993. He is currently the Director of the Center for Health Policy Law and Management at Duke.

Peter Jacobson is an Associate Professor in the Department of Health Management and Policy at the University of Michigan, School of Public Health.

And last, but not least, is Dawn Touzin, an attorney with the Community Catalyst and Director of Community Catalyst's Community Health Assets Project.

Our agenda today is very simple. We're going to listen, hopefully learn a few things, and ask a lot of questions. As far as order goes, we will proceed with everyone giving a statement. Some of the presenters may go up to the podium, some of them may sit here. It depends on what they want to do. Or we also have the overhead projector.

We will then break for 10 minutes and begin again after that 10-minute break with a moderated session of Ed and em4tttrFtSrhe

silly, but that way I make sure that you're recognized.

And I guess, at this moment, I'd like to ask Bill to make his presentation and then we'll actually move in order down the table.

DR. LYNK: Good morning. Within the framework of the general session that was a specific topic that was suggested by the sponsors, and that specific session was phrased, are there systematic differences between the performance of non-profit and for-profit entities? And that's the topic I've chosen to try to address.

The basic point I have, I guess, is two-fold. One is strictly from the standpoint of the economics of incentives, I think we ought to expect to see, if we look carefully, that there are systematic differences between for-profit hospitals and, at least the typical, non-profit hospital.

And the second is that the empirical evidence, at least as I read it, cuts both ways, I think, on the existence of that differential effect. But I think that on balance you would say that it supports it, although it, by no means, supports it universally in the sense of for every non-profit hospital.

Now, Gary Young mentioned to me this morning that a paper I wrote in 1995 may have had some small influence on some interests in parts of this debate, so

let me talk just a little bit about what all went into that.

I first got interested in the ownership issue, I guess I'll call it, over a dozen years ago. And at that time, there was a substantial amount of theoretical discussion/conversation about it. As we heard earlier, Ken Arrow's '63 paper was influential. A lot of people would date it to Joe Newhouse's 1970 paper on hospital behavior.

But to sort of complete the square, I took a look at all of the empirical literature that was available as of that time. Table 1 -- I don't know if everybody's got a handout, but everything that's up there is in the handout. Table 1 is sort of a summary of --

think about what that actually said was that it's sort of the joint mean of all of the things that could influence price. The collective effect of that on for-profit prices was greater than the collective effect of that on not-for-profit prices. But that doesn't speak quite directly to the question of, with respect to the specific factor of market power, whether measured by market share or market concentration or whatever, was there a differential effect.

Let me illustrate that with Figure 1 in a merger context. And here's what I'm driving at. Suppose we had two for-profit hospitals that merged and merged in a set-up that created market power. You could decompose what's going on into two effects. One is, absent any efficiency issues or effects, you have an effect of market power which would lead them to increased price above the previous level. On the other hand, since many mergers have at least the potential for creating efficiencies, you have an efficiency effect that, apart from market power, would tend to lower the price. Of course, the full effect that you tend to see in a merger which I've compacted is supposed to be harmful to consumer welfare, is that market power effects dominate and price rises.

Now, what does that say for the non-profit

really directly on point with respect to this differential pricing response to market power creation. So, I decided to do my own study and let me show you what I found in Figure 2.

What I actually did is pretty simple. Controlling for a lot of other relevant factors and using data in California in 1989, I basically looked at net prices in less concentrated and more concentrated areas, controlling for whether they were for-profit or non-profit, and tried to see what the effect of concentration was in sort of an indirect effort to see what the effect of concentration increasing mergers would be.

What I found was that if you took my statistical estimates and simulated the effect of a merger, for-profit hospitals had an 8 percent or so elevation in price in my simulation, marginally significant -- actually, insignificant now that I think about it.

The non-profit hospitals, on the other hand, turned out to have a lesser effect and, in fact, negative. But the principal question that's the subject of this subset of the session was that there was a substantial difference above 12.8 percentage points difference in the response. So, if the question was differential response, that's the answer I got back in

1995.

Now, as it turned out, it's really the subsidiary finding that seems to have generated a little bit more attention, that at least in this sample, when you looked at the effect of concentration on non-profit prices, it wasn't just less than for-profit, it was actually less than zero. It was negative. And that generated some interest, I think.

Emmett Keller at Rand has suggested to me -- and this really is this Figure 3, I guess -- that if you took my own empirical results and just simulated the merger a little differently to take into account some scale effects, you might get a different result or you would get a different result. And he was dead right. I mean, without belaboring whether the suggestion makes sense or doesn't make sense, when you implement the suggestion, the effect on non-profit price pretty much vanishes to the point of insignificance, but the previous finding, the finding of the differential effect survives basically with its size and its statistical significance intact.

Well, there did follow a number of independent studies that looked at for-profit and non-profit pricing in a variety of ways using, to some extent, different methods, and to some extent, different data. One of them

was by Simpson and Shin who used more aggregated data, I think, from California to look at some of these issues. And for a number of reasons, methodology reasons and so on, they come up with a different answer. They're unable to find a significant difference between the conduct of for-profit and non-profit hospitals on pricing, at least the way they look at it.

For another example, Dave Dranove and Richard Ludwick did a study of non-profit hospitals that basically showed that if you delete some of the explanatory variables and add different variables and exclude from the data set a chunk of the underlying data, if you go through a variety of steps like that, it's possible to flip my earlier result -- the result of my earlier sample from a negative effect to a positive effect.

Now, they elected not to analyze at all the differential issue, whether -- they focused on non-

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interesting and, I think, on balance, at least in the majority, some pretty good refinements and methodology and even more important, it extended it to multiple years, which for those of you who've done these sorts of things, it implies a tremendous amount of work if you're going to be careful about actually examining the data.

But that's what they did and this is what they found. What they found is that in the late 1980s, which is where I was looking, they found a small positive

Now, in addition to those, though, there were a number of what I would call time series studies, sort of before and after studies. The first one by Robert Connor and his colleagues at Minnesota basically took a look at almost virtually all U.S. hospitals in 1986 and then again in 1994 and they asked themselves, what happened to the price of merging hospitals relative to non-merging hospitals and then broke that out by type of ownership?

Well, here's what they found. What they found is that for both for-profits on the left and non-profits

measure these things more precisely and they studied a different and later time period for their before and after sort of analysis.

Now, what they found is different from what Connor found from his earlier period. What they found is that the effect of merger on for-profit prices was positive, and actually positive and fairly large. They found that the effect of merger, on average, over the non-profit hospitals they looked at was negative, relatively smaller, but nevertheless negative, and they found a differential effect between non-profit and for-profits that was quite significant.

Now, those are the hospital pricing studies that I'm most familiar with that zero in on this differential response issue. I should mention that there are other approaches to look at this that I'm not talking about today. One of them is to look at hospital conversions, hospitals that switch from for-profit to

was quite significant or look at hospitals for-profit ways you'd for smallechange

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And I should mention, I also know that Cory

differential. But I think the nice thing about a quick tour through the published literature is you get to pick -- you don't have to really take my take on it, you get to make up your own mind on it, which is what I would encourage anybody who's interested in the subject to do.

Now, obviously, different studies differ and sometimes they differ in the soundness of the methods and sometimes they differ in the soundness of the logic of the inferences that they draw from the results. And although I don't have the time or the inclination to grind through all those methodology issues, that is the sort of way to eventually find a solution to form a general judgment about diverse findings from diverse studies.

I might add, although I wasn't going to get around to it, those who are curious about why you might be seeing a relatively large number of hospital mergers might just take a look at the evolution of the industry over the last couple of decades. By about every measure that's relevant to inpatient activity, with the census probably being the most relevant one as far as bed capacity is concerned, the demand for the industry's basic inpatient product has shrunk quite a bit, whereas it's turned into a much more outpatient intensive form of operation for a typical hospital, and that's really all.

If there's an issue about what might be driving the number of mergers, that may very well be a good part of the answer. Now, having said all of that, let me add two, I think, important qualifiers about what the theory and the available evidence do and don't predict on this.

First, I'd stress, to repeat myself slightly, that the phrase "on average" when we're describing non-profits is absolutely critical. The theory behind all of this doesn't predict that every and any -- or even any non-profit hospital merger is going to result in no price increase, nor does it predict, with any sort of confidence, that any one merger is going to result in lower prices.

In fact, as one of my earlier figures indicated, all this really indicates is that there is a range of incentive effects that exist within the universe of non-profits, and further, that assuming that that distribution of incentives isn't completely degenerate, in a statistical sense, that it, in fact, has numerous hospitals at various ends of the scale, all it predicts that the average on a properly measured sample of non-profits should be lower than on a for-profit basis.

And the second qualifier is that we should think a little bit about what we're talking about -- or what I'm talking when I say price on all of these things.

describe that sort of set-up as lower price in the presence of less price discrimination.

There's obviously a lot more to be said on the subject, but I think I'm pretty much out of time and there are a lot of other people that have got many more things to add to the subject, which they will.

(A a .)

MR. FAY: Good morning, my name is Eugene Anthony Fay and I'm the Vice President of Government Affairs for Province Healthcare Company in Brentwood, Tennessee. Province Healthcare owns and operates 20 for-profit rural hospitals and manages another 35 not-for-profit and governmental rural hospitals in a total of 17 states.

Today, I am here on behalf of the Federation of American Hospitals, which is the national representative of privately owned or managed community hospitals and health systems throughout the United States. The Federation's members encompass a broad range of facilities, located across the country and in Puerto

addition, the Federation's members manage over 300 not-for-profit hospitals all across the United States.

I am pleased to be here today to talk about hospital ownership types and I thank the FTC and DOJ for inviting the Federation of American Hospitals to participate.

As background, there are several forms of hospital ownership within the United States. These range from public hospitals, which are either owned by the state, county or perhaps the Federal Government; non-profit hospitals, such as university, community-owned and religiously sponsored hospitals; and investor-owned hospitals, including privately-owned and/or publicly-traded hospitals. Currently, about 25 percent of all general acute care hospitals are public hospitals, 60 percent are considered non-profit hospitals and 15 percent are investor-owned hospitals. These numbers have remained relatively constant through recent years.

Notwithstanding this broad array of ownership types, a more in-depth analysis reveals that these ownership variations are distinctions without a significant difference. For example, all hospitals, irrespective of ownership and whether or not they're in an urban or rural area, have the same mission, and that mission is to provide the highest quality, appropriate

the court decisions which have emanated from civil and criminal prosecutions of violation of these laws, and the settlements entered into do not distinguish between investor-owned and not-for-profit hospitals and neither were these laws promulgated with that intent.

All hospitals that participate in Medicare are subject to a law known as the Emergency Medical Treatment and Labor Act, known as EMTALA. EMTALA requires that all hospitals provide a medical screening exam and necessary stabilizing treatment to all individuals who present themselves at the hospital's emergency department. Investor-owned and non-profit hospitals are treated the same under EMTALA.

Obviously, there are some differences among the different forms of hospital ownership. We submit, however, that those differences are differences without a distinction and do not rise to the same level of consequence or importance as do their similarities. Some of the differences are as follows:

First, financial reporting. Investor-owned hospitals have more transparent financial reporting than non-profit hospitals. Investor-owned hospitals are subject to SEC regulation and the recently enacted Sarbanes-Oxley Act, which regulates the filing of initial public and secondary offerings of the securities, and

provides for annual, quarterly and special filings through the Securities and Exchange Commission and is available to anyone through the SEC's web site at any time. Thus, the complete financial information pertaining to the hospital management companies is readily available as a result.

In contrast, non-profit hospitals are exempt from SEC registration requirements. They are, however, required to file annual corporate tax returns, known as the Form 990, and may be, in certain cases, such as California and Florida, be required to file more in-depth reports along with the investor-owned hospitals as well. Those reports typically do not contain the same degree of disclosure as required by the SEC.

A second difference is that non-profit hospitals are eligible for federal and state grants, loan guarantees and interest rate subsidies which are generally not available to investor-owned facilities. Non-profit facilities also have access to tax-exempt bonds which is not generally available to investor-owned hospitals. As a result, investor-owned hospitals borrow money at a rate that is approximately 100 or 200 basis points or 1 to 2 percent higher than tax-exempt financing. However, it is important to note that investor-owned hospitals do have access to the stock

been foreclosed for participating in certain federal programs such as Hill Burton and FEMA. However, as Congress reexamines these historical distinctions and recognizes how few differences actually exist, it seems more inclined to remove artificial barriers and establish parity among all hospitals.

A recent case in point is the Nurse Reinvestment Act, signed into law last year, which allows nurses who receive federal scholarships to work at any hospital regardless of its ownership status. FAH will continue to encourage Congress and others, including the FTC and DOJ, to follow suit as the similarities among investor-owned and non-profit hospitals far outweigh their differences.

In short, and from a broad overview, investor-owned and non-profit hospitals and health systems operate in relatively the same environments, subject only to their local, size, and the types of services they offer. All hospitals operate in a highly regulated environment. All hospitals are required to do and do render their services at the same levels of care as required by law, including the customer and practice of providing such care in their respective communities. With limited exceptions, all hospitals are governed under the same federal and state laws, rules and regulations. And as a

consequence, we believe that all federal laws, rules and regulations addressing competition should apply equally to both investor-owned and non-profit hospitals and systems.

Thank you very much.

MS. MATHIAS: Thank you, Tony.

(A a .)

MS. MATHIAS: Gary?

DR. YOUNG: Good morning. In my presentation, I'm going to focus on the importance of non-profit ownership in the context of antitrust law and policy. I'm going to give you my impressions of the literature, and as you'll notice, much of that literature will overlap with Bill Lynk's presentation. You know, where Bill focused on some of the studies that he's done, I'm going to focus on some of the studies that I've done, not because those studies are necessarily the most unique or most important, but those are the ones that I know and because my mother sort of insisted on it.

I'm going to address three questions that I consider to be significant in this type of forum where we're looking at the whether and how non-profit ownership relates to antitrust law and policy.

First, in general, do non-profit health care organizations use market power to obtain higher prices?

If so, are some non-profits more likely to use market power than others? As Bill Lynk noted, we tend to look at the average performance of these organizations, but, in fact, there may well be important characteristics to distinguish one not-for-profit health care organization from another relative to its inclination to use market power to raise higher prices. So, are there distinctive characteristics of non-profits that can be predictive of such behavior?

And then, as a third question, assuming that non-profits use market power, are they likely to channel the additional revenues into community benefits? So, if they do use market power, what do they do with that so-called surplus? Do they channel it into community benefits? From the perspective of some antitrust commentators, that may be an important consideration.

There have been a number of observational studies that have been done looking at the relationship between non-profit ownership and market power and higher prices, so-called correlational types of studies. My reading of that literature suggests that, on average, non-profit hospitals do use market power to obtain higher prices. But there are a number of considerations that need to be noted here.

One, many of the studies focused in certain

states or markets where there's a very high degree of managed care penetration. And we know that managed care penetration varies markedly across the country. The importance is where managed care penetration exists, particularly at high levels, there's a great deal of so-called selective contracting going on, which both based on theory now and empirical research seems to stimulate price competition in a health care marketplace. And in such markets, we do find, using again correlational studies, a relationship between non-profit ownership, market power and higher prices. Where non-profit hospitals have more market power, they seem to have higher prices, controlling for other things.

Price levels versus price changes. I think that's something that sometimes has not been as closely noted as it should be. I think that one can find non-profits to be more inclined to be using market power if

inflation over time, they may see that the relationship is much stronger. I've looked at markets across the country and where I find the relationship between non-profit ownership and market power and higher prices to be most prominent is when I'm looking at price changes as opposed to price levels.

Also, another factor to consider is that, again, much of the literature actually focuses on non-profit hospitals. We don't really have much literature relating to other types of non-profit health care providers, such as nursing homes. So, the literature is very much focused on hospitals.

And on a point that Bill Lynk made, I don't think the literature is quite as clear as to whether or not non-profits are more inclined to use market power or more aggressive in their use of market power than for-profit hospitals. To some people, that may matter; for other people, it may not matter. Some people may say, well, if they do use market power from an antitrust standpoint, that's what's significant whether or not they're more aggressive than for-profits. But I think that that's an important consideration to know when one looks at this literature.

Bill also noticed that in addition to these correlational studies, there are also merger studies,

before and after, pre-test/post-test kinds of analyses, looking at what the hospital's costs and prices were like before a merger and then after the merger. Different from the correlational studies.

Again, my review of that literature, my impressions of that literature indicate that the potential cost savings of such mergers are very sensitive to the competitive conditions in which they occur. Is it a competitive market or a less competitive market regardless of ownership type?

Like Bill, I looked at two recent papers or two fairly recent papers on the subject, one by Connor, one by Spang. Those studies do seem to suggest that mergers can slow the rate of a hospital's price growth, but that those cost savings seem to pretty much essentially go away in much less competitive markets. So, when the mergers are occurring in less competitive markets, the cost savings is much less, and in some cases, non-existent.

As far as whether it matters whether the merger is occurring between non-profit or for-profit hospitals, Bill did note that some -- his interpretation of those papers suggests an advantage in favor of non-profit. As I look at those papers, the results might point in that direction, but the concern that I had was that, at least

as I read those papers, they were not -- when they looked at ownership, they were not controlling for market conditions as well as other factors.

So, since these characteristics can confound one another, I was concerned that, in fact, that their focus on ownership type as it impacts merger savings really wasn't very clear because it wasn't done in a

often sit on these boards, large important employers in the community. And wouldn't they want to restrain price increases because, in the end, they end up paying for their price increases through higher health insurance premiums?

So, can we think of the non-profit hospital as having a board that functions as a consumer cooperative that will protect consumers? I think that's an interesting point and I won't go into it here, but I think you can even formalize that in the context of some fairly well received economic models of non-profit hospital behavior.

But I think there's also a couple of things to point out. One is what is the composition of the governing board, does it, in fact, include employers? And, actually, we know from some surveys that have been done by the American Hospital Association, as well as some other trade associations, that composition of hospital governing boards has been changing quite a bit over the years and including more insiders and having fewer seats for individuals from the community like employers.

Two, many hospitals today are not functioning independently. They're parts of multi-hospital systems, and so, the independence of a local governing board may

be considerably attenuated relative to what it might have been many years ago.

So, drawing from that, I did a study with some colleagues at the Agency for Healthcare Research and Policy a few years back where we tested the relationship between market power and price growth among non-profit hospitals that were distinguishable on two dimensions. One, whether or not they belonged to a multi-hospital system, okay, getting at that issue of whether it's an independent hospital or one that belongs to a multi-hospital system where control over many of the decisions may, in fact, be with a corporate office that belongs to the chain, to the system.

And then, if the hospital did belong to a system, what was the geographic configuration of that system? Was it a very regional large kind of system or was it more of a local system? And the study was done on a sample of California hospitals using a time frame of

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system. And then another group of hospitals that we classified as non-local system hospitals. These are much larger systems, more hospitals, 15 hospitals on average where the average distance between the hospital and the corporate office was over 250 miles.

What we found was that all three types of non-profit hospitals exhibited faster price growth in less competitive markets. But we also found that the non-local system hospitals exhibited a significantly faster price growth than did the other types of hospitals. And the idea is that these hospitals were hospitals where, perhaps, local control was considerably attenuated given the geographic spread, the quite likely result that employers from the local community probably didn't have much say in the governance of those hospitals.

Now, the implications of that study? Well, we can study two scenarios. Scenario A, you have a four hospital market. Each hospital has 25 percent market share. Two of the four hospitals have been acquired by -- I'm sorry, I read B and I mean A.

Four hospital market, each hospital has a 25 percent share and then two of the four hospitals merge. The post-merger HHI, measure of market concentration, market power, is .375 and the change in the HHI is .125.

Go to Scenario B. Same thing, four hospital

market, each with 25 percent share. Two of the four hospitals, in this case, are acquired by a non-local system. They don't merge together and remain under local control. They are acquired by a non-local system, a system with a corporate office. Governance is located way outside that community.

Now, here, the post-merger HHI is the same as in Scenario A, .375. The change in the HHI is the same, .125. But the results from our study imply that the price growth in Scenario B would be 50 percent greater than in Scenario A pointing to the potentially powerful impact of local control and what that may mean in a merger situation.

The third question I wanted to address was, whether if non-profit hospitals or non-profit health care providers use market power to obtain higher prices, might they use the surplus and channel that into community benefits, that their mission is to serve the community and that they won't be using it for profits or for other -- or channel it into higher salaries necessarily but it will go into community benefits.

There are several studies that actually point to the possibility that non-profits, in fact, do channel at least some of their surplus into greater community benefits. One study found that more market power for

profit hospitals, the non-profit sector to the for-profit sector. And there are some studies that, on average, non-profits do provide more uncompensated care than for-profits, a study by the Lewin Group, a study by GAO.

But that difference may be sensitive to at least a couple of factors. One, the location of the hospitals. One study found that the difference between non-profit and for-profit hospitals in terms of the uncompensated care they provide may well be a function, may well reflect the fact that for-profit hospitals tend to be located in communities where the need -- the demand for uncompensated care is less. So, it may be more a matter of where they're located than anything else.

Also, board composition. I mentioned that, in fact, board composition for non-profit organizations, non-profit hospitals has been changing over time. Greater insider representation, fewer seats for community representatives, and in a study that I did, I found that the difference between non-profit and for-profit hospitals in terms of the uncompensated care they provide may well be sensitive to other non-profits -- to the type of composition, board composition the non-profit hospitals have. As they have more insiders that distinction, that difference in uncompensated care provision may decline quite a bit.

In addition to comparing the average performance of non-profit hospitals and for-profit hospitals, another way to look at this issue, okay, about whether non-profit hospitals provide more uncompensated care is to take advantage of the conversions that have been occurring where non-profit hospitals are acquired by for-profit companies or vice versa, where a for-profit hospital then comes under non-profit ownership.

There have been several studies that have addressed this, a couple that I have done, and those studies indicate that following a conversion from non-profit ownership to for-profit ownership, that is where a non-profit hospital is acquired by a for-profit company, you don't see substantial changes in the level of uncompensated care that's provided or in price levels.

So, here's a study that I did a few years back where we looked at all conversions that occurred in Florida, Texas and California, three states where there's been a lot of conversion activity during the time frame of 1981 to 1995. We look at percent gross revenue devoted to uncompensated care, and as you can see, following conversion, very small change for the 43 conversion hospitals that we looked at, and there was no significant difference before and after, or relative to a matched group of hospitals that we compared to the

conversion hospitals experience.

Similarly, for our measure of price, net patient revenue per adjusted discharge, we also found that the conversion, moving from non-profit to for-profit status had no impact. So, there may be some evidence that non-profits do channel some of their surplus into community benefits, but whether they may do that in a way that's substantially different from for-profit hospitals, based on looking at all the literature together, you know, is more questionable.

Thank you.

MS. MATHIAS: Thank you, Gary.

Corey?

DR. CAPPS: Thanks for having me. I'm here with the same issues as everyone else. I'll give a little bit of case background and then a slightly

that you won't act uncompetitively. So, if the merger is unacceptable for for-profits, it's also unacceptable for not-for-profits.

And then there was University Health and Mercy Health Services in the early '90s as well. But at the same time, when Rockford was appealed, Judge Posner said, hey, there's economists in the world, you can do stats, why don't you go answer the question of, first, how does market power relate to prices, and secondly, how do for-profits and not-for-profits differ? And that was sort of a call to economists, at least, to go out and do some research and at least one did and one of them is here, I guess one of the early responders to this call, Bill Lynk.

This came up in the Grand Rapids, Michigan merger of Butterworth and Blodgett where they turned the reasoning of Rockford on its head and they said -- in Rockford they said, if we have evidence that non-profits don't charge or don't use their market power, then we'll go ahead and let them merge basically. And they said, before in Rockford, Mercy and University Health, we didn't have such evidence. Now, based on the testimony and publications of Dr. Link, we do have such evidence. So, market concentration of non-profit hospitals is not correlated with higher prices, but with lower prices, and

that's a result of what Bill showed you earlier. So, he may have done himself a disservice when he said it had a modest impact.

Because in that case, the Judge said, yes, it's a well-defined market, yes, these hospitals will have market power after the merger, but because of their community commitment and so forth, they won't use it.

Yet, since that period -- this was '96, '97 for Grand Rapids, you'll at least hear, sort of in some press accounts and sort of in the wind when you're talking to various health people, a lot of complaining. Now, in general, health care costs are going up. How much of that can we blame, if any, on market power and how does that relate to the for-profit/non-profit question?

On the for-profit side, you sometimes here complaints about Tenet raising prices. They were the subject of a number of mergers. But look at the non-profits. You've got Partners Health Care. That was big in the press not too long ago. Sutter Health, I believe, came to a big impasse that was publicized widely with BlueCross or maybe that was in Sacramento, or I think even both. Some complaining about Butterworth and Blodgett. I'm from Chicago, so closer to home we have the Victory St. Therese merger in Waukegan and the Northwestern Memorial, Evanston Hospital in Chicago and

Evanston as well, and then also there were a few -- there was a story not so long ago in the New York Times about Long Island Jewish and North Shore Health System saying that they raised prices dramatically after exactly two years roughly after the merger.

So, the issue is, to what extent are these complaints valid? And that's, of course, why we're having this whole series of hearings. And, more specifically to today, what do the studies since Lynk's 1995 influential paper tell us about for-profit versus non-profit studies?

Not all studies that look at hospital pricing are specifically focused on for-profit versus non-profit. What they tend to do is regress prices on some other stuff and they include a dummy variable for for-profit and non-profit status. So, they sort of accidentally, in some cases, bear some light on this issue.

One of the big ones that's been cited a few

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Melnick and Zwanzinger data, lowering price after a merger.

Dranove and Ludwick got similar results and Lynk and Neumann had some thoughts on that as well that you heard about earlier. There's also Connor, Feldman and Dowd, which uses a bit older data, basically comparing 1986 to 1994 and says, in 1986, condition on market power, not-for-profits were charging less than were for-profits; but that from '86 to '94, not-for-profit hospitals increased their prices faster. And when they interact, they're -- basically, if they interact, the market power measure with the dummy for for-profit status, the coefficient is insignificant, which suggests that there's no real difference in how the two types of ownership will exert their market power.

On an aside, since you're here and you care about health care and antitrust, Connor, Feldman and Dowd do find that on average, mergers do lead to cost savings. So, that's useful to know.

Another one that hasn't been mentioned yet is Brooks, Dor and Wong. They look specifically just at appendectomy pricing and they find -- and they were expecting to find a difference and so they say, rather paradoxically, for profit hospitals have significantly less marketing power than public or voluntary non-profit

hospitals. So, again, non-profits, in their case, were actually pricing a little bit more than for-profits.

There was a case study by some -- I believe both FTC folks here -- of a non-profit merger in Santa Cruz, California. I think this one was a three-to-two merger and they do find pretty significant evidence that the prices did go up and they concluded that this suggests that non-profit mergers are, indeed, a legitimate focus of scrutiny.

Another issue you need to think about, and the data here and evidence are a little bit more limited than they are on prices, but what happens to quality. Maybe non-profit hospitals do raise their price, but that's just because they're great hospitals and it's costly to be a great hospital. The research here is more limited, but Gowrisankaran and Town -- Town is another alumni -- do look at the effects of concentration on risk adjusted mortality rates for heart attacks and pneumonia and they do find that competition is good, at least for privately insured patients in the sense that, after adjusting for risk, less people died. So, that's a good thing. But there's no significant difference between for-profits and non-profits.

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for simulating the effects of mergers, and they find that non-profit hospitals face less elastic demand, which should suggest higher margins at non-profit hospitals than for-profit hospitals, but that because their costs

Now, to make my parents proud, I'll turn to some of my own work. We were originally just interested in the idea of geographic market definition and similar to Gaynor and Vogt, how could you develop models to give good predictions about the price effect of a merger. One of the things we were particularly interested in is that health care works different from most other markets, especially in the post-managed care industry. Because what employers really buy from insurers are choice sets, at least in the selective contracting environment. So, if you go with this health plan, you can buy these 12 hospitals; you can go to these 12 hospitals. If you go to some other insurance plan, you can get these nine hospitals.

So, we developed a model to estimate the value of choice sets in this setting. How much is it worth to have access to these 10 hospitals? And then we can ask, well, how much less is it worth if we take one of the 10 hospitals out of the choice set. And that gap is exactly what the hospital is going to be talking about when it comes time to negotiate price with the insurers. If you're a really valuable hospital and all the employers will buy another health plan if that hospital leaves, then that hospital might be able to charge a lot.

Incidental to asking this question we said, and

how does it vary by for-profit and not-for-profit status. Once we had this measure of leverage, we can regress profits on that measure of leverage, including a control for for-profit/non-profit status and see if there's any significant difference. So, we did this for San Diego and what we come up with is this measure of leverage, which we call the willingness to pay rank and certainly, in San Diego, the top five hospitals all happen to be not-for-profit hospitals. There's 22 hospitals total, four of which are for-profit. And then the sixth highest ranked hospital comes in as a for-profit hospital. So, none of what I'm saying here is meant as a criticism of the value or operating characteristics of not-for-profit hospitals in any way.

What happens when we look at pricing? Well, in general, in any market outside of health care, this wouldn't be controversial. The firms with highly valued products charge a premium. You produce high quality because then you can go to the marketplace and charge for that. And the contention of those who would give favorable treatment to not-for-profit hospitals is that they won't do that because they're not-for-profits and they can't disburse their rents or something like that.

When we take this theory to the data and say, all right, let's regress prices on our measure of

willingness to pay and leverage and include a control for profit/non-profit status, is that control significant? And the answer, similar to many of the other papers I cited, is that it's not. And if you want to see a picture here, here is one. So, across the bottom is our measure of bargaining power that individual hospitals have and on the vertical access is how much profits they get from private payers. So, we threw Medicare and Medicaid out in computing profits because those aren't really negotiated in the same way.

And what you see is a nice upward sloping line so that the model works and there big squares are the for-profit hospitals and basically they're right on the regression line with all the not-for-profit hospitals. So, that's a visual representation of the idea that there's no real difference. If you're wondering what that hospital is right up at the top, that's U.C. San Diego, which we think may have some accounting issues because they have commingling of fund, I guess, between the University and the hospital or something like that. So, we may have a bad profit measure for that hospital.

But if you don't look at that one, it's a nice upward sloping line and there's really no difference between how for-profit and not-for-profit hospitals use their bargaining leverage to get more money out of

insurers.

We also wanted to simulate the effects of mergers, similar to Gaynor and Vogt and we were really asking, are sort of the outlying suburbs their own market in the SNIP sense? And so, we look at Chula Vista, which has three hospitals and it's about 10 miles south of downtown and we took our estimates and we simulated the effects of various mergers among the three hospitals in this suburb. As it turns out, we weren't meaning to look at this issue, but they were all non-profit hospitals.

And what we found, first -- had I been talking on some other day, I would have keyed in on this more -- but Chula Vista is a relevant market in the sense that acting together all three hospitals could exert a significant increase in price, that's the bottom line, of 13 percent. But that in various pair-wise mergers, in particular Scripps Memorial and Paradise Valley, you would get a large effect from just a two-way merger and this is a two-way merger of not-for-profit hospitals.

So, if I wanted to summarize what I'm saying here, there's nothing about this that says not-for-profits are bad, nor that there are more antitrust concerns than for-profit hospitals, but rather they're about the same. The preponderance of the evidence since Lynk's 1995 study, at least in my judgment, says that

non-profits and for-profits are about the same in terms of the extent to which they'll use market power to get higher prices.

So, the -- I think the third slide I showed with the quote from the Rockford ruling seems like a more prudent policy than what happened in the Grand Rapids, Michigan case. Basically, the evidence says they act about the same, and so, presumably, they should be treated about the same.

One final note, when you think of not-for-profits, you think that they have this non-disbursement constraint, that they can't pay back their money to the shareholders so if they do make a bunch of profits from, say, merging and charging really high prices, they'll do some really good things with those profits and so we might want to let them merge. And what really good things do they do? Well, they could do more indigent care, more research or anything along those lines.

So, that could lead you to the conclusion, along the lines of we should have loose antitrust enforcement as a way of funding these really good activities, and the intermediate mechanism is let non-profits merge, charge monopoly prices and then make a lot of money and then fund the good things with that. That is a really inefficient way -- using monopoly profits to

fund social goals is really inefficient. So, for any of you that had microeconomics at some point, you've surely seen a graph like this where there's a dead weight loss associated with charging prices well above marginal cost. So, if we want to achieve those goals, there are better ways than treating not-for-profits specially.

Thank you.

MS. MATHIAS: Thank you, Cory. I think Frank is next.

DR. SLOAN: Thank you for inviting me. I can see, sort of sitting here and listening to everyone else, how difficult it must be to be in the audience when you hear so many contrary views.

I have been doing this kind of work for a number of years and summarized what I thought were the findings from the literature in a handbook of health economics chapter on non-profit and for-profit in the year 2000. You can see from this that there's a lot of work that is ongoing, much of which -- of this new work isn't in that summary. The point of that summary was pretty much, I think, the same as what Mr. Fay said, was that there isn't much difference.

But today, I'm going to talk about a few differences I have found since then, sometimes finding no difference, sometimes now finding a little difference.

I'm not going to talk about pricing at all, but rather about some of the other behavioral differences that may occur and I'm going to concentrate on ownership conversions, even though I'm going to talk a little bit about just ownership per se.

The work that I am describing was funded by the Robert Wood Johnson Foundation, the HCUP Program, and much of this work is published or is forthcoming. The questions that we asked in that study were, why do some hospitals choose to convert and why do they select a particular ownership form and what percentage of ownership conversions was a fair price paid for the hospital by the acquiring organization; in other words, one that would reflect sort of a competitive rate of return rather than either too much or too little?

How does conversion affect hospitals' internal decision making processes? We were concerned that there had been a lot of these outcome studies, but not very much looking inside the black box. So, we did some of this.

And then, how do health and financial outcomes compare among hospitals before versus after conversion? Given the brief amount of time, I'm only going to be able to look at a couple of these questions.

Antecedents of hospital conversion. Sort of

one view would be the hospitals are out there sort of like little e-commerce firms waiting for great deals and when great deals come, they're acquired and they're buying and selling like firms might sell in other markets or that they're merging and doing all kinds of things that we see more generally.

What we find when we looked at -- so, we looked at hospitals that either could have stayed the way they were, they could have changed ownership form, they could have closed or they could have merger, because although we were primarily interested in the change of ownership form, the question was, some of them may have not even been able to find anyone like a chain to acquire them. They may have closed or they may have merged and kept the same ownership form.

It actually turns out to be hard to find data on this that you could believe are accurate and we used two different sources and often the two sources conflicted and we did -- I had Duke students do a lot of phone calls to try to figure out what actually happened when we found conflicts between the two databases.

We studied ownership changes, closings and mergers between 1986 and 1996. We used a discrete time hazard model.

Now, it turns out that the -- compared to

hospitals that did not convert, that merged or closed, hospitals that changed ownership status had, at baseline, much worse financial statistics. So, it's not like these firms are doing -- these hospitals are doing great, you know, and they're just trying to do better; these are hospitals that if they had not changed their ownership, had not been acquired by say a hospital company or somebody else, they might have closed. They would have done something else. They're in the market for doing something different given the changing payer situation, given the decline in demand, more generally, that Bill Lynk brought out and all that. So, there's some pressure to do something.

There are some hospitals that can't find partners or chains or a local hospital to merge with. Those hospitals had much worse financial status at baseline.

There were mergers that as the mergers occurred, they tended to occur more often, on average, in less highly concentrated markets. This may or may not, I see here, suggest possibly a market power motive for a merger. Sort of an atomistic market is where you'd be more likely to find mergers than in more concentrated markets.

Now, going to -- what I'm going to mostly talk

about is the effects of ownership conversion on cost and quality. And here I'm going to be talking about three studies, one of which came out in the fall of 2002 in the Rand Journal of Economics called, Are For-Profit Hospital Conversions Harmful to Patients and to Medicare. A second one came out in an MIT press book in 2002, Hospital Ownership Conversions, Defining the Appropriate Public Oversight Role. And the third is a paper that has been provisionally accepted by medical care which is, Does the Ownership of the Admitting Hospital Make a Difference? Comparing Outcomes and Process of Care of Medicare Beneficiaries Admitted with Myocardial Infarction.

First, going to the study that is published in Rand, Are For-Profit Hospital Conversions Harmful to Patients and Medicare. Here, we took Medicare claims data for 1984 through 1995. We merged the claims data with household data on characteristics of the individual, like their education, their income, if they have limitations in activities of daily living, et cetera, whether they were married. And then we merged that file with data on hospitals, including data on the hospital characteristics for Medicare cost reports. And then our own ownership conversion file, which we had developed from AHA data, telephone calls and from Medicare cost

reports.

Health outcomes were measured in the following ways, survival after admission date, at 30 days, six months, one year, and then we looked at Medicare payments for the hospital stay. We also measured financial outcomes, profit margins, employment changes and charges -- we looked at the wage bill. That is what the personnel costs were and we were looking before and after conversion.

The key explanatory variables were hospital ownership conversion from a public or non-profit to for-profit status or conversion from for-profit to public or non-profit status. That is, we did not study conversions from public to not-for-profit hospitals or the reverse.

Findings on survival. We found persistently -- we couldn't get rid of it actually -- in hospitals that converted from public or not-for-profit to for-profit status there was a statistically significant increase in mortality at one year following conversion. The effect persisted for two years following the conversion and disappeared at three years. A similar pattern was found for mortality at 30 days and at six months post-admission, but effects were not statistically significant at conventional levels.

Now, we put in there hospital-fixed effects, so

there is nothing about the fact that that hospital is on 5th and Maine that caused this to occur. It is out. We put in time-fixed effects. So, there is nothing that occurred in 1994 that caused this to happen. We washed it clean of all that. That doesn't mean that nothing could have happened, but if none of the -- or it's not that the people are less educated and it's not that the people have lower activities of daily living and go to certain kinds of hospitals. All that is washed out. So, there have to be very subtle explanations as to why that has occurred.

Now, we think we found a reason that this occurred. Well, first, let me say that there was no effect on survival for hospitals converting the other -- that's actually wrong. From for-profit to public or not-for-profit, we found no effect. So, we found an effect from public or not-for-profit to for-profit, but not from for-profit to public or not-for-profit.

What we also found, we found that hospitals, actually in both directions, increase their operating margins when they converted. But what we found that is sort of not a smoking gun but is a hint as to what happened is that during the first -- during the conversion year and the first and second year post-conversion, for-profit hospitals -- those are hospitals

that converted to for-profit -- decreased their staffing. There was really a cut in the budget. Now, I think that may have been that we were going through an era where the for-profits were especially -- Columbia HCA was in a very aggressive stance and was cut -- you know, it was a business model, they were cutting -- you know, telling their managers, let's get some profits, and this is what could have happened.

At three years and after, we found the staffing went back up and the mortality went down. In the permanent situation, there was no difference. In the transition, there was a difference, which is not easy to get rid of.

The results could have been a reflection of the period in which the study was conducted because of particular situations at a particular hospital of management styles that were going on, and we only examined one dimension of outcomes of care. We did not look at changes in morbidity kinds of outcomes or outcomes from functional status changes and so forth.

In another paper, this is the paper we did for MIT Press, we looked at data from the health care cost and utilization project, which has lots of hospital discharge abstracts and we could only observe the status of the patient at discharge. In the other data, we were

able to track the patient because we had Medicare enrollment data, so we could track the patient post-discharge. We studied survival, pneumonia complications, length of stay, discharges to other hospitals, up-coding of diagnosis, expected source of payment. Basically, our finding no effect of ownership conversion. There was one minor effect. No evidence of up-coding of diagnoses for stroke, hip fracture, coronary heart disease, congestive heart failure, pneumonia. Even though that has been alleged, we can't find that the for-profits were more likely to up-code those diagnoses.

For patients aged 1 to 64 at admission, actually, the public patients and the self-paid patients, as a share of total patients, increased when there was a public or not-for-profit to for-profit conversion. We found no evidence that, in fact, there was a shift in the propensity to take patients who may not have as much payment associated with their stay when the hospitals converted to for-profit.

A similar pattern when we looked at births. Some difference in stays, that the for-profits cut back the stays a little bit more, but on the whole, hospital admissions appeared to be preserved post-conversion. Again, when hospitals -- this is not like sort of buying and selling tobacco or something here. When a hospital

converts, often the community is asking a lot of that hospital that converts in terms of preservation of mission, et cetera.

Pneumonia rates were up post-conversion to for-profit, but I wouldn't make much of that because the vast majority of findings were null. There were no differences according to whether the hospital converted to for-profit, away from for-profit or did not convert at all.

We studied effects of ownership rather than ownership conversion and we looked survival at 30 days and at one year following an admission and we also looked at the use of particular procedures, that is in the use of procedures in the treatment of AMI. We controlled for many other factors, I mean, dozens of factors, socio-demographic factors, clinical factors, et cetera.

We found it does not make a difference in terms of your survival which hospital you go to. So, there has

Staiger paper, which was cited, and that is for-profit location patterns are different. They're locating in areas where there is more bypass surgery done.

So, the non-profits in those same areas are also doing more bypass surgery. There's clearly a huge difference. But it's not like that somehow you could -- the non-profit across the street, if that ambulance is taking you there, you wouldn't get bypass surgery. These are all Medicare patients.

Summary of findings. In general, hospitals and communities are pushed by financial pressures to convert. The status quo would lead to unfavorable outcomes, including hospital closure. No evidence that conversions have a negative impact on access to care. Hospital admissions are not changed post-conversion. Evidence on the effects of conversions on costs is mixed. By that, I'm really talking about that heart study, which shows that, yes, it looks like there's a lot more cath and PTCA at for-profit hospitals. But when you control for the location, the propensity to locate, you don't find it.

Now, you could say, well, why aren't they located in areas where you don't do this kind of thing? That might be a question to ask. But the ambulance won't take you there. It will be a long way to get to that hospital, even to that area because you're in an area

congenial panel. So, I want to maybe take issue on a couple of matters with my distinguished colleagues, and as we go, we'll see this.

First, I want to give my sense of the context and talk a little about some of the similar issues my colleagues have talked about. But then I want to turn and raise some issues for the FTC and DOJ. What should their role be in this area? And then talk very briefly about -- at least what I see are the policy implications.

Where I'll start is really with some very consistent statements from what you've already heard. I will assume that there are no operational differences between for-profits and not-for-profits. What I want to focus on, though, is what that means for the community, and in turn, how we think about that. How the regulator should think about that, how the courts should think about that. And my second assumption is the courts generally treat them as operating similarly, so here I will actually disagree somewhat with, I think, Cory's statements about the judicial trends, and I'll come back to that in a few minutes.

So, I want to ask three broad questions. Whose interests should be promoted? Is the not-for-profit form obsolete? And what are the implications for competition policy? Again, underlying this is, who owns the health

care enterprise and do we care? In the end, do we really care who owns it? As Tony Fay said, there's really no difference, so it doesn't matter. And that's one of the issues I want to talk about.

So, the first kind of issue we want to talk about, I think, is why do we continue to support not-for-profits, why do they survive, why aren't there more conversions, why isn't there more shifting to a for-profit model. Well, I think there are several aspects of this, at least in the short term. When we talk about the no difference between the two, that's probably right. From both an economic and a practical perspective, both are concerned with fiscal viability. But in the long term, it seems to me that there may well be differences in terms of the mission and how that mission is conceived of. And here, I want to come back later in the talk to considering this board composition issue that I think is very important, and often, unfortunately, overlooked.

Ownership status -- well, first of all, there's a community benefit and a community input. The not-for-profit status should, in my view, take into account the community. After all, that's what it's serving. It's serving not just a community and patients, but a broader community of interests, both physical and in terms of providing health care.

Ownership status can be very important in some communities. When I was in the government, I worked in the Office for Civil Rights at HHS in the late '70s, early '80s when we were dealing with a lot of hospital closure cases, including the New York City Hospital closure case when Mayor Koch wanted to close much of the New York Health and Hospitals Corporation.

To make a long story short, for the purposes of this presentation, Mayor Koch wanted to close Metropolitan Hospital. It's the flagship of Harlem. Many of the hospitals that he wanted to close raised no real objections. There were real problems with quality of care in some of them. Some of them were ultimately converted to clinics and I think that was a much better result. But there was intense community opposition to closing Metropolitan and it wasn't just about health care. It was about the stature of the community and the importance of that hospital to the community. So, I want to throw that out as something that -- almost a non-economic or intangible issue that ought to be considered.

And then there is this issue of serving the uninsured over the long term. The mission of a not-for-profit is to serve the uninsured, provide community benefit. That's not necessarily, in the long term, the mission of a for-profit. Does that matter? My

colleagues have suggested maybe it doesn't. I'm not convinced yet.

A second factor is that not-for-profits may well keep the for-profits honest in terms of providing levels of uncompensated care. Of course, how we define uncompensated care may well be the crux of the matter. If, for example, you're including bad debt in that definition, then I suspect there may be real differences in the amount of charity care provided.

And, finally, despite Tony Fay's argument on regulation, all facilities, regardless of ownership status, being responsible to the regulatory structure -- and I certainly don't disagree with that, but I do think there's a difference in terms of public accountability with regard to the mission that really does mean that there are ultimately some operational differences.

At the same time, there are some obvious controversies surrounding the NFP form. Do they meet their community obligations? How do we structure those? How do we define community benefit? Is it just uncompensated care? Is it just setting up clinics in locations that are more accessible to low-income people? Educational mission? Preventive care? States define community benefit very differently and I think we need to start getting a more consistent definition of that.

Second, there are constraints on capital formation. Although I will add it's not entirely clear to me that capital formation, per se, is the problem. But I think there are issues with this. And as noted, we still have issues with conversion whether one thing converting from not-for-profit to for-profit is a good idea or a bad idea, what do we do with the amount of money that the community has put into the not-for-profit? How do we distribute the assets? One of the issues that we need to look at empirically is when there have been conversions, how has that money been used? Is setting up foundations really beneficial to the community? Does it add to the pool of uncompensated care that's provided or are those assets simply shifted into different directions that are non-health care related? If so, then there's a net community loss it seems to me.

Well, suppose for-profits dominate or come to predominate. As a counter factual, does that matter? One might argue, as suggested before, that there would be a greater return to communities through tax revenue. One can easily argue that tax revenue will overshadow, ultimately, the community benefit in terms of a return to the community, although I think you sacrifice public accountability and greater accountability through market mechanisms and there are some advantages, I would agree,

to a market discipline in this field. But if I take what my colleagues have said at face value, the market mechanism, the market discipline is being imposed regardless of ownership status. There are some interesting findings here.

But I still want to come back and will come back to this mission issue. Who will serve the community? Who will locate in under-served areas? It's not clear to me that the for-profit organization is going to locate in these communities.

I've looked at a range of cases. I teach health law, so I look at all these cases when I teach, and I want to talk about some broad trends when I look at the antitrust cases, conversions, joint ventures, without looking at the fraud and abuse issues, and tax exemption challenges. I think the courts really are treating these cases without regard to ownership status. I really disagree in some important ways with Professor Capps' analysis of the Rockford trend.

I agree that Butterworth is a bad decision, in part because of how Professor Lynk's research was used. So, in fairness to the judge in Butterworth, that was in the only empirical finding or set of findings on the issues. So, I'm not convinced that the judge used Bill's findings inappropriately; it's the other factors in

merger cases have lost. The focus in the courts, across these cases, has been on integration, risk sharing and efficiencies. The more you're integrated, the more you share risk, the greater the documented efficiencies, the fewer antitrust and tax exemption challenges you have that will succeed. But there's no consistent protection of community interest and there's a continuing failure to define fiduciary obligations.

What, in my view, should the FTC and DOJ role be here? Well, I would argue first that the government ought to be neutral between for-profits and not-for-profits. At least in the short term, not-for-profits are still going to be the dominant form. But it's not clear to me that the government should take one side or the other. Rather, I think that the role of the government is as it has been doing, and that is to monitor the competitive environment.

And here is where I sort of want to depart somewhat from the direction that we've been going in up till now, and that is to say that I think the government needs to do a better job, and that's both state and federal in this case, in holding not-for-profits to their community obligations. It seems to me that there is some, not just legal, but really fiduciary obligation to meet the expectations when you're granted not-for-profit

or tax exempt status. You ought to be held to that standard.

Second, and related to that, I think it's important for the government to monitor joint ventures and other mechanisms that not-for-profits are going to use to generate capital, not to use that form, the not-for-profit form, to gain a competitive advantage. For example, you can imagine a joint venture that sets up an entity to -- let's say for an imaging center or an ambulatory surgical center, between a physicians group for profit and the not-for-profit hospital.

Well, then you can imagine actually setting up a management company that's a subsidiary of the medical group and that subsidiary then builds a hospital to attract physicians to the area. Well, then what if that organization builds a hotel to serve patients, and then we need a Starbucks to serve the hotel. How far are we going to go to allow the funds -- the not-for-profit structure to generate funds that actually raise capital?

Then you get to the important question that many of my colleagues have raised, but how are the funds used. To the extent that the funds are sent back to the community then that's good. Then maybe we don't have the dead weight welfare laws. Maybe then it is more efficient if, in fact, the capital generated is going

back into providing a community benefit.

Another part of the FTC/DOJ role, it seems to me, is to coordinate in these issues with the IRS, particularly in terms of some of the issues regarding joint ventures which raise both antitrust and tax exemption issues. Of course, they also raise fraud and abuse concerns, but we're not talking about that today.

I would also urge the FTC and DOJ to use the guidelines to define community. If the courts aren't going to do it -- and since the courts have really deferred very much, it seems to me, in antitrust analysis, to the 1996 guidelines, then one way to think about this is let's get a better definition of what the community is. What's the range, the area, the type of community that a not-for-profit should be serving? Do we define that by payer source? Do we define it by geographical area? I think we need more attention to that.

The same thing in terms of ensuring community benefit in conversions. If conversions occur, the market prefers conversions for whatever reason, as my colleagues have suggested, it's fundamentally critical that the money be returned to the community in some way. And I think preferably for health care because that's what the not-for-profits were set up to do, to provide health care

for people who can't afford it. It's one of the functions in every state.

And we might think about new laws and regulations for cacrkehipxbation for not-for-profits. Again, I think there's an empirickehquestion of whether not-for-profits are struggling with lack of cacrkehand would need more. But to the extent that any facility needs cacrkehto survive, do we want to think differently about how not-for-profits are able to raise cacrke.

But I think there's also a set of issues for the health care executives and trustees, and here is where I want to specifickely deal with the issues raised on the role of the governing board that Gary Young, in particular, rkeked about, because I think this is an area that's reaely been overlooked, at least in terms of my work.

I should say one other thing about the FTC/DOJ role and that is, I think it's important, maybe, maybe, I'm not sure they even have jurisdiction, but I'd like some more evidence that for-profits are actuaely providing that kind of uncompensated care mentioned earlier and what the trends are depending on the competitive environment, et cetera, et cetera. Again, I'm not sure that's the FTC/DOJ role.

But getting back to this issue of fiduciary

What's critical is that they be held to it.

I think we need to scrutinize conversions to ensure that the community benefit is met. I'm not arguing that you shouldn't allow conversions. The market will operate. Some hospitals simply can't survive on their own, and if you have a for-profit that's willing to come in, save the hospital, provide care to the community, then I have no objections to that. But they have to be held to that standard.

And I think the key role is public accountability. Here, again, I define that more broadly as mission-oriented rather than adhering to a similar set of regulations.

In conclusion, why should we care who owns the health care enterprise? Why should we care whether the not-for-profit form is obsolete? To begin with, I don't think the not-for-profit form is obsolete, nor should it be. Health care, I still think, operates differently from other markets, and as long as it does, then I want to see the not-for-profit entity survive.

At the same time, survival qua survival is meaningless without pursuing a mission that's broader than generating profits. Do we intend to hold the entity to its community obligations? If not, do we have an alternative mechanism for providing care to the

uninsured?

It seems to me that who owns the health care enterprise is still in flux and will be in flux for a long period of time. In the end, I think it's worth considering whether who owns the health care enterprise matters. I think it does. Thank you.

(A a .)

MS. MATHIAS: Thank you, Peter. Next we have Dawn and after Dawn we'll take a quick 10-minute break.

MS. TOUZIN: So, I stand between you and the break.

I bring a somewhat different voice here. I don't have statistics and slides, but instead I'm going to tell stories. I'm here to address the question from the consumer perspective of how do consumers perceive the performance of non-profit and for-profit entities with regard to cost, quality and access.

And I approach this work from our work with consumers on state and local levels on health care issues, particularly institutional accountability. We work on corporate transactions, mergers and acquisitions, community benefits and free care programs.

Community Catalyst has been at this for over eight years. We've worked on hospital and BlueCross conversions and we've helped draft and promote conversion

legislation.

We began this fairly agnostic in terms of, did we favor non-profit or for-profit forms in health care. We instead approached it from two major categories of questioning. One is, what's good for the health of the community? Should a conversion happen when it's proposed? What are the potential health impacts? And in posing that question, we look at the total community. The uninsured and under-insured, those who are currently facing barriers constraints to health care systems, as well as those who are already in the system. Those of us fortunate enough to be insured.

We also questioned whether there are alternatives, given the charitable trust and inclination to maintain the mission of a non-profit.

Earlier conversions, particularly those in the mid to late '90s that we got involved with, there was little focus on some of this area, primarily because there was little experience on the part of the community. These things weren't on the radar screen, and then as now, as Peter mentioned, often conversions seem to have no alternative. You had struggling financial organizations where the construct was convert or die.

The second area of questioning is, if conversion is going to happen, are assets being

preserved? Communities are concerned about not just the financial assets and whether a conversion foundation is set up with the fair value of the organization, but will

community. The community no longer has the ownership interest.

In many conversions, consumers also feel a lack of voice in terms of their participation in the review process of the conversion. The decision is made to convert, the review is conducted quickly and there's very little say on the part of the consumers.

I can give you some examples of more current activities that have been going on and how some of these illustrate these points.

In Kansas City, we've been working with a group of coalition members on the conversion of a large hospital chain there. The concern has been whether or not there will be inner city closures of a 13-chain facility or reductions in service in view of more profitable suburban locations. They sought commitments versus just assurances that this would not occur to no avail. The value of the dollars and what would happen to it has ruled in this conversion.

We're working with groups in Hartford, Connecticut on free care programs. It's a group of lower income, primarily Hispanic and black people of the community, who went to hospitals in their areas and said, I'm uninsured and I need treatment, can you help me, and saw how they were received in that environment, in that

construct. They looked for signs that made it friendly, that made them think that they could even walk in the doors and be welcomed in the first place, and one person was politely escorted out when asking about free care.

We look at Tenet and the lawsuit that we're working with, California Congress for Seniors, regarding their impact on earnings source, the fraudulent billing and the increased services alleged on the part of Tenet. And we see the reaction that to repair credibility in this environment, Tenet is -- to compensate for the lost dollars, talking about selling or closing 14 hospitals.

We look at Health South inflating receivables to meet Wall Street expectations. Here in the D.C. area, we look at the effect of the bankruptcy of NCFE and what it's done to Health Alliance. That was supposed to be the fix and the fix is broken.

There's a growing consumer backlash to conversions, whether it's justified, whether there really is a difference or not, on the part of the consumers, they're feeling there there is. Just last week, in Slidell, Louisiana, 77 percent of the voters in 68 precincts rejected a referendum required for a conversion of a hospital there. Kansas denied the application of a BlueCross plan there to convert and be acquired by Anthem. In Maryland, similarly, the application of a

BlueCross plan to convert and be acquired by WellPoint was denied. In Kansas City, Health Midwest and the Health CA purchase of that system, although it was approved, met with considerable consumer concern. The same happened with a hospital in Logan County, New Jersey and Franklin, New Hampshire.

We've learned that foundations don't compensate for what's lost in the mission of a non-profit. The most well-meaning foundation cannot compensate a community for what potential is lost there. And today, we're seeing a great threat in that the monies from a conversion don't even go into a foundation. We've seen budget-strapped state legislatures looking at these funds as a source of plugging their budgets.

So, on balance, there's great concern about what happens as non-profits go to for-profits coly5

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has taught us that acquisition over management seems to be the focus. That was realized looking back that at one point even the Kansas AG questioned the executive compensation levels of that non-profit plan.

In CareFirst, the BlueCross plan in Maryland, part of the reason why the commissioner there disapproved the plan was $170 million in merger bonuses that would have gone to the top seven executives of the corporation.

We see hospitals in Connecticut resembling the billing practices of Tenet in terms of overcharging the uninsured.

When the report card is based on the expectations of Wall Street over Main Street, it doesn't matter in some regards whether you're non-profit or for-profit because the incentives are the same. We find that the mentality of the non-profit leads into too many of the for-profit organizations and the behavior becomes distorted.

But that does not have to be the case. And there's also some backlash considerably building in that regard. Rather than accept as inevitable that non-profits have to behave like for-profits5.1 -tchdore t2 TD.b n 2s a5

In terms of governing hospitals, for instance, Massachusetts has passed an essential services law that requires that before certain services can be significantly reduced or discontinued there must be a public review process.

Kansas did an in-depth health impact study to determine what the impact would be on the small and individual markets when the BlueCross plan conversion was proposed. Looking at more than is a good dollar value going to be gotten out of the deal, but instead, what will the impact be to the total community, not just the people already in the club.

In New Hampshire, a regulator recognizing that the merger of two non-profits was not working undid that. In West Virginia, we found a bankruptcy judge recognizing that the interests of the community in health care services and access is as important as the financial interests of the creditors. And in Maryland, now that the proposed conversion was denied, they're working there on legislation that will put, hopefully, the heart back into the non-profit mission that's there. There's work being done in terms of who should sit on the board and better representation and what the behavior of the non-profit should be like and requiring that it stay non-profit for an extended period of time.

Consumers feel that cost and access are being sacrificed to profits and they want more regulation. Kaiser just realized a survey that indicated that 64 percent want more regulation on insurance, 34 on hospitals. As a point of comparison, 44 percent felt the same way about the tobacco industry.

What we're looking for are creative uses of regulatory, statutory and common law authority by those in power to do so on both a state and federal level. To find ways to allow and encourage well-managed non-profits, focused on the goals of maintaining and improving access to drive to require that for-profits guarantee access to the medically under-served.

The difference received by the public is significant, that for-profits have less oversight, less commitment to the community and a significantly negative impact on their access to health care.

Thank you.

(A a .)

MS. MATHIAS: Thank you, Dawn. We'll take a 10-minute break and reconvene at 11:45. Thank you.

(W , a b c a a .)

MS. MATHIAS: If we could please remember to speak into the microphone for the court reporter, for the conference call and for the people who sit at the back of

the room. We do want to make sure that everybody is heard.

Also, I had originally stated that the panelists would ask questions of each other. Actually, after a little bit more thinking and talking to a couple of other people, we've decided that just Ed and I will be actually asking the questions, but we hope that, as we ask

questions, although we may direct it to one person, that everyone will feel free to address that question and just let us know, again, by turning your tent.

And Ed has the first question.

MR. ELIASBERG: All right, thank you, Sara. Actually, let me start out, Bill -- Bill Lynk, this one is for you. You spoke first and a lot of people have since followed and, also, it looks like a lot of people have keyed off of your work in the various -- the presentations they've made. And so, given that, do you have any thoughts or comments, given what you've heard from the other panelists, if anyone would like to comment on what they've said.

DR. LYNK: Well, maybe -- probably a couple of comments, probably there will be more after further reflection, but I'll start now. One is just to repeat one thing that I said. I think, you know, different

studies are going to differ and they're going to differ what they look at and how they looked at it. You know, that's not much comfort if you're trying to form a single, solid opinion about what the world really works like, but the only real solution is to make some independent judgments about which ones are focused on the right questions and which ones were done better than which other ones.

So, you know, you will find divergent results and a lot of us who actually do these studies spend a lot of time wondering why what we find isn't exactly the same as the guy before us or the guy after us found. So, it's not a very glamorous task, but that's sort of the way it's undertaken.

The other observation that I would have, I think, has to do with the Butterworth case. I assume it's been a while since Peter Jacobson may have read the opinion in that case, but I actually was there, and you could get the impression from Peter's precis of the matter that really all of the -- all that the merging hospitals did is they tossed up to the judge a reprint of my article, the judge keeled over and said, well, of course you can merge.

Well, it wasn't quite that way. There actually was a fair amount of evidence that bore on some of the

relevant issues that was quite independent of anything I might have published. And just to mention three of them, as I understand it from the attorneys from the hospital, the FTC tried very hard, and succeeded, in subpoenaing actual reimbursement records from a couple of managed care payers within the State of Michigan. Again, as I understand it from the hospital's attorneys, they did so because they justified their subpoena by saying, we're going to show you that when you get market configurations of the sort that we argue the merger will produce, you get higher prices.

Well, that was a gamble and they lost, because when their economists looked at the data, just as I looked at the data, it just wasn't there. And the appeal, according to those who were subpoenaing it, was that that related specifically to Michigan, which is where the merger was taking place.

The other point that you may not have picked up on is that in arguing for the reliability of their prediction of higher prices, the FTC basically threw down the gauntlet and said, we can show you where these hospitals, these non-profit hospitals already have sort of a local monopoly, as they put it, in certain services that they gouge consumers with high prices on those services. Well, that's what we like to call a testable

hypothesis. When you looked at the actual data, the services that they were relating to, there was nothing to it. There was no empirical evidence of that at all.

And the third point that actually I thought was dispositive, and which I had nothing to do with, is that at least one of the two hospitals was operating at what appeared to be a significant cost disadvantage for a variety of reasons and they had some efficiency plans in the works that, at least in principle, who knows in fact, could have been sufficient to swamp any market power effects on the margins, assuming that the cost structure basis was lowered enough.

So, as I said, your question is one of those where you think of 30 other things on the flight home, but those are the reactions I have at the moment.

MR. ELIASBERG: Thank you.

MS. MATHIAS: I believe Peter has something.

MR. JACOBSON: I actually agree with what Bill just said. I didn't mean to imply in any way that the Court simply accepted his study and that was the basis of the decision. I thought I had explicitly mentioned other factors. Let me just add a couple. One was that the Court made a big deal of the fact that the FTC's witnesses didn't visit the site. That was very important. In fact, the judge did. Whether the judge

should have is an important question.

Secondly, there was a very explicit anti-managed care bias in the opinion that, I think, significantly colored the results.

Third, I think the Court relied more heavily than anything else on the covenant, on the community's statements that we will be able to control price increases. If anything, your study was just one factor that fit nicely into many other important ones. And,

services, and the question is, do we believe it more when it's a non-profit than when it's a for-profit. At least, in this case, the answer seems to be no.

And one final sort of point is that what were now -- what were just called duplicated services in most other industries we call competition, right? Two firms selling the same thing. So, keep that in mind when you hear that.

MS. MATHIAS: We've heard that there are different community benefits that both the for-profit and the not-for-profit can contribute to a community depending on where they're acting. I was wondering whether or how should the agencies take those into account when evaluating, for example, a merger. Are those benefits that transfer to the community something that we should weigh and how should we weigh them?

Frank?

DR. SLOAN: One thing I was concerned about in discussing community benefits, who is the community? Like we are an academic teaching hospital at Duke and we give a lot of money to the medical school. Most graduates of Duke do not locate in Durham, I think is a safe assumption. And if we are also safe, doing unfunded, unsponsored research, funding that. Who is the community for that? Maybe the world.

We've not really gotten a grip on who is to benefit. It has never been operationalized. And I don't think that we're doing anything wrong really by subsidizing the medical students, but maybe you could argue that we are. But we don't have any debate of this.

And so, we're always left with uncompensated care. And on that, I think we have beaten that horse and beaten it and beaten it. You just cannot show much of a difference. I mean, on average. There's going to be hospitals that are just doing tons of it, but then there are there hospitals that don't. But that's the one thing we have been able to document.

Then, finally, should hospitals be providing community benefit? Now, I'm not sure that if I want to stamp out smoking, that the hospital is relatively efficient in doing that. If I'm worried about children getting fatter, that the hospital is efficient in doing that. If I think I have a drug problem in the community, that the hospital is better in doing that. If I want to promote exercise in the community, that the hospital is better than that. And so, there's maybe very little that the hospital has a comparative advantage in doing. We don't ask those tough questions.

MS. MATHIAS: I think Tony may have turned his tent first, but. . .

MR. FAY: I think the situation with Province Healthcare, which is a rural company, illustrates some of the unique circumstances you do have in rural markets, where typically there may be one or a maximum of two hospitals in the area. And when a transaction is contemplated, a conversion, if you will, or just an acquisition of a competitor, usually it's because the community and the sponsor of the hospital has agreed that a better benefit will accrue to the community.

In our case, for example, we acquire rural hospitals, a lot of which are really about to close or have reached a point in their capital cycle where they just can't raise the money to reinvest in their plant. So, they look at their horizon and see that they're going to be on a downward trend and we also, because of our capability to recruit physicians and set them up in practice, we make a promise that we will bring more physicians to the area, which over time, over about the first three years, acsa nn7fual the inablish newt trv, w fira, ws.-5.7 0 TD(16)2011.1 -2 TD(firhink the sa bece ofw we que ci

MS. MATHIAS: Dawn?

MS. TOUZIN: I agree that the challenge in terms of how do you define community benefits and how do you approach it is a tough one to take. We worked with consumers in New Hampshire when they were passing a community benefits law affecting non-profits in that state and there they have Dartmouth with a similar teaching hospital challenge. What they came up with was not to try to completely narrow it down to free care, although that remains, for many communities, obviously -- and especially in today's environment, one of the most significant measures.

But what they then did try to do was, at least,

asked whether and how non-profit hospitals' provision of community benefits should be considered in the antitrust context. You know, putting aside experiential kinds of things, systematic research or anecdotal kinds of cases, I think it does raise a very fundamental issue about whether antitrust enforcement agencies should even recognize what one might call sort of a Robin Hood kind of scenario where, you know, hospitals or other organizations exercise market power but then justify that by saying we use it to -- we use it to support community activities.

As I look at antitrust jurisprudence over time, it's never been clear to me that, from a purely doctrinal standpoint, that there should be any recognition of that kind of behavior. Those issues were raised in some of the NCAA cases a number of years ago around universities and, you know, from an antitrust standpoint, it's not even clear to me that that even should be recognized. If it is recognized it raises, I think a lot of very thorny issues that can apply both to for-profits and not-for-profits about how one would actually create some sort of analytic guidelines, analytic framework for determining when enough community benefits justify the exercise of market power in the form of higher prices.

MS. MATHIAS: Peter?

you're talking about a reduction of output to an inefficient level of the relevant product. And what gets done with the surplus really ought not to matter, I can't imagine how, in the antitrust analysis. It's a fact because of the legal non-distribution constraint that when you create the profit from that sort of blackboard scenario in Cory Capps' exhibit, that, you know, you can't spend the money on anybody's personal benefits, so you have to spend it on something else. But it's a very inefficient way to do it.

As I put it, I think, in an earlier paper of mine, that to try to defend an admitted elevation in price from a merger through this community benefit argument is a little like John D. Rockefeller defending a monopolization charge by saying he spent it all on good works and charity at the end. That may be true, but it really doesn't much matter for the antitrust analysis.

MS. MATHIAS: Did I hear a new tent? Okay, Frank.

DR. SLOAN: I have been a member of our hospital board for a number of years. Most of what we do at the board is worry about helping our hospital make money, you know. It's not a foregone conclusion that a not-for-profit will make money. If you want to see what we can read about what's happened to Mount Sinai, about

hospitals losing money. So, rather than sit there and say, well, we want to put flowers -- you know, we're doing this and, you know, this is what we're doing for the community, this is really a major business that we're engaged in. I would suggest that that's what most of the hospital boards are doing.

Now, maybe that's too bad, but it -- you know, it turns out that the competitive advantage isn't that big that you can just sit back and worry about whether you like the layout of the downtown. And that's just a fact of life. And as the budgets get tighter with the balanced budget amendment and HMOs are not totally gone and, you know, we continue to have Medicare cutbacks, that a lot of the time really is spent where do we go from here. And so, this is a theoretical proposition that we can sit there and just contemplate how we spend great amounts of surplus.

MR. ELIASBERG: Here's my question. I think, Bill, it might be best if you lead off on it. I debated that, but I think you're probably the best person, seeing how I think the idea may have developed in some of your work. But the question is this, what characteristics should we be looking for in determining whether the consumer cooperative model is applicable or not?

DR. LYNK: Well, I'm actually convinced that

fiduciary duty because, in some sense, talking about the other hat that they're wearing is almost an admission that fiduciary duty may be a little more complicated. But putting that aside, you know, that's a basic starter because you do ask what possible incentive could these people rationally have, I mean, unless there's something illegal going on for wanting to price it other than competitively.

Now, whether it happens or not, you know, obviously, is a subject we often try to look at. But at least as a starting point, I think that's not a bad place to begin.

The key question probably is whether the non-profit organization, the non-profit hospital is answerable strictly to local interests, and if so, what are those local interests, or whether it's answerable to some much, much broader organization, whether it's a religious organization or whether it's research and educational foundation and so on, because I know that if you looked at other hospital transactions, board of directors, and I think -- I'm not going to go to the mat on this one, but I think Long Island Jewish may have been an example of it.

When you took a look at who was directly in control, if that's a good description of what the boards

of directors are, you know, these were all very prominent people, but it was hard to see why they would have a direct interest in the price of health care on Long Island or Queens. So, as I said, I don't mean to suggest that that's sort of the end of the inquiry, but it's not a bad place to start.

MR. ELIASBERG: Gary, I was debating originally between asking the question to Bill or you and I see you've put your tent up, so why don't you go ahead.

MR. YOUNG: Well, I think Bill provided a very good foundation for the response that I would give and I think the question is a very important one. I mean, as I think about it, it may be the second-most significant question for a hearing like this to consider.

The first question to me is, you know, should non-profit organizations, as a class of organizations, be exempt from antitrust scrutiny, and I don't think that matters much about whether how non-profits behave relative to for-profits. I think the important question is how non-profits behave in and of themselves and if they do exercise market power in the form of higher prices, if they do use market power in anti-competitive ways that are consistent with the types of behaviors that the antitrust laws were intended to prevent, then I think the show sort of stops right there. I don't think it

really matters how non-profits behave relative to for-profits.

But then, assuming you move beyond that question and believe that non-profits should be subject to antitrust scrutiny, then I think the second question is, are there important characteristics of non-profit organizations that one needs to look to to understand how they may behave in given market situations. And I think board composition is very important.

As Bill noted as something that I tried to address in an empirical study, the independence of the board, I think, is an important consideration. I'm sure there are other factors as well. I think one needs to consider some important trends in the non-profit sector which is that there has been a growing trend toward greater insider representation, which can be seen in some studies that I've done and in some AHA surveys that have been done, as well as some other surveys that have been done by various academic or trade associations.

Another important trend is that at least 50 percent of all hospitals today belong to systems. They're not independent. And in those situations, local control is often attenuated because decision-making authority is moved from the local board to a higher level board, a system level board and local control may, you

know, be largely a fiction. I think that's an important thing to consider as well.

So, I think both from a theoretical and an empirical standpoint for the future development of antitrust doctrine, this is a very important area to pursue, because non-profits are not all alike, there are important characteristics that are likely to distinguish non-profits that have important antitrust implications.

MS. MATHIAS: Gary, I had a quick question. You just said that 50 percent of the hospitals belong to systems and I was wondering if there was a breakdown on the not-for-profit versus for-profit within that 50 percent, if you happen to have that in your clips?

DR. YOUNG: No, I believe that approximately somewhere between 45 and 50 percent of non-profit hospitals belong to systems. I think most for-profit hospitals, maybe almost all of them today, are a member of some sort of system. There are very few independent for-profit hospitals. I mean, there may be a small number around. And there may -- there's actually sort of a growth now of some specialty hospitals that are owned by physicians. But even those, I think, are by and large not usually one hospital, but at least a -- more than one.

MS. MATHIAS: I have a journal question I'll

you could be optimistic, I guess, and hope that we'll continue to see a similar impact to what HMO percentage was in the older studies. If they're more like indemnity insurances, then that may vanish.

Off the top of my head, no data whatsoever, I think they do meaningfully have an ability to play off hospitals against each other unless all the hospitals merge.

MS. MATHIAS: Gary?

DR. YOUNG: Just to add to that, you are also much more likely to see a strong relationship between market power and higher prices for non-profits in the settings where you've got higher managed care penetration, particularly as, again, I think I mentioned this in my presentation, if you're looking at price changes as opposed to price levels.

So, I mean, those are important considerations to keep in mind when you're doing empirical analyses to support an antitrust case. Because certainly if you go into some markets where there is very little managed care penetration, you're not likely to see a relationship between market power and higher prices because you're going to see more of the old medical arms race kind of fabric in that market than the kinds of markets you're going to see in many places in California, Massachusetts,

et cetera.

MR. JACOBSON: To what extent would increasing the concentration of managed care play an effect? That's sort of the flip side of the question. In a market say like Minnesota dominated by like two major insurers at this point, how might that affect relationships?

DR. CAPPS: Is that for me?

MR. JACOBSON: I'm just throwing it out.

DR. CAPPS: In the anecdote of Pilgrim and Partners, I guess Pilgrim is a third of Boston, so one observation, but take what you will, buyer power from the insurance side doesn't -- well, it's not a study, it's just an observation.

DR. LYNK: Yeah, just to throw out observations instead of studies, since I don't have any studies on it either, there is an awful lot of concern, at least if you listen just to the volume level, on the part of providers with growing consolidation of health care payers and, in fact, that idea that they might have monopsony power, which is the flip side of monopoly power, I thought got a little bit of a leg up when the government included it as at least one element, although by no means the only element, of its complaint that it filed along with a consent decree in the proposed -- in the merger of Aetna and Prudential be concerned that they would be able to

anti-competitively reduce fees paid to physicians and to hospitals, through controlling of such a large percentage of the payers, was seemingly what was behind it.

So, I don't know what -- I don't know how much empirical support there is for that. Roger Feldman had a paper, I think in the Journal of Health Care Finance and Economics where, I think, he wound up concluding that when you saw that sort of thing, that sort of concentration of managed care payers, it was more -- looked more to him like bringing prices closer to the competitive level than jamming them below the competitive level. But I think his conclusions were appropriately couched as pretty preliminary given the nature of the data. But there's certainly something to it in terms of people, a/k/a plaintiffs, who contend that there is a growing degree of concentration on the payer's side and it has potentially bad competitive consequences.

MS. MATHIAS: I'll go to Tony right after I make a quick plug. We will be addressing some of the monopsony issues in April, April 24th and 25th. So, come back for more on that.

Tony?

MR. FAY: Just kind of a rural perspective to the monopsony issue, a lot of the markets that we've gone into have been long-standing monopsonies because you just

don't have a history of a lot of different players, and they're either in the form where you have one or two major insurance carriers and those are the only carriers that market to the local employers or you have a situation, for instance, in Fort Morgan, Colorado, where we have a hospital -- where the major employer is a very large self-funded ERISA plan and it negotiates directly with the hospital. So, it's truly one-on-one. But it is an issue that I think is a little bit different in rural areas and it's probably been more long-standing.

MR. ELIASBERG: I think it was Peter who made an allusion during his talk to the situation or the occurrence of where non-profits either purchase or buy significant stakes in for-profit companies or -- I don't think you mentioned it, Peter, but at least press reports have non-profits setting up for-profit subsidiaries to run in various lines of business.

I was wondering, first of all, the question of, one, just how common an occurrence is that. Are we talking about something that's sort of an aberration or something that's becoming more common? And second of all, what does that mean, if anything, with respect to whatever distinctions there are between for-profits and non-profits?

I'll allow anyone to take a crack at that.

DR. LYNK: I'm not sure if this is directly on point to the institutional set-up that you've got, but one thing that you will observe or can observe is that sometimes there are two non-profit organizations that want to get together and set up a joint venture. Maybe it's an imaging facility that neither of them is big enough to afford on their own so they decide to go in on it.

It's easy enough to split up the division of the costs on that. That can be spelled out with a fair degree of specificity. But if you keep it as a non-profit corporation -- the joint venture as a non-profit corporation, it's a little tough to measure or even define exactly how the division of benefits is supposed to work on that score, whether one seems to be getting the upper hand on the other as far as getting the balance of the benefits of the joint venture.

At least according to what I've read, and to some degree, heard, sometimes it's simplest just to simply set it up as a for-profit corporation, own stock in it and by specifying the amount of stock, you automatically get at least a well-specified division of the direct benefits. There are some, obviously, indirect benefit issues that doesn't influence, but that's at least a partial explanation for some of the circumstances

you may have.

MR. JACOBSON: I don't know empirically what the trend is. I suspect, though, as we move in the future, this will occur more and more frequently for competitive purposes. And I think it's another instance of blending the lines between the two, as Bill perfectly suggests.

Here you have the additional problem of just not only raising antitrust problems in terms of a percentage of any position from an entity involved either in an exclusive or a non-exclusive arrangements, but the tax consequences, how do you measure where the money's going. The whole issue of Revenue Rule 98-15 over control matters.

And I think just one quick point. It gets back to something Gary said not too long ago, and I think agree strongly with this. There's no inherent reason, that I can see, why you would treat, for antitrust purposes, the corporate form as dispositive as opposed to the activity. It just becomes more complex when you're in joint ventures, determining where the revenue is going, who's got control and what the relationship is between the for-profit and not-for-profit.

MR. FAY: I definitely agree with Peter that tax policies have driven a lot of why not-for-profits

unique to us in health care.

MS. MATHIAS: Well, we are very close to 12:30 and just to -- before we wrap things up, I thought I'd give each panelist the opportunity to talk for about one more minute if they have any remaining comments that they want to throw in.

And although we've been starting with Bill the whole time, I think this time we'll reverse order and let Dawn start and then we'll proceed down the table. If you don't feel like you have anything else to add, don't feel like you have to create something.

MS. TOUZIN: Mine will be brief, I think, and that is I have some serious questions as to how effective antitrust is in terms of consumer perspectives. I think we get into a lot of economic matters that, from the policy aspects that I know of as concern for consumers, are problematic, I think, in terms of this arena.

So, I think you have a significant challenge in terms of how to meet something -- more of a model that satisfies what I hear from consumers.

MS. MATHIAS: Thank you. Peter?

MR. JACOBSON: Thanks. I'd like to make sort of two points quickly. One is that when I look at the case trends, regardless of any disagreements we may have about interpretation of any particular case, frankly I

looked at the '90/'96 guidelines if they provide something. But generally, that's the case.

I do think we don't need a whole lot of more research on how non-profits differ from for-profits. We've pretty well exhausted that. I do think that looking at what these community foundations are doing

MR. YOUNG: As a professor, it's really an anathema for me to say that we have enough studies, so I probably won't go in that direction. But I will say, as I mentioned earlier and just to emphasize that point, I do think it's a bit of a red herring to spend so much time within the antitrust context to be comparing not-for-profit hospitals to for-profit hospitals. I don't think that's particularly a significant issue to consider.

You know, again, I think more to the point is whether non-profit organizations in health care settings deserve an antitrust immunity and are there characteristics of those organizations of the marketplace that simply make them inappropriate to police from an antitrust standpoint. And, actually, for that matter, I think you could also apply that to for-profit organizations in the health care marketplace and question whether there are characteristics of the health care marketplace that simply make antitrust enforcement of for-profit organizations inappropriate.

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went after mergers between non-profit organizations. Do we want to reverse that policy? Do we want to rethink that? I think that's appropriate for this hearing to consider.

But assuming that we do not want to reverse that policy and do believe that antitrust enforcement policies are appropriate for non-profit organizations -- and as I mentioned, I think a very fruitful journey to go down is to have a better sensitivity to the characteristics that distinguish non-profit organizations and what that can tell us about how they're likely to behave in situations where mergers, joint ventures or other types of transactions occur that raise potential concerns about anti-competitive consequences.

MS. MATHIAS: Tony?

MR. FAY: I just wanted to conclude with a quick note on governance. Governance at the local level is whatever the system wants it to be. A hospital has to have a local board under its JACHO accreditation and while certainly in some systems, those boards are rubber-stamp entities, I know in our system, for instance, we take it very seriously. We have several outsiders on the board, local community leaders. We get physicians on the board. They're typically seven to nine member boards and they're involved in key decisions such as hiring the CEO,

signing off on any rate increases that we do. They're involved in executing all major contracts including managed care contracts.

We've just learned, not only through our company's short history but the long history of our company's founders, that the more of that control that you delegate to the local level, the more successful your enterprise will be in the long run. So, we try to foster that model as much as we can realizing, of course, that you -- in a system environment, you cannot do it 100 percent.

MS. MATHIAS: And, finally, Bill?

DR. LYNK: I guess I would just say that the only -- I don't really have any contribution at this stage to this distinction issue, but what does sort of strike me as a wrap-up is that as of about, oh, the late 1980s, at least as I saw the landscape, there was a pretty mechanical dismissal of the distinction or even the consideration of ownership issues. I think there was the reluctance, for whatever reason, to even consider the issue and, you know, if you had multiple types of hospitals in the same market, you added up their shares and you didn't think twice about it, despite the fact that according to Newhouse and a number of others, there might have been reasons you should have.

Fast forward about a dozen years after that and the only thing I think is interesting is that people, I think, do recognize that at least potentially in principle and at least in some of the empirical evidence, there may be a distinction.

Now, you know, Gary most recently was the one to use an expression of antitrust exemption. I'm not aware of anybody that I know of at all that ever thought non-profit organizations ought to have an antitrust exemption, and I don't think anything anybody's heard here today would justify that, far from it. But I do think it may -- that this may not be good news for trying to analyze proposed mergers within the 30-day limit, but I do think it does add an element of something that some people, you know, may think is worth thinking about.

So, for example, when you see a merger proposed that seems to you numerically to create an overwhelming degree of concentration, yet at the same time, you see all of the seemingly informed local citizenry in favor of that merger, you know, you may want -- you may just think twice about whether they may not know more about what the real control and governance issues are that in play there than you do.

MS. MATHIAS: Well, I do thank all of you for coming and for staying with us the extra five minutes to

hear all the comments of our enlightened panel. We do appreciate their time, their effort and the education that they've given us today. I think they all owe -- we all owe them a round of applause and so I'd like to lead us in that.

(A a .)

MS. MATHIAS: And then we'll be back here this afternoon at 2:00 looking at joint ventures and joint operating agreements. We hope all of you can come back and listen in, and we'll have the conference call-in number back up at that point. We'll go offline now.

As I said in the past, and it gets tiresome for the people who have already heard it, we kind of consider this like a campground. So, whatever you brought in, take out with you, please. Thanks.

(W , a 12:35 ., a c a .)

AFTERNOON SESSION

(2:00 p.m.)

MR. BYE: We're going to jump right into it. This is very much a working session. Matthew Bye, my colleague and myself, Mark Botti, are the moderators. Mostly, we're just going to try to orchestrate comments from our panelists. We're not going to introduce them in detail. Their biographies are in the binder out in the hallway. I'm giving you the order of presentation just so you know who's coming when.

We're going to lead off with Meg Guerin-Calvert from Competition Policy Associates; Robert Moses from Oxford Health Plan is next; Robert Taylor, who I don't think has joined us yet, but when Robert comes, Robert Taylor from Robert Taylor and Associates.

MR. BOTTI: That brings us to David Eisenstadt from Microeconomic Consulting and Research Associates, Inc., MCRA I think I know it as; Jeff Miles of Ober, Kaler; Bob Hubbard from the New York Attorney General's Office; and William Kopit who will go last. Let me turn it over to Meg. Meg, please?

MS. GUREIN-CALVERT: It's a great pleasure to be here. I'd like to thank Mark and Bill Berlin for having invited me. I thought what I would do, since there's an illustrious panel here who define a number of

different perspectives and I suspect that the discussion and question and answer session after this will bring out a lot of issues, I thought what I would try to do today is to present an overview or a framework for what the issues are in looking at hospital joint ventures and in joint operating agreements.

In terms of a starting point I would really like to raise, there are four steps of issues that we will be likely looking at and spending a lot of our time talking about today. The first is, what's the appropriate framework in the health care industry, in particular, involving hospitals, but also generally for analyzing joint ventures and for joint operating agreements?

The second, and this is a particularly important one because it is oftentimes very difficult to assess, is very much piece specific, but there are some general principles in terms of what are the various reasons for which hospitals are engaging in joint ventures or joint operating agreements? What are the business rationales? What are the expected gains? And, again, one of the topics that was raised for today is how do you measure those gains and when should you measure them? And then how prevalent are these types of ventures in their various configurations?

The third, which is obviously one of the

the existence of several other competitors in the hospital industry and the hospital construct is oftentimes the case in markets in which you see joint ventures, but there is the prospect for gains from ventures among smaller entities while still having competitive discipline from all the other market competitors.

Again, it doesn't happen in every case. Every case has got some fact-specific issues. But, again, the analytics as to what's the driving need for the venture, what's the economy that's going to be accomplished, have some similar issues.

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Intellectual property and production joint ventures are two other areas where the agencies have a lot of practical experience of dealing with joint ventures among competitors, allowing them to go forward, and so those are ones that provide us, again, some analytical framework with which to work.

In terms of the business rationale, you know, the standard joke is, you show me one, and I can explain one to you. Joint ventures and joint operating agreements in the hospital sector somewhat have that flavor. What I've tried doing here is to mention some of the motivating factors, matters that I've either looked on while I was at the department, I've read in the literature or had the occasion to work on, I tried going back to all the business reviews that the agencies have looked at in terms of ventures and in the trade press and they fall into these basic categories. The simplest and the easiest ones are capital equipment and joint ventures. Those are dealt with straight-forwardly in the guidelines. Bottom line on those is, in order to bring in high-cost equipment into a particular community, possibly a smaller community, the only way to accomplish it is maybe through a joint venture of some participants.

The second major area in which we see it occurring is tertiary services. This is an

private sector is more people started looking at joint ventures as something short of merger. So, there's a little bit of a chicken and egg problem as to which came first.

But as I think that case showed, and I'll talk about in a minute, it's proven very difficult to accomplish some of these joint ventures because there are

services to the community above and beyond what otherwise would have occurred, or in some cases, maintenance of services in the community.

The biggest issues, I think, that have been underdeveloped is this first one, in particular, that these kinds of contractual arrangements are among some of the thorniest ones for hospitals to deal with. Even if there is the best of intentions at the beginning going into these ventures, it is very difficult to set them up and keep to schedules with respect to integration of staff, integration of services, how it is that the balancing occurs, how is it that the cost savings will actually occur, and let me -- since my time is basically up, let me just say that the obvious risks are that you have agreements among competitors and whether or not people actually achieve the integration of services.

I think the bottom line is, one needs to look very, very carefully at the difficulties that are encountered in setting up these and the gains that people hope to achieve. Many of the reasons why they do not succeed as quickly or as well is because hospitals are in a circumstance where to be able to exceed in a joint venture, they have to, in perpetuity, give up a particular service.

In closing, I'd say the bottom line is we

should spend as much time on applying the framework, evaluating the cost and benefits as we do at looking at whether the tweaks in the operating rules would be better relief than breaking up the venture or stopping its formation.

(A a .)

MR. BOTTI: Thank you, Meg. We'll ask Robert Moses to share his remarks with us now. As you can tell, we were watching Meg's time closely and she was the lead-off, so we were a little bit easier on her than we will be as we progress. So, I'd ask everyone to try and stick strictly to the 10 minutes.

MR. MOSES: I will try to do that. My name is Bob Moses and I'm Senior Vice President and Chief Health Care Counsel of Oxford Health Plans. Oxford operates health maintenance organizations in New York, New Jersey and Connecticut and insurance products in a wider part of the country. We insure about 1.6 million people.

My comments today reflect not only my experience as in-house counsel to two HMOs, two managed care organizations for a period of 10 years, but also observations over 20 years of being involved with the health care industry, including being on the New Hampshire Certificate of Need Board.

As Meg said, there are really a number of

different kinds of joint ventures and reasons that hospitals and health care provided might engage in joint conduct and new types of combinations are constantly being developed. In fact, I heard of a new one yesterday and I'll talk about that in a few minutes.

There's no doubt that when hospitals get together to finance, build or operate a new service, like putting a cancer center where one didn't exist before, there's some benefit to consumers. In fact, the New Hampshire Certificate of Need Board thought this was so important, this kind of collaboration was so important, that we wrote regulations that actually favored collaborative activities in these kinds of circumstances. There are a lot of other circumstances that could bring value to the community, including preserving existing capacity, and we saw that in New Hampshire a couple of times, too. There have been any number of combinations up there that enable a local hospital to stay in business, which preserves the existence of a local 24-hour emergency room where one might not have existed before.

Sure, there are competitive concerns with these kinds of collaborations, maybe there ought to be two cancer centers instead of one, but in circumstances where there's some kind of discrete benefit that's readily

to jointly negotiate and we worked something out. But over the last year or two, first we get a termination notice from four or five hospitals and then we start the negotiation. Certainly, when four or five hospitals in one community issue a termination notice, that can be pretty disruptive for members, particularly when it happens sometimes, the hospitals will start telling the patients, calling up the patients and their doctors and saying, well, you can't come here in 30 days or put up a sign in the emergency room saying we don't accept Oxford Health Plans, and that's happened on a few occasions, even though we've actually never lost a hospital contract.

Yesterday, I just heard of a new one. We have a contract with an independent hospital. Separately, we have contract negotiations with a group of hospitals that resulted in a pretty substantial increase to one of these systems. Yesterday, I got a notice from the system hospital that it had just gotten licensed by the New York Department of Health to operate about 100 beds at one of the other hospitals. Why did we get that notice? Because they wanted the rates that we had just negotiated with the new hospital. So, they didn't even wait until the old contract was up.

You know, as you think about negotiations, it's

important to understand what that means to rates. The general rule of thumb in health care premiums is that hospital costs are about a third of the premium rate. So, every 10 percent in hospital costs increases, not for any one but overall, translates to about 3 or 4 percent increase in premiums.

After the hospitals that are part of a joint operating agreement or virtual merger issue the notice of termination, they often come to us with really pretty outrageous price increase requests, sometimes as much as 40 or 60 percent. So, you can think for yourself what that might do to the rates.

We don't end up there. It sometimes takes a year to get to the right place and we can usually mitigate these over two or three years. But the hospital increases we've seen over the past couple years really have -- there's been a great acceleration of the trend in the past couple of years.

In addition to the pure rate increases, hospitals are often asking for, and increasingly getting, concessions that can also drive premium rates up, and this is more common in system negotiations or in group negotiations than it would be in individual negotiations. For example, hospitals might insist that the contract apply to all services. Why should this matter? That

would seem to make sense. But to give you an example, we can contract for laboratory services at less than 100 percent of Medicare with commercial laboratories, but I have never yet once seen a hospital contract where we've paid less than Medicare or actually usually less than one and a half times Medicare for laboratory services we obtain at a hospital. And, obviously, that goes right to the bottom line.

That kind of requirement shows up in other ways, too. For example, sometimes hospitals -- and, again, this is more prevalent in systems than it is with individual hospitals, although it happens in both situations. Sometimes hospitals will say, you can't carve us out of the network, we have to be able to participate in every product you offer. And what happens in those cases is it makes it harder for us to get into and stay in Medicare products because we can no longer contract with one group of hospitals to assume risk for a Medicare population because we can't assure that hospital that they won't be able to keep members from going to a hospital that mandates that they participate in all of our products.

Can all these increases be attributed to joint action? No. It's pretty clear that there are some circumstances where we would give these same concessions

and pretty good rate increases to the individual hospitals, but some of the hospitals in these groups wouldn't get it and the ability to negotiate as a group and to mandate all the hospitals in a group remaining in the network really limits our options to be able to steer more business to a hospital in exchange for better rates.

So, you know that health care costs are rising and you know that hospitals and joint operating agreements in virtual mergers are negotiating price and related terms. You also know that the antitrust result would be pretty obvious if this was viewed as a naked restraint. So, the question is, when should this be viewed as a naked restraint and when should it be viewed as a joint venture, subject to the rule of reason analysis and ancillary restraints?

Like I already told you, I am skeptical of general claims of efficiency because I've never seen them result in a rate reduction. But here's another couple reasons why I think you should be skeptical. First, in my experience, when you create a virtual merger, the first thing that happens is that the combined entity develops a whole new management structure. This means that right off the bat, the entity incurs more cost than the two entities did by themselves. So, any net efficiencies, any net savings that might be achieved by

the benefits of clinical integration? To me, medical staff activities can be looked at much the same way as educational activities of the professional association and developing clinical pathways is a lot like standard setting activities manufacturers engage in. We all know that manufacturers don't get to set prices because they produce under common standards and we also know that manufacturers don't get to set prices for the products that they don't produce under the common standards just because they set standards for a different set of products.

Of course, if there's a real joint venture, that's a different situation. We actually tried to find that out once with one group of hospitals who told us they were developing clinical pathways. We said, hey, if this is all one product, why don't we negotiate a single price so it won't matter to us which facility the patient goes to? Hospitals said no. We all want the exact same price increase, not only for the services about which the clinical pathways were developed, but all of them.

Recently, some hospitals have also said, you know, of course our activity is a joint venture, we share profits and losses. Some of the other folks on the panel may know better, but what I think this means is that each of the hospitals promises the other that if they have a

loss and the other has a surplus, they'll share a little bit back and forth.

Well, I'm sitting with Bill, so Bill and I will remember. Bill and I argued, in the Maricopa County case, that sharing profits and losses ought to be what saves HMOs from per se analysis. And we got that little footnote in the decision.

But without the existence of some kind of a joint venture product, the sharing of profits and losses is really just another mechanism to enforce adherence to a price fixing agreement. When all the hospitals jointly negotiate identical percentage increases, the benefits to each will not be the same. The hospitals may start from a different basis, they may have different costs. The percentage negotiated may be good for some, but not for others. Agreeing to share the wealth simply encourages each party to adhere to the cartel, making it more likely that everyone can benefit at least a little.

Improving antitrust enforcement in this area, in my view, does not require drawing new lines. The existing lines between per se and joint venture treatment are already fine. What I think is needed is a new degree of skepticism about aspirational claims of efficiencies and other consumers benefits. Hospitals have promised benefits should be held accountable for achieving them.

In conducting your review, you should make sure you understand exactly how consumers will benefit, whether through lower rates charged to managed care organizations or otherwise. You should require the parties actually follow through with their promises.

We were able to do that on the New Hampshire Certificate of Need Board in a much more limited way. We issued certificates of need which required parties to come back to us to show that what they did was consistent with what we had approved. I think you can do the same.

You can always break these things up later. I think, again, we've seen two examples recently of mergers or joint operating agreements that broke up voluntarily. The Mount Sinai NYU situation in New York shows that you can break these things apart without much harm to either party. In Manchester, New Hampshire, a merger that I know the Department considered looking at, that merger also broke up on its own when the parties realized that -- well, actually what happened was they actually tried to get the efficiencies there. They were going to close one of the hospitals and there was so much public outcry that they decided to break that one up. And I just talked to one of them yesterday and they're pretty happy that they're not combining.

And anyway, to close, holding the managers

accountable and making sure that the consumers get the benefit of joint operating agreements and joint ventures and developing an antitrust authority and enforcement policy that discourages these kinds of activities when there is no consumer benefit, I think might help mitigate the increasing costs of health care. Thank you very much.

(A a .)

MR. BOTTI: David Eisenstadt.

MR. EISENSTADT: Good afternoon. The title of today's presentation is "Do Economists Have Anything Useful to Say about JOAs?" When I showed the presentation to Bill Kopit this morning, he suggested I truncate the title after the first two lines.

(La .)

MR. EISENSTADT: Actually, when I told Bill a couple of weeks ago that I had been asked to speak at this session, his first question was, what does an economist have to contribute about joint operating agreements. These are, in effect, legal constructs and are analyzed under legal rules. And in some ways, I don't disagree with Bill, although there's one scenario or one type of JOA that, I think, raises a set of interesting economic questions and that's what I'm going to address today.

There are three types of JOAs to consider. The first involves JOAs that result in joint pricing but no cost savings. The second, JOAs that preserve independent pricing and achieve cost savings. And third, JOAs that assert cost savings as well as the need for independent pricing.

Only the third type of JOA presents independent economic issues for analysis. The first type of JOA is simply price fixing, presumably or presumptively anti-competitive. The second type of JOA is a competitive rules joint venture, presumably pro-competitive in the way it's structured, given that it preserves independent pricing. And the third type of JOA, which is the one I'm going to talk about today, could be either pro or anti-competitive. These are JOAs that simultaneously claim cost savings and the need for joint pricing.

The key economic questions for analysis are, can these cost savings be achieved without joint pricing? Bob Moses alluded to that question before in his presentation. And second, can all possible cost savings be achieved without joint pricing?

The analytical framework that I'm going to use for discussion is two firms enter into a joint operating agreement. If only one joint operating agreement partner invests, quality and brand differentiation increase for

both JOA partners. So, there's some quality improvement, also some brand differentiation. If they both invest, according to the way they're supposed to invest under the JOA, quality and brand differentiation or improvement increase even further.

I'm going to assume here that the JOA partners cannot fully monitor each other's investment behavior, which raises the opportunity or the prospect for free riding. I'll also assume, for simplicity, that all costs other than the sunk investment costs are zero. That will stylize the analysis and there are three constructs or three scenarios I'm going to consider.

The first is pre-joint operating agreement. I'm going to assume independent pricing and I'm going to ask what is the consumer welfare and profit levels that are achieved under that scenario. I'm going to compare that to the consumer welfare and profits achieved after the JOA, but also assuming independent pricing after the JOA, and last, I'm going to look at consumer welfare and profits post-JOA but under joint pricing and I'm going to compare both consumer welfare and profits and then ultimately ask the question, how would the firms choose to behave as joint operating agreement members if they did not -- if joint pricing were not permitted, but they entered into the JOA and there was a prospect for free

riding.

The first example I'm going to go through, which is this one, shows that joint pricing is necessary in order to achieve all the consumer benefits from the JOA. But the second example will show you that joint pricing is not necessary for consumer welfare to be maximized under the JOA product.

The pre-JOA equilibrium, which is shown in this graph on the wall -- many of you may be looking for a marginal cost curve here. Again, marginal costs are zero. So, this is a very simple profit maximizing calculus. Marginal revenue, which is halfway down that demand curve, equals marginal cost along the horizontal axis. The output is .5 for each joint venture member before the JOA and the profit maximizing price for each is .5. Again, this is before the JOA. Consumer surplus before the JOA is the shaded triangle underneath the demand curve. I've normalized everything to one here to make it simple. That consumer surplus value is equal to .125.

Now, we create the JOA, but there's independent

invests. There is some rotation in shift of the demand curve, which is the top demand curve you see on the graph. So, there's both a quality improvement and there's some brand differentiation that's created which creates the market power. Because of the market power that's created, price increases from .5 to .75, so there is some market power created, but there's also a quality improvement, as noted by the demand shift.

And when the investor goes ahead and makes its appropriate level of investment, but the other partner free rides, its profits still go up. They are .29 compared to .25, which was the pre-JOA profits. So, even the investor is better off when it's JOA partner free rides. The investment cost at the bottom here it just assumes to be .085.

How does the free rider do? The free rider or the other member of the joint venture? Its profits are .29 plus .085 because it shirks and does not make the investment and its total profits are .375. And what does consumer surplus look like when only one of the joint venture members invest? Consumer surplus, again, or consumer welfare is the shaded area under the demand curve. That area equals .1875, which exceeds the pre-JOA consumer surplus. So, even when only one JOA member

welfare.

What happens when the JOA permits joint pricing or joint pricing is permitted under the JOA? The profits for both firms, when they invest in joint price, are equal to .37 for each firm. That's lower than the free riders' profits, which equal .375, but larger than the profits when one firm invests and its JOA partner chooses to free ride, which equals .29.

When both firms make the appropriate level of investment, demand increases even further. That's the top demand curve you see in the diagram. When both firms invest appropriately, consumer surplus is .2274. That exceeds the consumer surplus when only one firm invests, which, in this stylized example, equals .1875. So, here's an example where consumer surplus increases when the firms are allowed to joint price and when they are allowed to joint price, they have the incentive to make the appropriate level of quality improvement necessary to maximize consumer welfare.

So, now, the interesting question is, what would the firms actually choose to do under the joint venture if you did not allow joint pricing? Would they elect to free ride or would they elect to make the appropriate level of investment? That's actually a game theory problem in economics. Those of you -- I'm sure

all of us here have probably seen "A Beautiful Mind." You're all familiar with the concept of the Nash Equilibrium, and here to tell you what the game theory outcome from this is going to be as well as the opposing example that shows how joint pricing does not necessarily maximize consumer welfare, is my colleague, Dr. Serdar Dalkir.

DR. DALKIR: Thanks, David. This is a game theory example. Just simply taking the numbers David has shown you on the graphs, the profits. If you put them under different strategies for the two JOA partners, which we call Firms A and B here. On each row are the strategies available to Firm A, invest or do not invest, and the green number, in itself, shows A's profits on under each strategy. In each column is B's strategy, similarly, invest or do not invest, and the red number in each cell shows B's profits in that situation.

Each firm is striving or working to maximize its profits, so let's take an example. If B invests, what would A do? So, you're looking at the first column that says invest at the top. B is investing. A's best move is not to invest because .375 at the bottom row is greater than .37 at the top row. And likewise, symmetrically for B, the same logic applies. And the net outcome is the two firms are attracted toward the

northeast and the southwest corners of the matrix in which one of the firms invests, the other does not. So, we have an asymmetric outcome under no joint pricing.

Very quickly, this is a different situation where we lowered the investment cost. Now, A's profits, when it invests when B is also investing is .43 which exceeds A's profits, if it didn't invest, .375. In this case, A would also invest if B's investing even when joint pricing isn't allowed under the JOA. So, this is an example that shows you both firms investing is a possible equilibrium, possible outcome, depending on the structure of the investment cost in this simple example.

MR. EISENSTADT: So, what can we say? Well, economic theory is indeterminate. Joint pricing may reduce or increase consumer welfare. The likely result depends upon each party's willingness to invest pre-JOA. That's something I assumed here. Neither party would have had any willingness to make this investment pre-JOA. But that's relevant for consideration and a legal matter.

Second, the nature and magnitude of the joint operating agreement related savings, e.g., what's the improvement in quality that would actually be achieved? Is it significant or is it cosmetic?

Second, what's the amount of market power that's created that determines how much demand rotates

and how much price will increase as a result of the market power created by the joint venture -- the joint operating agreement?

And last, what are the parties' abilities to write and enforce a contract that minimizes the propensity to free ride? I'm assuming here, in the stylized example, that there's no way to write a contract that adequately protects each joint venture, joint operating agreement member against the other party's free riding, but there may be contractual ways in order -53.4 Fer again4i

talk about and he said, well, it's a pretty broad topic, you can decide yourself. And I felt sort of like a kid on Christmas morning and I had a lot of trouble because the topics today, I think, are so broad, determining what to talk about. Joint venture, joint venture analysis has always been very interesting to me, especially some of the subtleties. Mergers, of course, and virtual mergers. And I decided that maybe the best thing to talk about would be virtual mergers because, I think, probably there's a good deal of misunderstanding with regard to those, including what they are and how they ought to be analyzed and what the issues are. So, that's what I'm going to talk about today.

I think, as everybody knows, there are good mergers and there are bad mergers and the same is true of virtual mergers. There are good virtual mergers and there are bad virtual mergers. Bob Moses, I think, explained somewhat the bad side. I'm going to try to explain a little bit about what I think are the good side of virtual mergers. I think maybe the best place to start is to try to explain what a virtual merger is or at least what I mean by virtual merger, because in listening to the previous speakers, it seemed to me that virtual mergers were being commingled with a number of other types of collaborative transactions which I wouldn't

consider to constitute virtual mergers.

And to provide a definition, I'm going to quote from an article. A virtual merger differs from an outright merger in that the parties involved usually retain a degree of operational and financial independence that parties in an outright merger do not. Virtual mergers also differ from joint ventures in that the parties involved in a virtual merger coordinate all aspects of their operations, at least to some degree, whereas those involved in a joint venture combine only those operational aspects that serve a specific purpose of the transaction, such as operating an offsite MRI unit or jointly contracting with payers to provide specific services.

Moreover, parties to a virtual merger usually delegate much of their decision-making authority to a parent entity created to oversee the activities of the combined organization, whereas the management of each entity involved in a joint venture has independent decision-making authority and decisions are made by mutual consent.

So, if you look at it from the standpoint of the continuum of integration, virtual mergers, depending on how they're structured and operated, really can be anywhere from pretty much a cartel arrangement up to and

including a total type of integration through a merger itself.

I think one of the difficulties is the structure and operations of virtual mergers can vary significantly and importantly. But I think there are certain concepts that are rather common to anything that's properly called a vertical merger. Typically, for example, the hospitals do not actually merge their assets. They form a new company that operates both of the hospitals usually en toto. There's usually a single board of directors of that new company, let's call it New Co -- that calls the shots, and typically, either the hospitals themselves or the parent corporations of the hospital become the sole member of the new New Co company.

Typically, the hospitals transfer a good deal, if not all, operational control of the hospitals to the new company. Typically, the parents do retain some type of reserve powers, and the degree and types of these reserve powers are varied. Typically, revenues flow into the new entity and then there's some predetermined method by which profits or losses are allocated. And functionally, the virtual merger ought to function as a single entity, and I'll talk a little bit more about what that means.

Why do hospitals do virtual mergers? Meg mentioned some of the reasons before. In all the virtual mergers that I've worked on, the reason was a religious reason. The transaction involved a Catholic facility and a secular facility and there were either problems that couldn't be solved relating to the ethical and religious directives or there was a problem involving restraint on alienation and the transaction would have had to have been approved, actually literally by the Pope. I've gone through one of those transactions that required Papal approval that was obtained and I really hope I never go through another one. They can be rather difficult.

There are some other reasons besides the religious reasons. One is the, I guess, so-called living together before we get married rationale, that is it's a foot in the water thing to try to test the water. These transactions, from my standpoint, frequently run into problems later, and I'll mention those in just a few minutes. And then, finally, in some cases, the community actually demands that the entities retain their separate identities within the community and there are several reasons that this might occur.

The antitrust issues are fairly easy to state. There's the typical Section 7 issue of primarily whether the result of the transaction will be a firm or a

competitive activity and really inducing the hospitals not to undertake some of the activities that they might otherwise undertake.

If you look at the rationale of why mergers, actual mergers are treated as single entities, post-transaction pricing is not per se illegal. The same sort of rationale can apply to a virtual merger depending on how the virtual merger is structured and how the operations are carried on afterward. The reasons mergers are analyzed under the rule of reason, the reason they're not per se illegal is that there is a presumption that they will result in efficiencies. Efficiencies are plausible for a merger transaction.

In the case of virtual mergers structured and operated correctly, the same thing may well be true. You ask yourself -- you look at the transaction and the way the hospitals operate and you ask yourselves functionally and operationally, are they functioning as a single entity. Do they integrate most or all of their operations completely?

This is going to require typically a factual and a relatively specific factual investigation of the transaction. In some copperweld situations, you don't need to do this. You can look at a parent and a sub and immediately, as a matter of law, they're a single entity

for antitrust purposes and you move on. You can't do this with regard to virtual mergers for several reasons.

Number one, and the most important is, they vary too much. The ultimate issue, at least in my judgment is, are the post-transaction incentives of the participants in the merger, are the incentives an all-for-one, one-for-all incentive or is the incentive a to-each-his-own incentive. Are they going to function singularly or are they going to function plurally?

I think the most important variables you look at are the reserve powers of the parent entities, both in number and also in importance. You look at the incentives established by the way that the enemy allocates profits and losses and you look at the degree of the post-transaction integration, particularly the integration of clinical services and whether those clinical services are operated centrally.

I've seen instances in which virtual mergers have achieved significantly more integration and significantly more efficiencies than actual mergers. I'm sure all of you are probably aware of actual mergers that really resulted in relatively little integration and relatively little efficiencies. I could name two or three transactions involving hospitals today.

Where the virtual merger from a functional

standpoint parrots the effect of an actual merger, there's no reason in treating the post-merger facilities as separate entities. The ramifications are, I think, that the agencies should carefully take the time and effort to closely examine the structure and the operation of virtual merger transactions. The examination should be factual and practical instead of theoretical and esoteric. They ought to examine the reason the parties undertook a virtual merger instead of an actual merger. And I think there has to be more suspicion when the rationale for the virtual merger is a testing the waters rationale as opposed to when the rationale is, for example, a religious rationale, because in a testing the waters situation, I think it's less likely that the parties are going to be willing to integrate their facilities in a way that the eggs are really scrambled.

Virtual mergers, I think, can generate the same or even greater efficiencies than actual mergers. And so, I don't think either the agencies or the courts shouldn't be inherently suspicious of this type of transaction, but as I've said so many timesthe virb ggs TD(or even

MR. HUBBARD: Hi, I'm Bob Hubbard. I'm from the New York AG's Office and I, similarly, am glad to be here. I think I got invited here mostly for being a litigator and working on the Poughkeepsie case, and be that as it may, that's how I'll try to focus my comments on that.

I know that I agree with Jeff that the sort of scope of the topic here is very broad, and given that the factual predicates are really hard to think through, I'm going to try to focus on joint operating arrangements. I know that the Poughkeepsie Hospitals labeled themselves virtual mergers. I'm sure that Jeff wouldn't endorse that label.

But, in any case, the joint operating agreement -- I think from an antitrust litigator's perspective, at least one trying to be a plaintiff or representing an agency that is trying to further the public interest and make sure that consumers aren't harmed, you have a fundamental strategic analytical question right from the beginning. What does joint mean? Is it like a merger? Is it a Section 7 problem? Or is more focused on operating? Is it sort of an agreement that's ongoing? Is it a cartel? Is it a Section 1 problem? And you have to really focus on that overall strategic analytical question in my view.

Now, I tend to think about a joint operating agreement differently than a joint venture question. A joint venture question, I think, is comparatively easy. You ask the question whether there's a new product, whether the joint activities or competitive interactions are limited to that new product and whether there's any spillover effect. I think the analytical framework works pretty well. But a joint operating agreement, and I think Poughkeepsie was kind of that thing, is you have to ask that overall competitive -- that overall strategic analytical question about whether this is one entity or a cartel, whether this is, you know, a merger or an agreement.

I do note that we, in the New York AG's Office and other states and I know the feds, look at a lot of transactions and the Poughkeepsie litigation was the only time we've ever sued, on antitrust grounds, any hospitals in New York. And it's not because that's the only work that we ever did in hospitals, we do it all the time. So, I think that it bears mentioning that it's the exception, it's not the rule, and that most of us would never get anywhere near these kind of concerns.

But when the Poughkeepsie concerns came in, you know, the first question we asked was, you know, should we consider doing something, and actually, the question

And they labeled themselves a virtual merger. So, obviously, we considered whether this was a merger problem and we considered, you know, even whether it was a monopolization problem. And then we considered whether, indeed, it was a cartel, that is that there was coordination among competitors and they maintained their independence. Ultimately, we chose, in New York, to pursue this on a cartel theory that it was, you know, price fixing and market allocation. That was, fundamentally, based on our analysis of the facts. You know, we thought that the facts were that they were a cartel in that they were maintaining independence on all sorts of dimensions and everything else.

But I would be remiss if I didn't note the problems that would have been encountered by pursuing the merger or monopolization theory. The case law out there is pretty hideous as we all know. Is it -- we probably would have faced arguments that New York City actually was in the same geographic market as Poughkeepsie. Maybe we'd go all the way to Chicago. Who knows? And I think particularly in that time period, you know, paraphrasing, I guess it was Justice Stewart in one of those cases in the '60s, it was clear that in challenging transactions among hospitals, at least that time for government plaintiff, the rule was the government plaintiff always

lost. And because most of that had been done in the context of merger theories, we thought that pursuing the cartel theory was a much better way to proceed.

Now, I note that we always had the opportunity to pursue both theories. Both the merger theory, the cartel theory. We pretty firmly rejected that. We thought that, you know, being -- you know, litigation requires focus and decisiveness. The advocacy themes were much clearer. I think that these advocacy themes are particularly important in the context of not-for-profit hospitals. It's not so much -- you know, you have to convince a judge that these hospitals, you know, people who are pillars of the community, and I say that with all respect, you have to convince the judge that these hospitals did something wrong. Unlike with alternate theories, what you have to do, you have to get the -- the judge already is kind of convinced that something was wrong, but that there's a remedy for the wrong. So, we thought that the focus on the cartel theory was important just in the context of what we were doing and the kind of actors that we were proceeding against.

And, finally, one of the things that drove our decision was the kind of effect that looking at this as a merger would have on how it would sort of pollute the

Section 1 claim. All of a sudden, market definition questions would become more and more important. You'd start talking about the reasonableness of the price. The price rises instead of whether the prices had, indeed, been fixed, and that kind of -- the benefits of a per se

that certainly prevailing in litigation is an important consideration, but I do think that it's important in implementing and achieving a better competitive result. I see transactions in New York all the time and the competitive problems in New York, at least from my perspective, bear more similarity to the inefficiency of cartels than they do to mergers. It could be that hospitals were a very atomistic market when health care reform came to New York in 1996 and there still hasn't been all the consolidation that there have been elsewhere. But for New York, there was a mention of the Mount Sinai transaction. I mean, there's announcements of mergers, you know, and then 18 months later, there's announcements that they've fallen apart. It's kind of strange.

In a lot of industries, when there's a merger and it doesn't work out, there has to be a divestiture or a spin-off or something like that. Mount Sinai, they just sort of announced that it hasn't worked and they moved forward.

Where are we now also in terms of health care reform? One of the primary reasons that we thought that the Poughkeepsie litigation was important was that the New York State Legislature had passed and the Governor had signed health care reform in '96 that tried to

replace the regulated system with a system of negotiated rates and tried to replace a highly regulated system with a competition system.

And it's time to -- well, one of the things we can do is sort of gauge what effect that has had and one way that I try to think about this just looking at community hospitals. There were many -- most people thought that New York had far too many hospital beds. There was an over-capacity problem. There were many things that were not used very efficiently. Community hospitals are one way that you can look at what effect health care reform had.

I'd note that when you have a merger, when you have one decision-maker, community hospitals are sort of redeployed someplace. I personally think that cartels tend to preserve community hospitals and single decision-makers, that is mergers, tend to redeploy the assets in different ways and ways sometimes that are better to the ultimate benefit of society.

And the kind of ways that community hospital assets have been redeployed are really pretty interesting. There are, indeed, many community hospitals that are thriving in New York. There are many that have been converted to non-medical uses, particularly downtown ones and other things where there are problems. But many

have sort of made changes that are quite interesting and are the sort of broadening of competitive choices, that I think as a very useful thing, have been transformed into long care facilities treating alcoholism, drug abuse. They still have the emergency room facilities and otherwise. Sometimes they'll have outpatient services. All those kinds of changes, I think, are a very useful way to evaluate the benefits of health care reform.

Thanks.

guidelines on health care. And I think, when you look at joint ventures, you look specifically -- there are two guidelines that deal with joint venture statements, two and three. They deal with equipment and they deal with clinical joint ventures. And it seems to me that both of them quite adequately serve the market. And I don't really see any need for additional guidance in regard to either of those kinds of joint ventures.

But I would note, as I was looking through them again the other day and preparing for today, I would note that there's a footnote -- I don't remember which one, I think it may be five -- but in any event, there's a footnote in statement two dealing with joint ventures involving equipment that I think should tell us a lot about an analysis of joint ventures and particularly an analysis of joint operating agreements, which is where I want to spend most of my time.

And the footnote reads as follows: It says, this statement that is the statement that you look at joint ventures under the rule of reason, this statement assumes that the joint venture arrangement is not one that uses the joint venture label, but is likely nearly to restrict competition and decrease output.

For example, two hospitals that independently operate profitable MRI services could not avoid charges

On the other hand, some of these joint ventures might be joint ventures where there's a likely loss, and in those cases, I think you have a lot of difficultly getting people to share that loss. So, then there's another factor, I think, that relates to that. If you do a joint venture, what kind of credit do you give to the

enforcement agency should care. If you're talking about a situation where a lot of small players get together, there's still a lot of other players even after the combination.

But, to my mind, that's not what's happened in most of these cases. To my mind, what's happened is you're talking about a JOA in a situation where the resulting firm actually dominates the market. And, to me, that's a serious question.

Now, in such markets, if we presume a market where the resulting firm would dominate the market, I think we would all agree that that would create a serious question of merger enforcement. But we would also, I think, also agree that that analysis of merger enforcement should be treated under the rule of reason because that's how we treat mergers and I think that's fair.

But if we have the same market structure where, in my hypothesis, we've got a JOA that's dominating the market, I submit that the way we should treat it is not under merger guidance, under rule or reason, but we ought to treat it as, per se, illegal price fixing.

Now, why do I say that? Well, let's look at a couple of things. First of all, the aggregation of market power is exactly the same and the dangers of the

aggregation of market power are exactly the same as if we were talking about a merger. I mean, the only difference is we're calling it a JOA and it's not a merger, it's not complete integration by any stretch of the imagination.

pricing, I think, largely, you've got no issue. But -- so, the efficiency benefits are less predictable and, therefore, less likely.

I would also suggest that the standards that's created is one if you have to look at a standard and say, okay, but there are some JOAs, under certain circumstances where you could hypothesize, as David and Serdar did, you could hypothesize that under those set of circumstances, you really would be better off. Efficiencies would be maximized in the circumstances where you allow joint pricing. Again, analytically, that's correct. But I would say two things about it. One is it really doesn't give the courts any way to formulate a test that's useful before the fact. I mean, there's just too many dimensions to it.

And the second thing I guess I would say is that is not historically what we decided to be, or divined to be, the legal standard. The legal standard is not whether or not this is necessary to maximize efficiencies. It's not the legal standard for price fixing as opposed to joint venture analysis. The legal standard is whether or not it's necessary to sell the product at all. That is what the Court said -- the Supreme Court said in BMI. I think it's what the District Court said in Poughkeepsie and I think it's what

the FTC/DOJ guidelines say if you read them carefully. And I think it's correct because I think any other standard really is not workable, even though I understand there's some analytic validity to it.

Now, where would I go with all this? Well, it seems to me that the general guidance covering JOAs is already in what the Federal Government has done, the FTC and the DOJ, and that is statement nine regarding joint provider networks, which was added to the guidance in 1996. I think the standard in there is analytically correct and I think it pretty much says what I just said. But the problem is it seems to me it's too unspecific. It certainly doesn't deal with JOAs in any specific context at all and I think that what we need to do or what the government needs to do would be to create some more specificity addressing JOAs and I think it would have enormous benefit if they did.

What would be the benefits if they did? Well, I think they would be great. I know there's a lot of talk now about the retrospective of the FTC, what the FTC is doing with respect to hospital mergers. There may be some JOAs included in that, I don't know, although I guess there's also jurisdictional questions. If it's not a Section 7 question, can the FTC do it at all? But anyway, that's for another day.

But the point is, they are looking retrospectively at mergers. Presumably, they will bring cases. Presumably, they will win some of those cases. Presumably, if they win some of those cases, people will say, oh, we can't really do this with impunity anymore. I suppose we would all agree to the extent that these folks have been jacking up prices. The people that get sued, if they've been jacking up prices improperly, then

hospital to a non-religious hospital. There's conceptually no reason it can't work the other way just as well, a sale of a non-religious hospital to a religious hospital if the religious order, you know, wants to maintain a presence in that area. Why not? And even the mergers themselves, if you think about it, what it really means is that the merged entity couldn't involve itself in sterilizations and abortions and probably most hospitals in this country can get away with that, without doing that and still live.

So, while it's true that it would have some impact on the religious/non-religious hospital sorts of affiliations, I'm not sure that that's enough. If you weigh the benefits, on the other hand, to say we shouldn't do this. And my view is we should.

Thank you very much.

(A a .)

MR. BOTTI: Why don't we take a 10-minute break.

(W , a b c a a .)

MR. BYE: We're going to move to the panel discussion phase for the remaining time that we have left. First of all, the rules of the game, we'll throw out questions to the panelists one by one, and once they've answered that, if they want to comment on any

other speaker's presentations, they're welcome to do that. Otherwise, if they want to answer a question, just turn your name tent on its side. We have a conference call listening in, so if everyone could try and speak into the microphone, that would be great.

First question, we'll start with Margaret. We're wondering if you could elaborate on the distinction between joint ventures and JOAs, please.

MS. GUERIN-CALVERT: I guess there are probably as many similarities as there might be differences. I think the common feature is that if you think about a joint venture and you think about a JOA, some of the elements that are similar is that you have an organizational structure, a set of agreements that allow for the creation or the formation of the joint venture that involves certain kinds of commitments and, as David described, certain kinds of investments, which tend to be particularized in the case of joint ventures, but also are going to exist in the joint operating agreements that are made by the participants. So, at the level of organization, for what we're looking at here, there's a great deal of similarity in terms of the fact that you have various entities that come together that form a set of agreements.

Second, you may have operating rules. And the

operating rules for a joint venture, again, there's a set of arrangements that are going to be entered into, in terms of making sure that the things which the joint venture is going to be doing, whatever it is, it is going to be produced; whatever it is that is going to be combined; the sets of things that constitute the activities of the joint venture are going to be designated in the operating rules. And whether it's set there or it's set at the organizational principles, it's going to lay out what each of the commitments are that the parties need to be made, what the enforcement mechanisms and the contractual mechanisms are going to be.

Separately, it may or may not designate various pricing rules that are going to be going on or pricing mechanisms for the products at issue. We all know that some joint ventures do have joint pricing; some do not, of all of the services or some of the services, but that would be involved. And then treatment of the members of the joint venture, as to the activities that they have, their ability to exit the joint venture. Those are all typically laid out in the organizational principles or in some places in the operating rules.

On the JOA side, you have the same kinds of things, in terms of commitments that the parties are

going to be making and specification of the activities. I think, just from this discussion, where some of the differences start coming in is I think we are all somewhat more familiar and it's a little bit cleaner in the case of a joint venture to identify the specific activity, the specific metric of what the game is going to be and perhaps much easier to distinguish, the activities of the joint venture from the non-joint venture activities of its participants.

Some of that is, again, just the nature of the kinds of joint ventures we see, and I'd build on something that Bill said, which is that it may well be precisely because there are not as many opportunities to be doing joint ventures, or they are particularly difficult to do because there are difficulties in writing the contracts and that that mechanism may not have been pursued as much.

I think if we go on the joint operating arrangement side, what we have again is a focus on what are the common features of the operations, the set of services, the set of products, the set of elements of each of the participants that are going to come under common operation and management. And oftentimes there the elements of the agreements are somewhat different than what we see in joint venture agreements because

there's much more focus on building up systems, building up structures, building up common management.

And I think what I'd say in terms of listening to all the presentations is what makes JOAs very difficult to evaluate is precisely this last issue. We have more familiarity with thinking about what the new product or service is on the joint venture side. On the JOA side, the but-for world is perhaps loss of independent, inefficient activity; whereas under a joint operating agreement, there may be the opportunities for gains, maybe not maximization, but nonetheless substantial efficiencies but identifying what those are on both sides of the investigation deserves, I think, a whole lot more attention.

Let me just throw out one example that I have rarely seen on the joint venture side, except in a B2B context, I see often on a joint operating agreement side,

concessions to -- we would sort of have an agreement with the negotiator around concessions that each one of would make and he would then say, well, excuse me, I have to go back and talk to all of my constituents. And, low and behold, they were pretty happy with our concession, but not so happy with theirs. And we'd have to renegotiate the whole thing again, so it can take longer.

I think that's probably the principle here. I think Bill is right, in some sense the merger or a virtual merger or even a cartel, once you get that aggregate economic benefit together, they exercise whatever market leverage they can based on the defined market share. I think the questions are are we all getting something back for it in the form of higher quality or more services, and the answer is I'm sure we're not getting it back in prices, but I think that it's easier to achieve efficiencies in many kinds of -- in true mergers. There may be mergers as Jeff -- virtual mergers as Jeff discussed, whereby the arrangement is such that efficiencies can be achieved and they're passed on in some way. But those are the only -- those are the differences.

MR. BOTTI: Let me take the same question and move it right down the line, maybe somewhat different circumstances. And I can ask you, David, whether you've

been involved in these negotiations, but in the context of what the economists had to add here, it just seems to be the type of question that at least some of the economists I work with would love to debate with me.

And that is I would have thought I would get the opposite answer there, that is that youat is I bTD(. Ya)Tj-11.1

presumably in there for whatever market power gets created, it's presumably inclusive to that as a market power that would get created as a result of the merger.

So, I don't -- in the way an economist would tend to look at this, that the problem is are they structurally consistent from these different forms, cartel versus merger versus joint operating agreement, and if there are no structural differences between them, which in this example, there are not, the next question would be, well, are there incentives to be taken under each type of agreement, and there the incentives to behave for an individual cartel member might be different than the incentives for the merged firms.

MR. BOTTI: Okay, thanks. You want to comment on anything generally that you've heard or -- no?

MS. GUERIN-CALVERT: Just to add on that, I agree completely with what David said. And, again, the assumption that you built into that that David appropriately responded to was that there's only one dimension of competition. And, if, in essence, what a joint operating agreement has done is essentially said, you know, and again, I would distinguish between operating agreement from a cartel. One of the things we've been a little bit loose with is that a cartel is a cartel, and any economist would basically say that to the

extent you have a group of firms getting together that are not in any way producing a product together and all they're doing is fixing prices, that's one set of analytics.

If you're looking at a joint operating arrangement, where you could get somewhat different results would be is if within the context of the joint operating agreement there were some dimensions of competition that were going to continue to go on, it may well be that in the negotiation you might get somewhat more differentiation or some other changes, but again, I think the way you set it up is, you know, by definition, a monopolist, a single entity, is more likely to achieve the monopoly outcome than a set of firms are. But if the set of firms have set it up in such a way that they've got a single negotiator, you'll get the same outcome. I think very much it depends on what also you mean by market power, that if you truly have, as David answered the question, essentially a monopoly, the outcomes are going to be the same.

MR. BOTTI: Jeff, did you want to add something?

MR. MILES: Yes, I think I would add two things. Bob mentioned, I think, that one inefficiency he saw in some virtual mergers is that the -- I guess the

negotiator doesn't have authority but has to go back to the group. In the virtual mergers I've been involved in, just as a factual matter, that's not the case. I wouldn't see any difference between the negotiations between -- involving a virtual merger or a natural merger.

And, second, when you asked your question, I'm not -- I think you made an assumption that perhaps I wouldn't agree with. You compared a merger in which there are no diversion interests to, I think you said, a virtual merger where there are diversion interests. And depending on how the virtual merger is structured and operated, there are not necessarily diversion interests in a virtual merger.

MR. BOTTI: Let me pass it on to Bill, and just to be clear, I didn't mean to impose any very strict assumptions on raising the issue.

MR. MILES: Well, yours were not as strict as David's, but --

MR. BOTTI: Bill, please?

MR. KOPIT: Yeah, I would agree with Jeff in his point about how in at least a JOA, most of the JOAs that I'm aware of, there is binding authority to negotiate a contract. And I think that makes it worse, not better, because then the exercise of market power is

exactly the same as a merger. But as I think I said before, I don't think the benefits are close to -- conceptually or analytically are close to being the same. And let me just say, to disagree with Meg, I mean, I don't know what economists would say about this, but it seems to me that the circumstances you have with most, if not all of these JOAs, and I would define them, you know,

letter said, wouldn't it make sense if we allowed our hospitals, at that time there were three or four, our hospitals to pick specific services that they would do so that there would not be duplication of these services, and then each one would get efficiencies and that would be beneficial, and shouldn't we be able to do that.

And the letter is longer than my paraphrase, but the letter was hell, no, it's per se illegal. But then if you kept reading in the letter, Mark said, well, but of course if you engaged in a legitimate joint venture, then we'd have to look at this differently. So, let's just think about this. The Wichita -- the hospitals in Wichita, okay, have been told that they can't -- they can't divide the market, they can't allocate the market, and so one of them does all the hearts and another one does all the neurosurgery and all that. Even though there's efficiencies with each of those, presumably, that's per se illegal.

But they've been told they can do a legitimate joint venture. So they get a smart lawyer and he comes back to the FTC and he says we've solved the problem. Now we've got a joint operating agreement with all the hospitals, and we've all gone together, and we're going to share profits and losses, and that should make it all all right, you know, shouldn't it? And the answer is no,

that makes it worse, because the good news about the Wichita arrangement is it never would have happened, trust me, I know that, because I represent some of the hospitals in Wichita.

The proposal didn't come from the hospitals. The hospitals would still be dickering over the nature of that cartel, because one hospital would say, I don't want to give up hearts. Hearts are more profitable than, you know, what you have to give up. So, that cartel never would have happened, but if you have a cartel where they share profits and losses, nobody loses, except the consumers. And as long as you have joint pricing. And, to me, that's why the JOA is, if anything, worse than a pure division of markets cartel.

MS. GUERIN-CALVERT: One of the things -- I think it would help all of us if we clarified some terminology in the sense that I think all of us up here would regard that naked price fixing agreements are anti-competitive and have no pro-competitive benefits. I think I sense, though, that we are in a position where no one is saying that all joint operating agreements are cartel arrangements and that a lot of the joint ventures that we see in this industry and in other industries are ones that require tough trade-offs. Where as part of operating agreements or ventures, one party agrees not to

do something; another party -- and the joint venture agrees to combine the assets and to go forward. And that is why I think particularly in the collaborator guidelines there's a lot of effort at looking at the competitiveness of rules that deal with the free riding problem that David talked about, how do you get output expansion, a new, bigger cancer center, when everyone has some different incentives and a tendency to want to free ride.

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occurred.

But I just -- I would like us to maybe not be talking about cartels but rather talking about joint operating agreements and joint ventures.

MR. BOTTI: Oh, I'm sorry, Bob, do you want to get into this?

MR. HUBBARD: Well, I mean, but the point is that it's a question of whether it's a cartel. I mean, and that's the point. Now, whether or not you agree with the conclusion is a factual matter that it's operating as a cartel, that's what you have to look at. There are differences in how you analyze a cartel and how you analyze a merger. And the firms that are involved in the cartel can have just as much market share as those involved in the merger, and it's different.

some ventures were given Section 1 treatment. I was wondering if you could just give us some examples.

MR. MILES: Yeah, I mean, I think one of the problems I run into and one of the reasons I advise firms wanting to merge or collaborate in some way to merge if possible is that I don't want to spend the next ten years on the telephone when they call me up twice a day every day to ask me whether there's an anti-trust problem if they do X, Y or Z. And if they implement a transaction so that they're a single entity, they don't have to do that. It's a transactions cost savings, as much as anything else.

And the other thing is I think after they hear warnings about Section 1 of the Sherman Act over and over and over again, then there's going to be some deterrent effect on them from taking certain actions that might, under Section 1, have an antitrust issue, not necessarily be unlawful or even necessarily be problematic, but just raise an antitrust issue.

MR. BOTTI: Jeff, did you want to comment on anything generally beyond that, or should I move on?

MR. MILES: Yeah, I do want to comment on one thing, and I think Meg sort of said this, but I don't like the idea or the supposition that every JOA or a virtual merger is a cartel. I mean, that simply isn't

the case. The -- what I would call a virtual merger, the virtual mergers I've worked on, have really been from a functional standpoint like a merger, like an actual merger. And just to suppose that they're cartel arrangements is just not my experience in dealing with these entities.

MR. BOTTI: Bob, one thing you mentioned in your comments was that there was a consent judgment, emphasis on neither word from our perspective, and I'm wondering, what's in that? I mean, one thing I'm curious about is what was the permitted conduct, if there was any, carved out of that consent judgment. I thought that might be informative to us as to where you viewed the dividing line between a cartel, a merger, virtual merger, whatever these lines are.

MR. HUBBARD: Well, I mean, there were carve-outs for various things that you would expect. There were various Norr Pennington-like activities that they'd be allowed to engage in. If they wanted to, they certainly could engage in joint ventures like buying linen services together. There were notice provisions on things like that. The most fundamental challenge in negotiating that, however, was what happens now, because as the process of following that agreement for years, various -- you know, cardiac had been at Vassar and MRI

was at St. Francis. What do we do -- whose is that at the end of the day? And is there some sort of adjustment we should do because of that history?

Ultimately we worked through all that and the end result was that, you know, they stayed wherever they were sited, but --

MR. BOTTI: Can I ask you, did the decree address whether they were permitted to merge?

MR. HUBBARD: No. I think that, you know, those two hospitals, and it may be Rome, it may be something else, those two hospitals would never merge. And it was, you know, I did want to respond briefly to Jeff, also. I mean, perhaps we should be using the phrase competitor collaboration instead of cartel, because cartel has a negative connotation, illegality and everything else. But I do think that it's more useful to think about JOAs as competitor collaboration than it is as a merger, and I think there's a significant difference talking about competitor collaboration than a merger, and I think there are inefficiencies in those collaborations

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MR. BOTTI: Absolutely not.

MR. MILES: I want to bring up --

MR. BOTTI: That was a statement.

MR. MILES: Well, I want to bring up Poughkeepsie because as you know, you were kind enough to send me all the papers in the case, and in reading the papers and the opinions, my impression is that that transaction, to the extent there was a transaction, was not what I've been talking about as a virtual merger, in the sense that it appears they ultimately planned to do a virtual merger but they never got around to it. They started out in the case arguing that they were a single entity. As I understand it, the bishop got upset with that argument and made them withdraw it, and I would assume it didn't come up again in the case.

MR. HUBBARD: Well, first of all, as a New York State employee, I'm subject to FOIA, anybody wants the papers in Poughkeepsie, they can have them. And secondly, I do think that Poughkeepsie was actually a fairly easy case, because there weren't -- you know, there were separate revenue streams, there were separate medical decisions. Everything was separate.

The only thing that was joint and the only thing -- you know, they were arguing about efficiencies of having only one person negotiate the price, you know,

it's just -- you know, you sort of have to -- and so I agree, that -- and this is part of my -- I conveyed my conclusion that I didn't think they would ever merge, because they always reach the sort of goals of merging or getting closer to a merger or doing some things with a single decision-maker, and they never really did. They just kept reaching accommodations.

And that, you know, maybe makes me believe that they were operating as a cartel and had inefficiencies that related to it. If they had merged back in '95, you wouldn't -- every single thing that they -- you know, like every time there was a new product, they'd have this little fight about, you know, where it was going to be sited, how it was going -- you know, they had this fairness formula. They were fighting about all that stuff all the time instead of providing good health care services to the people who walked in their door.

MS. GUERIN-CALVERT: I think -- I mean, extrapolating in terms of general principles, you know, I think you've put your finger on one of the issues, what tends to happen in actual mergers is people start out with a much clearer game plan, perhaps, of the efficiencies that they think once they've got the deal done they can accomplish. And I think what we have all seen is that it oftentimes takes much longer to

question I had for some of the other folks on the panel, and it's very easy for me to see the gain to consumers when there's a particular product or service that's added, it's -- I was wondering from -- I'd like to hear from some of the other folks who have represented these looser collaborations, and I think probably I've never seen one of Jeff Miles' virtual mergers. You know, what exactly are the efficiencies that are achieved and how exactly are they passed on to consumers? And, you know, what I'd suggest is this, you know, I look at some of the work that was done in the North Shore case, for example, and we can see some of the claims that have been made by other looser collaborations, and the only thing that I have ever seen from any of those is increased prices to the companies that I work for. Now, somewhere, somehow, presumably efficiencies were promised, or gains were promised, in all of these cases, and the question is can we go back later and say, okay, what happened here?

I think that's the way antitrust analysis used

going to happen, and I think we know that those guesses aren't exactly always right. And they may be, as Meg said, for reasons that are not controllable by the parties, for example, costs could increase for other reasons, and as a result, all of the efficiencies that people hoped to achieve didn't occur.

But at the same time, sometimes I just wonder what they are, because like I said, they never, ever, in my experience, have been passed along to the consumers in the form of lower prices. Maybe they're passed along to the consumers in the form of new investments in quality material. Maybe they're passed along to the consumers in the form of investments in IT resources. I really don't know. And, but I think it's a question we should ask, because it will enable you to evaluate what really happened and what benefits were really achieved or was this really just a cartel and did prices just really go up. I think that all is really going on.

MR. MILES: I guess I would say a couple of things. Number one, I find it interesting that the transaction that was mentioned by name was an actual merger and not a virtual merger. Number two, I agree with Bob's -- I think what you're saying is there ought to be some way to ensure that in these transactions the people produce the types of efficiencies that they say

they produce, and I think that's been a real problem at the government level for a long time.

I am certainly familiar, I've done it myself. You go into the agency and you say here's what we're going to do and we've got this nice, beautiful report from a consultant that says they're going to be savings of X, and the agency is skeptical but at least conceptually it looks okay, and then the transaction is done and the parties don't do a damn thing to achieve those efficiencies, and I think -- I personally think that is a serious problem, and I don't know the details of the FTC's retrospective, but in concept, I really like it.

MS. GUERIN-CALVERT: I think it raises an interesting issue, Bob, partly to answer your question. There have been a number of studies that have gone back over the last 20 years worth of mergers and tried to identify a lot of the nature of the efficiencies. And in a lot of the mergers that have occurred between 1980 and 2001, the ones that have been studied have been studied up through 1999, a lot of where the efficiencies are coming is if you compare what the but-for world would have been without the merger and the world after.

And in a very large number, what has happened is that you have the closure and consolidation, kind of

like Bob was talking about, of one of the facilities being turned into outpatient or administrative or some other form or clinic and all of the inpatient services being consolidated into a single entity, so that you get those kinds of gains. It is harder to measure, particularly if you look at increases in the output or expansion into tertiary services. They are, by their definition, more expensive services to deliver.

So, it's -- I think you have to kind of look at it on the supply side as to what's being provided, but obviously it's an issue as to whether or not post-merger there have been, you know, pricing increases. And I think again in general, what the studies show is that some mergers do result in price increases that can't be explained by cost increases but that overall the patterns that we see is actually pricing increasing at a slower rate than cost increases. I would agree in some respects with what Jeff said, that I think in any industry, when people come into the agencies, there's a lot of pressure, efficiency defenses are very hard to mount.

And, you know, I think there's a great degree of skepticism on the agency staff's part about

some efficiencies have to have occurred, but all of the ones that the hospitals have claimed need to be achieved. And that's a much stronger standard than in any other merger, particularly because in many cases the balance that was reached was that the probability of a price increase was ultimately judged to be low, even though the efficiencies were high, and I think we shouldn't lose sight of that balancing part that's in the guidelines as well, that you do have to show not only that the efficiencies might not have been as great, but that you did actually see a substantial anti-competitive price increase, as opposed to a price increase.

MR. MOSES: My question, you answered the question, or addressed my response really in the context of mergers, perhaps in the kind of virtual merger that Jeff is talking about, where there's largely and almost entirely some top-down efficiencies that can be achieved. Do you see those sorts of things, those sorts of benefits arising in the context of joint operating agreements or the looser arrangements that appear? And how do you measure those?

MS. GUERIN-CALVERT: I guess my sense is again it's the but-for world. It's as compared to what each of the individual members might have been able to accomplish, where are the gains and the cost savings that

are being achieved, you know, what's the equivalent of shared purchasing of linen supplies? Is that something that's going on that's a benefit?

Alternatively, part of it is perhaps what investments are being made in terms of the quality and the delivery of care, such as common management procedures or IT systems that, I agree, it's very hard to measure, but those are some of the things that I see. And I'd open up to the other panelists in terms of what they've seen as metrics.

Moses just put his finger right on the point, which is, okay, maybe there are efficiencies, why do you have to jointly price all your hospital services? Before you were obviously pricing them independently. That was working for you. So, explain what's changed now that requires you to price them jointly. We know that you have more market power, but other than that, why do you have to price them jointly? And if you don't have an answer for that, then under existing rules, isn't that a restraint that's not reasonably ancillary to the venture, and isn't it per se illegal?

MR. BOTTI: Bill, since you ended with the word per se, I want to come back to something you said, I think you said, and I'll look at the transcript later, I guess, but I thought I heard you say something to the effect that we have these virtual mergers, joint operating agreements out there dominating markets.

MR. KOPIT: Some places.

MR. BOTTI: And when we find that we ought to call them per se illegal, because we don't want to get into the whole market analysis. And when you phrase it that way, it seems to me that, boy, I could challenge the case under Section 7 pretty readily, if I could just get everybody to agree it dominates the market. You see what I'm saying? They either have to be per se illegal when

they dominate the market and don't dominate the market or not per se illegal, and I'm wondering if you could --

MR. KOPIT: Yeah, it's a good question, and I think if anything it's the most troublesome point in the formulation that I propose, which is other than that fairly straightforward. And I guess my answer would go something like this. Analytically, there's no difference as to whether or not you're -- it's a dominant firm or it's not. Just like in price fixing, analytically, there's no difference between whether it's a dominant firm or it's not.

When I sat at the argument for Maricopa, I'll never forget that Justice Stevens asked the attorney for Arizona, the plaintiff in the case, he said, "Now, Counsel, are you telling me that it would be per se illegal to put two drug stores on the corner to set prices, site me a case." And the attorney for Arizona did an Archie Bunker, humma, humma, humma, and Justice Stevens said, "Forget it, there are no cases." And that's probably still true today. We all know how Maricopa turned out, but the point that Stevens was making was that if you're looking at per se price fixing, most people don't bother about the two drug stores on the corner, and therefore you probably won't find the case. The analysis may be the same, but that doesn't mean it

ought to get the same treatment.

It seems to me that while conceptually what I said could be applied to every joint operating agreement, but in reality just like maybe the government shouldn't have cared about Phillipsburg, the government here shouldn't care about the two drug stores or the two hospitals on the corner, when they have ten more on the next corner. That to me doesn't make any sense, so what I'm proposing, I think, if you will, is a market power screen. And why -- you know, is that incredibly unique? Well, yes and no. I mean, let's look at tie-in contracting. Tie-in contracts are per se illegal, but they're not per se illegal unless you have market power.

So, you know, as to what's dominant, well, you know, that -- I mean, obviously who knows? I mean, 90 percent probably; 80 percent probably; 60 percent, I don't know. But the point is, if you set that out as the construct, it seems to me you have a lot of salutary impact on the folks who damn well know that they are dominant.

MR. BOTTI: Bob?

MR. HUBBARD: Yeah, the only thing that I wanted to add was that there's a difference when you have a market power screen as a matter of prosecutorial discretion and as a matter of case law. I think that

having that sort of market screen as a matter of case law or advocating it as a matter of case law is a bad idea. But I certainly -- I mean, there have been instances in which, you know, people are doing things they shouldn't be doing. And, you know, we don't prosecute people that are doing things they shouldn't be doing if they really don't have an impact, if they really just don't know what they're doing.

And I think that in that context, the -- one of the analyses we went through in Poughkeepsie was does it matter. I mean, there was -- there were similar virtual mergers elsewhere in the state that, because there were other hospitals all nearby, it was easier to conclude that in Poughkeepsie it mattered, whereas, you know, just as a matter of case selection, you went where you perceived as a matter of prosecutorial discretion that there was domination of, you know, a market power.

MR. KOPIT: Right, if I could just add one thing, if you had guidance to this effect, what the guidance says is this is the agency's what-we're-interested-in. It doesn't say anything about case law; it just says under these circumstances, you get a little heartburn.

MR. BOTTI: Let me float a proposition, built on those comments, and see if anyone has a response to

it. If we were to observe joint operating agreements and virtual mergers in circumstances where it looks like the hospitals involved are unlikely to aggregate market power by entering into that, I think Melamed wrote something about exclusive dealing, he said something like this, well, if they're not exercising market power, they must be doing it for efficiency reasons. And if we start looking at it that way, and we think there might be efficiencies from JOAs, it seems to me the whole per se thing starts to unravel. So, I don't -- are there joint operating agreements, virtual mergers out there that actually exist where everybody says, oh, that doesn't have market power? I'd be kind of curious to hear about those.

MR. HUBBARD: I think there are, actually. And I think that, you know, it's -- I don't know how to say this, other than, you know, it's not illegal to be lazy, and there's a lot of people that don't compete just because it's hard to compete, you know? And that they look at what the gas station across the street charges, that's as good a price as any, I'll put it up. And I think that, you know, I sort of view some of those joint operating agreements in that mode. You know, they don't want to have to think about pricing, you know, they'll just do that jointly. I don't know that it's efficient,

but -- or I certainly would not conclude that there's an efficiency gain. I think it's just more likely that it's -- you know, that the decision-maker is just being lazy about this aspect of competition.

MR. BOTTI: I'm tempted to pick on David Eisenstadt to respond to that, but Bob had asked --

MR. MOSES: I'll defer to David.

MR. EISENSTADT: Go ahead.

MR. MOSES: All I wanted to say is I think that Bob really had it right. If you really get into -- if you take these things into a detailed market share, market power analysis, you really undermine the whole benefit of the per se. But what Bob said is not that they have market power or dominant market share, but does it matter?

And I think that that can be done in a lot looser way. It obviously does not matter when the two gas stations have the same price when there's a gas station next door. But you don't have to go through a detailed Hirfindahl-Hershman index to figure that out. There may be a -- you may have to do some analysis, but I

going to talk . . .

I think maybe to harken back to somebody mentioned the physician network analogy, and I guess I'm a little troubled by the concept that the only reason why we see JOAs out there among smaller hospitals or in contexts in which there aren't market power concerns is because people are too lazy or incapable of doing anything else. You know, I think what it suggests is a need more systematically to understand what are the motivating factors for this and what are the factors that but for those arrangements people would have to be dealing with.

I know one of the issues that has been looked at a lot in the context of physician affiliations and

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I HEREBY CERTIFY that the transcript contained