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I N D E X

P R O C E E D I N G S

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MR. BERLIN: Good morning and welcome back to the Department of Justice's and FTC's Joint Hearings on Health Care and Competition Law and Policy. My name is Bill Berlin. I'm with the Department of Justice. Today, we begin our sessions addressing health insurance-related issues. We'll continue this week through Friday afternoon and then pick up again, I guess, two weeks after that on May 7 and May 8 with more sessions on this topic.

Generally, this week -- today and tomorrow morning -- we'll be dealing with issues involving the market downstream from insurers to purchasers of health insurance. At the end of this week we'll be dealing with the monopsony market, the purchase of provider services by plans, and on May 7 and 8, we'll have some sessions on MFNs, PHOs and countervailing market power, and all that's in the agenda that's been on our website and I think there are some handouts out on the table.

This session, as well as all the other ones, the morning sessions will start at 9:15 and run until approximately 12:15 and we'll be starting up at 2:00 in the afternoon, including today, and that will run until about 5:00.

And I'd also like to note, as we've been doing, that interested parties may submit written comments in response to this or any of the other topics and the procedures and deadlines for doing so are on both agencies' web sites.

At the outset, I'd like to thank our colleagues at the FTC for letting us use this extremely nice and new conference facility. Originally, we planned to have or hoped to have these sessions in the Great Hall at Main Justice, but due to, not surprisingly, recent security issues, we just couldn't do that. And I'd also like to thank our panelists for being with us here this morning and all the future panelists in these sessions.

Let me just briefly describe this morning's format and then we can get started. Before I do that, though, I'd like to first introduce my co-moderator, Sarah Mathias, from the FTC. She's not only my co-moderator here today, but she's also been a key part of the joint team from both agencies that have been putting theikeso like to

raised. And, again, as I said, we will end around 12:15 this morning.

Before we start with Dr. Ginsburg's presentation, let me just briefly introduce the other panelists and we'll ask them to speak in the order that they're sitting at the table.

First we have Henry Desmarais, who's the Senior Vice President of Policy and Information at the Health Insurance Association of America. Dave Monk is an Economist and Vice President with NERA, the National Economic Research Associates, and one of his areas of focus is antitrust.

Professor Roger Feldman is a Professor of Health Insurance and Economics at the University of Minnesota. And Art Lerner, is a partner with the law firm of Crowell and Moring, practicing in the health law field.

And I'd also like to note, as you see on the agenda, that Barry Harris was going to be here with us today; unfortunately, couldn't be here due to a last-minute and unforeseen issue. But Sarah and I talked to him on the telephone in our preconference calls and heard him out on some of his views and we plan to try to introduce and inject some of that into the roundtable discussion.

So, without me jawing on any further, Dr. Ginsburg.

DR. GINSBURG: Thanks, Bill. I'm really pleased to have the opportunity to share our findings with the Department of Justice and the FTC as they look at competition in the health field.

I'm going to make three points today. One is that we perceive some increase in insurance concentration due to the withdrawal of weak competitors in some markets. We also perceive that hospital market power has grown more than insurer market power, in a sense this leverage has changed in the past few years. And then the final point is that the key to performance by health insurers is really the direction that they get from employers, and I think the problems we have now often stems from the type of directions or absence of it that insurers are getting from employers, their customers.

Briefly, this is my organization. We're a research organization focusing on providing objective information to policy makers and we're funded by the Robert Wood Johnson Foundation. And what makes us different from other Washington research organizations, I believe, is our emphasis on health care markets, and there's our web site.

Much or all of what I'm going to talk about

today is from our community tracking studies site visit projects, which is now just about to complete the field work for its fourth round. We do this every two years to look at market changes and we visit 12 randomly selected sites every two years. They're all urban areas with population 200,000 and above, and I'm sorry this is getting a little old when I say our recent visits, 2000, 2001. We have done 11 visits in 2002 and 2003. And we tend to conduct a lot of interviews at each site. We send a large team and we cover a broad cross section of the leaders of local health care systems and we triangulate the results, meaning we don't take anyone's word for it. If Hospital A says something, we'll want to compare it with what Hospital B and Insurance Company A or B says about that particular development before we have confidence in it.

Here are some thoughts of mine about the framework to think about for analyzing insurer performance. Insurers have responsibilities that are beyond the classic insurance function of managing risk or in health care, paying claims as well as managing risks. They have to negotiate prices with the providers of service. They have mechanisms to constrain utilization of services, given the fact of the moral hazard and health insurance. People who buy health insurance -- at

least the people who are paying for it -- usually want insurers to do things to constrain the utilization of services to get closer to what they value.

Also, today, insurers do disease and case managements and perhaps in the world of tomorrow, they'll be providing a lot of information for enrollees about both prices and quality of care or even the effectiveness of alternative medical procedures.

In a sense, health insurers are really one of two intermediaries between consumers and providers. The other intermediary is really the employer. And the employer plays this role imperfectly, often, as an agent in a sense, because employers can obtain health insurance coverage for their workers at far more favorable terms than the workers could get it as individuals. So, in a sense, the employers, at least in the perspective the economists have, are really spending the employees' money in order to produce something that's worth more to them than if they just paid them more in wages.

And we've seen, over the past, say, 10 or 15 years, some very sharp swings in the signals from employers to health plans that in the early 1990s, the signal from employers to health plans was we just have -- you have to save us money. Managed care looks promising, do that. And employers weren't worried at that time

about if workers didn't like it, but then when health care costs slowed, the economy boomed, labor markets got tight, the signal was different and the signal was, don't do the things the employees don't like. And this has produced profound changes, not only in what health insurers do, but in how the entire delivery system has adjusted.

When we look at the 12 markets that we studied, we perceived three categories that we can sort most of the markets into, and I think this might be instructive. I call them Type 1. There are four markets in our sites that we'd call Blue Cross/Blue Shield dominant markets, and I list the markets. All of the smaller markets have this. And when I say dominate, I'm talking about, say, roughly two-thirds of the commercial markets. And this large market share has been long-standing. I'm sure it goes back decades that these are Blue Cross areas.

In recent years in some of these markets, we have seen unsuccessful entry by national firms. What I mean is that national firms entered these markets, often in the mid-'90s or a little bit later when insurers were being very aggressive in entering new markets, and in many cases, those national firms did not succeed, did not get the share needed to be successful in the market, and in recent years, they've been leaving some of those

markets. We also perceive in these areas informal public utility pressures on plans. Plans are seen as very important parts of the community and they have responsibilities.

So, in Syracuse, the Blue Cross/Blue Shields of Central New York, ther hields of

like it to do.

Another type of market is when the market is concentrated into three or four major plans. Examples are Orange County, California, Boston, Seattle, and actually, in each of those three markets, and I don't know whether it's critical to this model, there is a long-standing local plan. Kaiser Permanente in Orange County, Harvard Pilgrim Health Care in Boston and Group Health Cooperative in Seattle. And, actually, in two of those markets, probably contributes to this. There are separate Blue Cross and Blue Shield plans which compete with each other quite vigorously. Again, the concentration is long-standing.

A third type of market that we encounter is what we call the more fragmented markets, Phoenix, Miami, Northern New Jersey. These markets are characterized by rapid population growth, national employers and the absence of strong local plans. In these markets, there has been some increased concentration from mergers, and national plans are important players in these markets.

So, this might be a context for thinking through the different structures that can be encountered in different areas.

Well, first, let me talk about what's been happening with the plans relationships with hospitals.

Well, in some of the Type 1 markets, these smaller Blue Cross/Blue Shield dominated markets, we've seen quite a number of exclusive contracts between the Blue Cross/Blue Shield plan and often the dominant hospital and sometimes exclusive contracts between the lesser plans and the lesser hospitals as well. These contracts seem to be in decline now.

I can imagine they were very valuable when the model of managed care was narrow provider networks and recently was looking at Little Rock where ArkShises5ng ss ArkShisesg

prominent hospitals are in, obviously, that gives those prominent hospitals more power in negotiating with insurers.

One thing that I hadn't thought about until having done some interviews is that excess capacity is very important and that's a big change from, say, the mid-1990s when utilization was very much constrained from managed care and there was ample excess capacity in hospitals. There's a situation today where capacity is much tighter. Part of that tightness is that some facilities have been closed, facilities that seemed not to be needed and perhaps were obsolete and, also, utilization has been growing very rapidly in the last two or three years, and this really makes a difference in planned hospital negotiation as to whether the hospital is worried about having a lot of empty beds if it can't contract with a particular plant.

And I think this is what I mentioned before, that there are community pressures on dominant health plans and, actually one I didn't mention before, which I should mention, is that in many communities, that are pressures on the dominant health plans to discourage non-hospital specialty facilities, such as a heart hospital owned by MedCath. For example, in Little Rock, Arkansas Blue Cross/Blue Shield will not reimburse care performed

in the Arkansas Heart Hospital.

In Lansing, Michigan, this goes back a few years, there were some physician-owned ambulatory surgical centers that were opened. Under pressure from the employers and the union customers of Michigan Blue Cross/Blue Shield, they would not pay for care in the ambulatory surgery centers.

Sometimes the pressure actually comes from a dominant hospital which, in a sense, will press the plan

Other new benefit designs, tiered hospital networks, one of the responses to loss of leverage with health plans and, perhaps, a desire to direct enrollees to more efficient facilities is within the network to establish separate tiers and, in a sense, provide financial incentives to direct enrollees to those hospitals that are either less expensive or, perhaps, perceived to be more efficient, better quality, et cetera.

I would envision that we're going to see a lot of sophistication in cost sharing. It's not just going to be, you know, 20 percent co-insurance or this deductible. I could see insurers differentiating co-insurance by the service it's applied to, and sometimes even having positive incentives. For example, free diabetic supplies for those diabetes patients who enroll and participate in the diabetes disease management program that the plan is offering.

Another trend that we're seeing is a lot of customization of products. Insurers have always customized for large employers and they're customizing for smaller and smaller employers. Not complete customization, but often, a lot of different varieties of things that say a smaller employer can choose.

A lot of emphasis on customer service and maybe

perceived has been cross-market mergers and it's been intertwined with conversions of Blue Cross/Blue Shield plans to for-profit status. The stated reasons for these mergers are to get better access to capital and to achieve scale economies which presumably could come from the use of information technology and marketing and the same promotional programs and in-care management and how to do it.

I think there are some additional factors that often aren't mentioned. One is, in a sense, expand the reach of strong managers. I would imagine that some, say, Blue Cross/Blue Shield plans are ran a lot better than others. And I've actually seen some of the mergers in the past as really being a well-run Blue Cross/Blue Shield plan taking over a not-so-well-run one, and then seeing -- like in the corporate sector -- an opportunity to run it better and gain from that. And, certainly,

9un it be [illegible] nes oi enrich the ones coming in.

What are the implications for competition from hese cross-market mergers of Blue Cross/Blue Shield?

ell, I think one thing is that to the degree that the cquired plan becomes a stronger competitor, that

certainly could increase competition in the markets. On the other hand, it may be a situation where you have a Blue Cross/Blue Shield plan that, you know, fairly has some real advantages and somewhat dominant. If you run them better, they can be even more dominant and that could reduce competition and lead to higher concentration.

Premium trends is, I guess, one of the reasons we focus on health insurance. And, you know, some of the factors behind the very rapid increase in premiums, certainly part of this is the insurance underwriting cycle leading to wider margins at the moment.

You know, my best read on where we are, I guess there are two ways to see where you are in the underwriting cycle. You can either look at Wall Street reports to see whether margins are going up or down from insurers or the other thing is you can look at what's happening in exit and entry from markets. And during the stage of the underwriting cycle when premium trends are exceeding cost trends, you expect to see exits from markets rather than entry, and from our on-the-ground sense at 12 sites, we are still seeing some exits, we're not seeing any entry. So, by that indicator, the underwriting cycle hasn't turned yet and, perhaps, isn't about to turn that quickly.

Of course, probably the major factor behind the rising premium trends has been rising utilization in response, I believe, to the loosening of managed care. Reduced authorization requirements, a very sharp decline in the use of capitation to pay providers. So, there's been a return to fee-for-service. And, actually, as capitation has declined, it's probably also declined in a way that's raised prices because some of the capitation contracts that the providers hated, they hated them because they agreed to a price that was effectively lower than they thought. And so, part of the withdrawal from capitation is a way to get the prices back up to where they think they can get them and not be -- have this distortion from, perhaps, their overly optimistic expectations of what they could do to control utilization that they're responsible to.

Easier access to specialists, you know, a major change, throwing out the gatekeeper model. These are some of the factors behind utilization rising.

Certainly, it's always important to mention the most important driver of costs, both long-term and short-term, is always new technology. Something that's very difficult to get a handle on quantitatively. The research on the role that technology plays in rising costs really just looks at a residual and calculates it

in a residual. I just don't know if there's a way to assess the impact of technology on costs other than doing it as a residual, other than going, you know, condition by condition, service by service. There doesn't seem to be a way to do it in the aggregate.

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relatively stable, perhaps slightly declining prices in relation to cost. But, certainly, there are prospects to sharp declines in Medicaid payment rates because of states' financial difficultly.

What can turn the trend towards rapidly rising premiums? Well, for one thing, a turn, the underwriting cycle, will happen at some point and that will make some difference. But I think the key thing is when employers take an increased interest in cost containment and pursue it more vigorously than they have in recent years.

Here are some policy implications. When the performance of insurers involves more than margins, that we want insurers to have more than margins that do not represent excessive monopoly power, we want insurers to innovate and to take steps and cut costs and also -- but part of this, I think, is the nature of the signals that they get and will get from employers.

Provider market power has grown rapidly in recent years. Sometimes it's been caused by mergers; often caused by employer insistence on broad networks. And insurer market power, in its monopsony market, can be a counterweight that's positive in some cases. And some markets appear to have only limited prospects for effective competition.

You know, think of markets that have dominant

Blue Cross/Blue Shield plans. It's probably very hard to envision really effective insurance competition in markets that have dominant hospitals. I think there are, as I mentioned, informal pressures, at least in the smaller communities often at work to, in a sense, move these situations toward the outcome of a more competitive direction, but it really is wise to start talking about in these markets where the prospects for competition aren't that great, what else can be done really to protect consumers against paying prices that are too high and not having the innovation and cost-cutting that we associate with competition.

Thank you.

MR. BERLIN: I have, I guess, what is a multiple compound question. If you'd rather stand or sit, I'll throw it out there.

DR. GINSBURG: I believe I can see you from here.

MR. BERLIN: Okay. My understanding from the calls that we've had to the panelists setting up these topics and reading some of the presentations is that there are three dimensions, at least, to the market definition issue. One is, is there a separate market in the distinction between HMOs, PPOs, POSs, et cetera? That's one. Two, the sort of self-funded versus fully

funded dichotomy, and third, the scope of the geographic market.

And I'm wondering, based on your observations regarding the managed care backlash, the proliferation of the trend to broader networks, product innovation and

well.

DR. GINSBURG: Sure. Now, the second part, you were saying for self-insured?

MR. BERLIN: Well, do you see, again, the line between employers that are self-insured versus those that are fully insured as blurring perhaps for certain size employers or any other criteria?

DR. GINSBURG: Well, yeah. I've, you know, for a long time always felt that the distinction between fully insured and self-insured was not very important for many things. You know, in a sense, there's been this very long-term trend of increasingly small firms moving to self-insured status and a re-insurance industry having developed to assist those small firms -- smaller firms in becoming self-insured. And I think actually by self-insured coverage being an option to more and more employers, this actually broadens the range ofd more

their tool.

So, I think it's definitely going to have the very positive effect of reducing selling costs, but I don't see this likely to have an effect on competition in health insurance because I just don't see it threatening the major insurers.

MR. BERLIN: You, in your description of your three types of insurance markets that you've used to categorize the 12 total that you've looked at, in your Type 1, the Blue Cross/Blue Shield dominant markets, as you characterized it, you noted unsuccessful entry by national firms, and I'm wondering to what extent you've seen that phenomenon in your Type 2 or Type 3 markets?

DR. GINSBURG: Certainly, some of it. But they -- say in a market like Miami, which I'm not sure that I'd put in the thing because we have a couple of markets that weren't clearly in one type or another. Certainly, a market like Miami has had successful national entry, United Healthcare, and it's had unsuccessful entry of firms that left. So, yeah, I would say there has really been a mix.

I would say, in recent years, though, that the only -- the successful entry of national plans into markets has come from purchasing hospital-owned health plans, and now that the hospital-owned health plans are

mostly gone, I would not be surprised if we wouldn't -- certainly, in the short term, I wouldn't expect to see much national plan entry. But then I have to remind myself of what stage of the underwriting cycle we're in.

But I think that that actually -- the most successful -- I mean, I think early on in my work we would see entry by acquiring a smaller local health plan. But I think the most successful ones have been acquiring some of these large hospital-owned plans. It's really striking that even though, you know, most people thought, and I think correctly, that this doesn't make sense, hospitals going into the health plan business, and they will lose money and certainly many hospitals did lose money. But there were some that actually were, you know, successful enough. They weren't ragingly successful. And that once it became clear -- often, it's not that it became clear they shouldn't be in the business, but that they needed the money for something else maybe to invest in bricks and mortar in the hospitals.

So, some of these plans have reached

supplemental insurance businesses, as well.

I'd like to start by observing that we believe that the health insurance market is both highly competitive and highly regulated. I'm willing to elaborate on both of those. According to a recent study, the number of managed care organizations competing in each of the top 40 major metropolitan statistical areas averaged 14 plans. From a low of about eight plans in the Buffalo, Niagra Falls and Pittsburgh MSA to a high of 41 competing organization in New York, northern New Jersey and Long Island MSA.

In addition, in each of these areas, there was an average choice of more than three different types of products in each area creating a very diverse marketplace.

As a result of the wide availability of different health insurance products, 62 percent of workers with employer-sponsored health insurance are offered more than one choice of health insurance products, and I think that also has a factor here in the competitiveness, because they not only have choice among plans, but even among the particular insurer might have choice of various types of delivery vehicles.

A wide variety of plans offer different and often multiple delivery systems. We heard Paul talk

about HMOs, point of service plans and preferred provider networks or PPOs. There is still some old-fashioned traditional indemnity products sold out there. Also, while our primary focus may be the employer market, I think we need to remind ourselves, there's a whole other market out there of individual insurance. In fact, about 16 million Americans purchase their own health insurance. That means they pay for the whole thing, they don't have an employer subsidy.

From our perspective, it's important to realize that there's really two distinct markets. There's a group market for health insurance, as well as an individual market. The two markets vary considerably in terms of the economic, business and regulatory considerations and we need to keep that in mind. I should observe that our member companies are in both of these markets and competing in both of these markets.

There are also important differences between the health insurance markets for small and larger employers. Hopefully, we'll get into more of that later during our dialogue.

In addition, some employers choose to purchase fully insured products while others self-insure, meaning that they bear the insurance risk themselves. As Paul Ginsburg said, they typically work with a TPA or a third

party administrator, which may be an insurer or may not be an insurer, to process their claims and to do other administrative functions for the self-funded plan.

Among the newest plan designs are what are being called consumer-driven health care products and that's interjecting a whole other array of competitors, both in terms of benefit design and players that are in the market. And, yes, I do believe that the Internet is certainly adding to the competitiveness. An individual consumer can now go there and determine who is providing products in their locale, what the costs are and the availability and so on. That surely must have an impact on competitiveness.

To understand the current insurance marketplace, it's important to recognize that insurers are subject to intense government scrutiny of their business practices. State insurance departments review and approve policy forms. They perform market conduct examinations and investigate consumer complaints. They also regulate the form and substance of information disclosures, insurers' investments, the discontinuance and replacement of policies, claims payment practices, appeals and grievances, and I could go on and on. In fact, I could take my full 10 minutes just enumerating the roles that state regulators play in the health

insurance market. Clearly, that's very different than when we're talking about, say, grocery stores or any other kinds of retail markets. This is a very different kind of product.

Further, all insurers are subject to state antitrust laws, rate regulation and other state and federal insurance statute provisions that are enforced by insurance regulators, state attorneys general, the Department of Labor and the Department of Health and Human Services. And even then -- and I think importantly for purposes of this hearing, insurers are not free from all aspects of federal antitrust laws and continue to be

and required divestitures as a result of proposed mergers within the insurance industry.

The other important point I want to make this morning, for purposes of our talking about the market and competitiveness, is that the degree of state oversight that I've discussed always raises the possibility that a state will adopt policies that have negative consequences for its health insurance market, more specifically, by reducing the number of insurers willing to do business in that state.

Quite frankly, HIAA often finds itself in the position of warning state officials that a proposed course of action is likely to have a negative impact on the insurance marketplace. Unfortunately, our words of warning are not always heeded. But let me give you a couple of examples. In 1994, the State of Kentucky implemented a number of changes in their small group insurance marketplace. They called them reforms. A few years later, the State issued a report that noted the following: The withdrawal from the market of 45 insurance companies. Anthem Blue Cross, the local Blues plan, reported a $60 million underwriting loss. The State Insurance Fund, Kentucky Care, lost more than $30 million.

again, they made some changes in their small health insurance marketplace. What was the result? At that time, actually, there were 34 carriers that were participating in that marketplace. As a result of the reforms, the cost of health insurance coverage rose so that by 2000, the market dwindled to about half a dozen carriers who were left and also -- and, in fact, leaving two carriers dominating the small employer market.

I'm happy to say, though, that most states eventually recognize the harm that they are doing as a result of their regulatory policies. And, again, Kentucky and New Hampshire are perfect examples.

Last year, Kentucky legislators worked with the health insurance industry in developing legislative proposals to help alleviate the problems of the past. And in 2001, the New Hampshire law makers, also working with our industry, enacted reforms to begin the process of repairing the damage done to their market. And the market, I'm happy to say, is beginning to rebound.

Let me add a few more words in terms of market definition considerations. It's certainly critical in evaluating a given market that all relevant forms of competition existing in that specific market are carefully examined. I think I would echo many of the points that Paul Ginsburg made in responding to your

questions. We have the PPO/HMO point of service that are bleeding into one another so that the distinctions are not as great as they might once have been. We certainly have fully insured and self-insured products.

And I should make the following point: Obviously, if I'm an insurer and I have an employer customer, I have to be mindful of the fact that that customer, at any time, can decide to become self-insured and to assume that responsibility and hire a TPA, not necessarily my insurance company, and that certainly has to color the relationships between the employer customers and the insurers and TPAs in which they do business. Because likewise, a self-funded employer, can, at any time, decide to purchase a fully-insured product.

So, again, I think, in looking at the marketplace, you have to be mindful of that.

The next point I would focus on is the actual patient or employee. Again, they have a role to play here and, in fact, they have the option of refusing the coverage that their own employer has offered, for whatever reason, sometimes because of cost, they choose not to take up that particular coverage. In any case, when they have choices, they are also playing a role in the competitiveness of the market.

Well, given all this variety and complexity

that I've discussed, defining a given market would require an enormous amount of data that may be very difficult to obtain and quantify. And, in particular, obtaining information about the self-insured marketplace, in terms of covered lives and costs and so on, may be very difficult to do. But further, a self-insured employer with plan participants in more than one location may have a presence in various markets throughout the country, adding further to the complexity of market definition.

With that, let me stop and I look forward to continuing this discussion later during the Q and A. Thank you very much.

MR. BERLIN: Thank you very much.

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MR. BERLIN: Next we have David Monk.

MR. MONK: First, I'd like to thank the Department of Justice Antitrust Division and the FTC for holding these hearings and for inviting me here to speak this morning.

Prior to June of 1999, there may not have been much interest in a session dealing with market definition in the health insurance industry. Fortunately, for those of us on this panel, the Department of Justice's consent with regard to the Aetna acquisition of Prudential

changed that.

Prior to 1999, there was no apparent controversy. Up until that point, there had been no enforcement actions taken by the antitrust agencies, so the assumption was that the agencies viewed the markets broadly. The issue is well-litigated, but uniformly, the same conclusions were drawn. Health insurance markets, at least statewide and possibly even national, product markets include self and fully insured products and all products, including indemnity PPO and HMO.

Now, as I understand it, the Department of Justice began to test this proposition in 1998 with their investigation of the Humana-United transaction. But that deal cratered before they were able to complete their analysis and the public did not know of their investigation. When the Aetna-Prudential transaction arose less than a year later, the Department of Justice had another opportunity.

After a long, and at times contentious, battle, the deal was approved with the consent in Texas. While not setting a legal precedent, the significance of this investigation and the consent is that it changed the discussion. The complaint focused on an MSA level, specifically naming Dallas and Houston, and on a product market, it defined a fully insured HMO and HMO-based POS

plan market only.

As part of the NERA team working on behalf of Aetna, this investigation into consent continues to play a significant role in my thinking on these issues.

Since that time, there haven't been any court decisions that I'm aware that affirm or dispute this position, nor am I aware of any further agency actions. There have, of course, been more transactions that have been approved, some with considerable investigations, but the Department has not publicly stated their conclusions concerning market definition since the Aetna-Prudential deal. However, my experience on more recent mergers suggests that an MSA-based, fully insured HMO market is still the Department of Justice's starting point.

So, without a lot of recent publicly available history to frame my discussion, I will address each of the components of the Department of Justice Aetna complaint and the consent and what I believe is the way to analyze the marketplace.

First, can an MSA be a relevant geographic market? Managed care plans rely on physician and hospital networks, which are inherently local and can reasonably lead one to view the demand for health plans as local. The licensing rules follow. While generally to insure in a state requires only a single license,

plans typically must notify the Department of Insurance of changes to provider networks before they can expand. But that ignores supply substitution.

When measuring the extent of geographic markets for health plans, it's also important to look at geographic expansion or geographic supply substitution. While the Department of Justice/FTC merger guidelines generally do not apply substitution to market definition, the ease and speed with which these plans can move from one part of a state to another make insurance markets an exception.

As I mentioned, all that is required for a plan already licensed in a state to expand to another area of that state is to contract with an existing provider network and then market their new product. This means that the expansion could occur with enough speed and, therefore, constrain price under the merger guidelines of a hypothetical monopolistic test.

To measure these effects requires an analysis of the relevant regulations and a study to see the

market.

The one exception to this may be small employers who would be -- who may find it not advantageous to switch to a self-insured plan. But this segment of the marketplace is highly regulated and, therefore, should not be much of a concern.

The final question is, do PPOs and HMOs

outside the network.

With regard to design, HMOs offer co-pays, while PPOs have co-insurance and deductibles making the out-of-pocket costs very different. And, of course, we think HMOs cost much less than PPOs or indemnity plans. But as Dr. Ginsburg has already said, these plan designs have really begun to converge. There's open access HMOs and POSs plans that allow members to go outside of the network and, in some cases, see specialists without first seeing a PCP.

Gatekeeper PPOs and exclusive provider organizations require patients to first see a PCP, and in some cases, do not allow members access to providers outside of their network, despite their indemnity-based license.

The benefit designs of convergence as well, PPOs now offer co-pays. HMOs now have hospital deductibles and use tiering to steer patients within their networks. And not surprisingly, with the convergence of the plan designs, there's been a convergence in price.

In fact, in a 1998 study done by Mercer and presented in their national survey of employer-sponsored health plans, in the Midwest, the average out-of-pocket cost for members of a PPO was $3,657. And by comparison,

the out-of-pocket cost for HMO members was $3,652, virtually identical. While other areas were not that close, the trend still seemed to hold. Analysis of bidding documents, broker spreadsheets and planned win-loss statements confirmed these trends laid out in the Mercer study and show that the consumers do react.

Now, as I mentioned, the question of whether HMOs and PPOs was empirically tested by both the Department of Justice and the merging parties during the Aetna-Prudential transaction. The DOJ concluded that the best way to test the proposition that HMOs and PPOs are in separate markets was to model consumer demand in specific metropolitan areas, focusing first on Dallas and Houston.

They employed a discrete choice modeling technique based on a database that they were able to construct for purposes of that investigation using their subpoena power. They obtained data from competing health plans, the merging parties, and also from employers, which allowed them to study the choices made by employers and employees.

From their modeling, they estimated elasticities that were in the range of minus three. Is that high or is that low? Well, based on margins, the elasticity required for any firm or group of firms to

profitably raise price can be -- the margins can be used to determine whether a firm or group of firms can profitably raise price. This is known as the critical elasticity.

If the estimated elasticity falls below the critical elasticity, it can be inferred that a price increase would be profitable and, therefore, the segment

is in excess of minus six, but it says that the missing data creates a bias towards challenging the merger.

In order to confirm this, we then looked at the Mercer data that I already mentioned. Because Mercer is a sister company of NERA, we were able to obtain the data underlying their survey and further test the proposition that benefit design and employee contribution strategies are important.

issues of benefit design and employee contribution strategies are very important and it leads me to conclude that from the evidence that I've been able to analyze, that HMOs and PPOs generally do compete in the same relevant market.

As we've heard, since 1999, the world has changed significantly. The managed care backlash has continued to push these trends forward.

So, where are we now? First of all, Department of Justice has definitely been asking the right questions. The tools that I've discussed are the right tools to use to analyze these questions. We need to study the reactions of health plans, employers and employees as the marketplace evolves. And, finally, any analysis that takes place from here on out needs to factor in the changing marketplace that is emerging due to the managed care backlash. We're in a situation now where the consumer is saying, I want more choice, I want more access, and why is it the costs keep going up. That's requiring the insurers to respond, and so, we have to look at how they're being responded.

Thank you.

(A a :.)

MR. BERLIN: Thank you, David. Next, Roger Feldman.

MR. FELDMAN: Now for something completely different, I'm also going to talk about health insurance monopoly, how to define the market, and as David said, we all appreciate the opportunity to address you this morning. Like him, I think the FTC and Department of Justice are asking the right questions.

I'm going to start off with the Marshfield Clinic decision to help frame my discussion. This is a quote from the Court's decision as written by Richard Posner, Chief Judge, Seventh Circuit. Posner opines that, "It is well known that individuals and their employers regard HMOs as competitive not only with each other but with other forms of health insurance, such as fee-for-service providers and preferred provider plans, such that there is a single market for all forms of health care financing."

Posner goes on to analyze HMOs which he regards as relative up-starts in the market for physician services. Kaiser's long experience notwithstanding. Despite saying that HMOs and fee-for-service are demand substitutes, Posner now backtracks. He says that many people don't like HMOs because they restrict a patient's choice of doctors and people fear they will skimp on services. HMOs compensate for these perceived drawbacks by charging a lower price than fee-for-service.

However, after saying that people perceive HMOs and fee-for-service somewhat differently, he plays his trump card. Even if fee-for-service were completely different from the consumer's standpoint, they would still be in the market, the same market, because suppliers of services, that is the physicians who provide a broad array of services, can easily convert from producing fee-for-service to HMO medical care.

Notice that this is a relatively odd definition of suppliers. I would think that the suppliers are insurance companies and HMOs who might be able to offer a new type of product. For example, the HMO could branch out and offer a point of service product. I think the emphasis on physicians misdirects our attention. It's certainly true that analysis of the physician's market is important, but this comes into play when considering the supplier of an input to the insurance company, not the supplier of the product itself.

However, this isn't the main problem with Posner's analysis. The main problem is his opinion that definition of a market depends upon supply as well as demand substitution. Let's imagine for a moment that all the firms making tanks and all the firms making skateboards could easily switch and start producing automobiles. Does this make tanks, skateboards and

automobiles part of the same industry? Of course not. Supply substitution is not relevant for defining a product market.

As clearly articulated by the horizontal merger guidelines, market definition focuses solely upon demand substitution factors that as possible consumer responses.

Supply substitution is important. It is used to identify firms that participate in the relevant market and it's used in the analysis of entry. But it is not used to define the product market. Therefore, I will use the guidelines approach because Judge Posner's economic analysis is flawed.

HMOs are a separate product, according to the guidelines, if a hypothetical monopolistic can impose a small but significant and non-transitory increase in price. I will argue that the evidence shows there are different health insurance products and I will discuss four extensions that need to be considered.

Here's the conventional wisdom, or if it isn't, I think it should be. There are distinct products for health insurance plans characterized by enrollees' ability to see their own doctor, including the ability to see specialist physicians without a referral and to use any hospital recommended by a physician.

Judge Posner, however, was right about one

thing. People don't like managed care and they are willing to avoid managed care plans by paying a premium for the alternatives.

Along with co-authors Bryan Dowd, Matt Maciejewski and Mark Pauly, I conducted a study of the willingness to pay for different types of health insurance plans among employees of large city and county governments in 1994. We found that consumers were willing to pay $34 per month more to belong to a fee-for-service plan versus a PPO and their willingness to pay for fee-for-service coverage versus HMO or POS, two other alternatives, were significantly larger. Just to put

to switch when their choice is two fee-for-service plans and they are confronted by a small but significant increase in price.

A $100 annual increase in the marginal net price would reduce the market share of the more expensive fee-for-service plan by 5.4 percentage points. But the same increase in the HMO premium would reduce its market share by 2.2 percentage points.

Next, along with co-authors Mike Finch, Bryan Dowd and Steve Cassou, I estimated a nested logit model of health plan choice for single employees and families in 17 Minneapolis firms. The nests were distinguished by freedom to choose your own doctor. We found that choice within nests was sensitive to out-of-pocket premiums

between dissimilar plans is much less so.

There are a couple points that need to be considered when you use studies like this to calculate the possibility of monopolization. First of all, you have to recognize that most health insurance is subsidized, often heavily, by employers or Medicare. Consumers use the out-of-pocket premiums to assess health plan choice. That is, they're interested in how much they have to pay from their own pocket, whereas health plans use the total premium elasticity to maximize profits. These observations suggest that the total premium elasticity is greater than the out-of-pocket premium elasticity because the total premium of the health plan, which appears in the elasticity formula in the numerator, is much larger.

Second, when analyzing the data for antitrust purposes, the premium subsidy formula matters. A percentage subsidy, for example, increases the price that would be charge by a monopolist because each dollar or $10 increase is shared with the employer and the employees in some percentage.

In the extreme, a 100 percent subsidy implies

charged, but the type of subsidy formula that's in place.

I analyzed an actual HMO merger that occurred in 1992 in Minneapolis when two large HMO plans, both of which were in the restrictive nest, merged together. In one firm where the two plans had 100 percent of the nest, which approximates the conditions that the guidelines want us to use, the simulated premiums rose by about 19 percent for both firms. This clearly meets the test of a significant increase.

But it raises a key question. Will the firm drop the merged plan? I'm going to come back to that question in a few minutes because it suggests we have to consider not only the employee's price elasticity but the firm's decision to drop the merged plan.

Bob Town estimated a differentiated products demand system for HMOs in the California HPIC, which is a state-sponsored purchasing pool for small employers. Town chose six hypothetical HMO combinations to generate post-merger market structures. Two of those six hypothetical mergers generated price increases greater than 5 percent, although none of them monopolized the market. This raises the possibility that there might be differentiated products within the HMO nest.

Now, let's take a look at Medicare health plans, which is an interesting market, different from

that of the employer health plan sector. Along with Adam Atherly and Bryan Dowd, I found evidence of distinct markets for Medicare health plans. We estimated a nested logit model with fee-for-service and M+C branches -- excuse me, nests and M+C branches. We found that the out-of-pocket premium elasticity for the M+C nest was very small, on the order of .03. That means if all of the M+C plans in a market raise their premium by 10 percent, they would lose three-tenths of a percent of their market.

Notice that the total price elasticity is much larger and the reason for that is because the government provides a very large subsidy for most Medicare consumers.

Tom Buchmueller also found a low fee-for-service price elasticity for retirees of a multi-state employer. So, this evidence demonstrates the existence of separate and distinct markets within the Medicare program.

Here are the four things I'd like to do if I were to extend this analysis. First of all, we need to look at the firm's demand for health plans. As I said earlier, it matters whether a firm continues to offer or whether it drops a hypothetical HMO that raises price. If firms were perfect agents for individual workers, then

the firms' menu of health plans would just be the same as the workers' choices. But because of transaction costs, firms are imperfect agents for individual workers. So,

does suggest that the price elasticity of firm choice is greater than one. This is a paper by Mike Morrisey and Gail Jensen, who estimated small firms demand for all types of managed care versus fee-for-service and they found a firm elasticity of around minus 1.9.

But this is a question that we really need more work to answer. Will firms drop a plan if it raises its premium? We really don't know the answer to that as well as we need to know it.

My second extension is how do we deal with quality change. The guidelines test for market power, I believe, is incomplete because differentiated products monopoly also involves changes in quality as well as changes in price and the guidelines test, as far as I read it, involves only changes in price. This is probably a little more economics than you want to swallow this morning, but if you assume that consumers have different preferences for product quality, we'll just call those consumers Theta-1 types who don't care a whole lot about quality and Theta-2 types who have a much stronger demand for quality.

Mike Mussa and Sherwin Rosen show that it always pays a differentiated products monopolistic to reduce quality sold to the Theta-1 types so they can raise price to the Theta-2 types.

I have two graphs here -- I'm going to skip over there -- which demonstrate graphically the Mussa and Rosen argument and cut straight to their conclusion. The differentiated products monopoly cuts the price and the quality for people who have a low taste for quality. If not many customers want that low quality product, the differentiated products monopolist may drop it altogether. So, that's a factor which is not considered by the guidelines, in my opinion. Some products might get dropped following a merger.

The Differentiated Products monopolist raises the price for the types who prefer higher quality and consumer surplus falls. The traditional guidelines test of an increase in price is, therefore, incomplete. We also need to consider changes in quality and the increase in price must be quality adjusted.

My third extension is that I think we should look at the effect of macroeconomic conditions on how to define product markets. There's soft empirical evidence which demonstrates that the price elasticity of demand for HMOs depends on macroeconomic conditions. That is, workers seem to be willing to pay a high price for fee-for-service insurance during good times and during poorer macroeconomic times, they tend to gravitate back to HMOs. It suggests then that the state of the macroeconomic

economy might compress the price elasticity during good times, pushing the products possibly into the same market and then pulling them back apart again.

I'm not sure if antitrust policy, in fact, ought to consider these fluctuations, but at the very least, it matters when you measure it. The empirical implications are that products definition could actually depend on the stage of the business cycle and I leave it as an open question because I'm not a lawyer in this field, should the guidelines recognize this type of product market expansion and contraction.

My fourth extension is self-insurance, which has been mentioned a couple of times already this morning. A self-insured firm bears risks and escapes many, but not all, state insurance mandates. About half of covered employees are in self-insured plans. That's a good baseline number for you.

I am going to argue that the guidelines test should be applied to self-insurance just like it's applied to any other potential product market. That is, if a hypothetical monopolistic could raise the price of a self-insured product by a small, but significant, and non-transitory amount, then self-insurance should be a separate product from full insurance.

In deciding the answer to this question, I

think supply side substitution becomes important. I would think that it's large for conventional and PPO plans, smaller for HMOs and PSO plans. When I say -- I think I made a mistake there, not in deciding that question, but in evaluating whether or not there's ease of entry into the markets, excuse me.

Let's take a look at firm self-insurance by firm size. I think there are really three groups of firms. First, these small firms, 3 to 199 employers, basically aren't going to self-insure no matter what. They're in the market for fully insured plans and they're going to stay there. And big firms, 1,000 and above, are only in the market for self-insurance. They see no reason to go out and hire somebody to bear the risk for them. It's really in this middle group, 200 to 999, that the choice between self-insurance and full insurance becomes relevant.

So, I think that when you're defining the product market for self-insurance, you have to look at the distribution of firms. If the distribution of firms is centered on this type, then I think you have pretty good reasons for believing that they actually are in competition with each other. But if you found a market which had only very small and very large firms, I don't think there's much room for the switch to occur in that

market.

And, finally, when you consider whether or not the firms who supply insurance can enter the market -- and, again, I want to emphasize this is not to be considered a market definition, but it is a relevant question when you want to ask who's participating in the market and who enters it. I think it's pretty clear that conventional and PPO sellers of insurance can easily enter the self-insured market. You see, workers are much more likely to be covered by self-insured conventional and PPO plans.

On the other hand, HMOs and POS plans are much less likely to enter the self-insured market. I think that's because HMOs simply lack the data systems and the claims paying ability to be self-insurers. In order to make those significant investments, they would have to compete against conventional and PPO firms that are likely to already be there at much lower cost. So, I think conventional and PPO firms can make this substitution of POS and HMOs much less so.

My conclusions are that there are separate product markets for health plans. Several issues need more investigation. The firm's demand for health plans is one of those. The effect of mergers on quality is the second. Macroeconomic conditions may define products,

and finally, is self-insurance a product market.

Supply-side substitution is very important in assessing the effects of health plan mergers. If I was giving advice to an aspiring young economist and they said, should I spend my career trying to define health insurance products, I would say, no, it's already been done, go look at supply substitution. That's where the interesting questions are.

(A a .)

MR. BERLIN: And our final presenter will be Art Lerner and I think we will need a little time to load up his presentation. So, talk amongst yourselves.

(B a .)

MR. LERNER: I'll start by saying that I also appreciate the opportunity to be here and thank the FTC and the DOJ for having these hearings and giving us an opportunity to talk and hopefully you'll get something out of it. I've already gotten a lot of out it, which as a reminder, picking up on Henry's theme, that I'm not an economist. So, I noticed that during the last couple of presentations.

I'll also mention that for those of you who know me, I'm at a bit of a disadvantage because I had what I was going to say, about 20 minutes of stuff in about 10 minutes. But now I've picked up about another

half-hour of stuff I want to say, so I have 50 minutes of stuff to say in about 10 minutes and we still don't have the floppy up yet. There we are, all right. We're all set.

Some of what I was going to cover we can skip over quickly, but I will touch on it very briefly anyway. And that is, when we talk about what a market is, I think it's clear from the prior speakers we're talking about a set of products within which a hypothetical profit maximizing firm that was the only one there could impose a meaningful and non-transitory increase in price and get away with it.

Picking up on what Roger said, I had noted the same thing, that according to the FTC merger and DOJ merger guidelines, the market definition question focuses solely on demand substitution factors, consumer response. Supply substitution responses by other firms or even the same firms, moving capacity or production into the sale of those products, is not to be considered in defining the product market, but is to be considered in assessing effects, entry, et cetera.

I'm not sure how important that is definitionally. That is the way the guidelines work. Ultimately, the question, of course, is whether a merger or conduct is going to have an anti-competitive effect

and you could argue that it's a little bit artificial to draw these distinctions, but nonetheless, that is the one that the guidelines draw.

So, what do you want to look at? You need to look at buyers -- in testing, whether a hypothetical market is a market, whether buyers will shift or consider shifting purchases between products in response to relative changes in price or other competitive variables and a series of other questions we see there that are posed in the guidelines. I think it's clear, unquestionable, that HMOs and PPOs are in the same market, okay? The question, I think, is really whether there's a separate sub-market. That would have been the words that we used a long time ago. If you assumed hypothetically that the HMO offers the lower price in exchange for lesser perceived quality in terms of access to service or something like that, there would seem to be no question that the price of the HMO product would pose an outer bound on a price increase by a hypothetical monopolist in the PPO market.

So, at some level, there is certainly a market in which they all compete. The interesting question, if there is one here, I suppose, is whether there is what we used to call a separate sub-market, I suppose. We don't use the sub-market anymore. Nobody uses it, but I

suppose we could.

I think it's important to keep an eye on the ball and remember that the question is not, is there a price difference between HMO products and PPO products and all the other different kinds of products or whether there are attribute differences between the products. The question is, assuming a competitive equilibrium in both and then the competitive equilibrium disappeared in one of them so that then somebody tried to raise price, would the change in relative price drive consumer response back and forth between the segments. That's really the question.

I don't think the question has changed that much from 3, 4, 5, 6, 10 years ago. But one of the questions has always been, well, if we define these products, are these products in a separate market or sub-market. Nowadays, it's getting increasingly hard to be clear about what's the "product" you're talking about.

Just to pick on Roger for a second, just to use him as an example. In one of his slides he referred to managed care plans versus fee-for-service. In another one he referred to whether or not you get to choose your own doctor. I'm not saying these are wrong. What I'm saying is when you then try to -- whatever you test in your economic research, when you then try to -- in the

companies.

You have a model where the employer gets claims processing from a TPA, operates on a self-insured basis with a stop-loss carrier and there can be very low stop-loss coverage.

I wanted to comment briefly on the fully insured, self-funded issue there, for example. The law firm that I used to work with, we were self-funded for years and didn't know it until I became the benefit manager within our 18-person law firm and found out, well, gosh, darn, we were self-insured. So, when you do these surveys that test a lot of small employers and say, well, are you self-insured and you say, heck, no, we're covered by the principal. Well, I was covered by the principal and we were self-insured for years and didn't know it because we had what was basically a self-insured plan with a very low aggregate stop-loss that kicked in, in which our experience, along with a lot of other small employers, were pooled to determine how much the aggregate stop-loss premium was. And through this magical device, I am told we didn't have to comply with some obscure benefit mandates from the District of Columbia.

So, the basis distinction between being a self-insured plan and a non-self-insured plan, I think, is

misty, at best.

I just finished a case last year involving a PPO network in Indiana. For those who might want to read it, it was the Gateway Contracting Services versus Sagamore and you can go through that case and read about all the different kinds of benefit designs and who had what and the plaintiff's attempt to try to define a product market of rental PPO networks, which is kind of interesting.

Anyway, we'll go on with the show here. Let's look at the different configurations of what's actually out there today. You have HMOs, are they insured, sold on an insured basis? Usually, not always. You can have a self-insured HMO product.

PPOs, often sold on an insured basis; often not, about 50/50, maybe even 60/40 self-insured.

Is there a network? Obviously, yes in both. Is there a gatekeeper requirement in the HMOs? Often. Less the case today when it used to be in terms of product design. PPOs, sometimes. Unusual, but you have some gatekeeper models on the PPO side.

Prior approval requirements. Before you can go to the hospital or before you can go to see a specialist, usually in the HMO, product designs but not always; PPO, product designs often, sometimes.

Is there coverage for out-of-network benefits? HMOs, increasingly common. Increasingly common. Look at Kaiser. The way Kaiser has moved is sort of a classic closed panel HMO product and look at the way they're sold now. A lot of their business is now point of service. In some states, it's mandated that they offer point of service. PPO, of course, yes.

All of this suggests not that there aren't differences in product design, but that you now have the same companies offering all these different product designs and consumers not being necessarily clear which type of product you're getting simply based on the license on which it was issued.

We were working on one merger investigation where we were trying to measure market share and the State Insurance Department sort of screwed things up by writing a letter to our client and saying, oh, by the way, these 123,000 people that you have, that you've had under this PPO license, they really should be under the HMO license given the way the product design is configured. So, they jumped. It's not easy.

Now, you could still say -- all of the things that Roger was testing, I think, are correct. In other words, you need to measure whether within different clusters or different types of designs for customers who

are interested in those types of designs, you could, in fact, exercise some degree of market power due to elasticity changes in all the rest. I am skeptical. I'm skeptical. But I believe that those are all -- again, all the right questions to ask.

Look at what United has done. United, who is one of the leading national HMO companies, their most typical HMO product now has no gatekeeper, referral requirements, no prior authorization and a point of service option. It sounds a lot like a PPO to me.

Then we've got EPOs, we've got ASO products, we've got three-tiered benefits, we've got stacked networks, we've got full replacement, carve-out networks, dual option, triple option, minimum premium plans, low threshold aggregate, stop-loss plans, capitated self-insured plans, HMOs with indemnity PPO wrap products around them, defined contribution plans, managed indemnity -- I've never known quite what that one is -- and then blended premium programs.

All of this is not to say that it's not possible, that the results that have been referred to could mean that there are separate product segments for antitrust purposes, separate sub-markets, separate markets within this field. One of my concerns, though, is that even if that were true, I don't think the normal

tools we have for measuring who's got what market shares have much utility in that. In other words, if your test was plans that require a gatekeeper, well, then looking at HMO enrollment statistics doesn't tell you that.

Plans that have a higher -- a big differential between -- you know, a 40 percent co-pay on going out-of-network versus 20 percent co-pay on going out-of-network. Licensing measures don't tell you that. And, furthermore, of course, the supply side response questions we're talking about are also important because, in large measure, it's a lot of the same companies that could switch over. I just like this slide. I was going to use this for product market definition, just a little change of pace.

What does the case law tell us? As the previous speakers have indicated, all the litigated cases have reached the conclusion that there is a broad market definition. I agree with Roger that many of these cases, the analysis is either thin or wrong-headed.

The old Ball Memorial case, there's a lot of pontificating in some of these opinions and they totally mush up the monopsony power and monopoly power get mushed together in the Ball case. I agree with Roger's comments about Judge Posner's comments in the Marshfield case. There's a lot of messing up in some of these opinions,

but they all reach the same conclusion.

The DOJ settlement, of course, stands alone in terms of federal government enforcement. There have been

you know, I know what the problems with the research is. I would say all of this research to me can be provocative, but I'm not sure how much it proves yet.

Who is in the market? Remember that the question we've been discussing is what is the market and David's comments about supply-side substitution -- Roger addressed it by saying, yeah, well, that supply-side substitution doesn't bear on product market definition. Under the guidelines, that's right. But under the guidelines, anybody who can substitute in is deemed to be in that market. So, in the example about tanks, it would be true that a tank manufacturer who could enter the car market would not be viewed -- you would not, therefore, say that tanks and cars are in the same market, but you would, based on those factual presumptions, conclude that tank manufacturers are in the car market. It's a little bit odd to think about, but that's only because we don't think of tank manufacturers as being able to make cars, and vice versa. But if we were around in World War II we would have seen that that's how it works.

What about narrower, even tighter, markets for particular purchaser segments? For Medicare Plus Choice enrollees for example? For Medicaid managed care? What about small business? What about, as Henry referred to, individuals? And Henry, of course, commented that he was

not either a lawyer or an economist, so I am sure -- I'm sure he did not mean to suggest that the individual health insurance market was necessarily a market for antitrust purposes, but we'll discuss that later. That's the situation where we all use the word "market" and sometimes mean different things about it.

We don't have time this morning to go through all of these individual ones. I just think the tests are the same questions. You'd have to ask the same questions about each of these segments to see whether you could find it to be a distinct product market and then, of course, you'd still then have to look at supply-side substitution to see what other firms could jump in.

In some cases, such as Medicare Plus Choice, the issue on concentration may be more a function of the restrictions the government puts on who can get in the market and why anyone would want to be in the market, maybe more of a problem than concentration itself. And that's it. Thank you very much.

(A a .)

MR. BERLIN: We'll take about a 10-minute break and come back a little after a quarter after to begin our roundtable.

(W , a a .)

MR. BERLIN: I'd like to start off the

roundtable portion of this morning's session with a question for Mr. Desmarais, who presented first and, I guess, acknowledged, proudly I imagine, that he's neither an attorney -- I'll speak only for attorneys -- or an economist. But I'd like to get either his general reaction to the things that he heard after he spoke or specific reaction to any point before we move into some more targeted questions.

DR. DESMARAIS: Well, there's been a lot of material today and, honestly speaking for myself, you're at a bit of a disadvantage when you can't really easily see the slides as people are presenting. I guess it shouldn't be a surprise that I was more comforted by those whose comments suggested that the market includes PPOs, HMOs, self-funded and fully insured; that, in fact, this notion of distinctness really isn't there to a great extent.

In particular, there's a couple of things that Roger Feldman said that I sort of paused about. He showed us a slide that looked at different size employers. Now, the chart was arranged so 100 percent wasn't the top. Seventy percent is where it cut off. And so, you might have been misled to think that everybody above a certain size was self-funded. But even at the largest size employer he showed us, at 5,000

above, only 70 percent of them were self-funded. And I think, more importantly, he was looking at a snapshot as opposed to trend data for us.

So, I think that -- again, I think our members would feel that the fully insured products and self-funded products, to the extent those are options for employers, and they can be options for employers even at small size because of the availability of stop-loss coverage, that that is part of the dynamic here that is going on. And, certainly, it's certainly true that the smaller employers tend to be those that are going to look for fully insured coverage for a number of different reasons. So, I think that's one point I would make.

I would also say that whatever the data are, the real world certainly shows us that employers are very concerned about health care costs, and so, they're not interested in seeing monopoly pricing out there. And, in fact, our companies regularly report that employers will drop their coverage every few years because they're looking for the lowest cost plan available in their community.

And so, the whole issue of customer loyalty, certainly among small employers and even individuals is not there and that's, I think, a dynamic and the concerns about cost are why the insurers are being creative in

That's really a concern of the providers. And how broad are the networks? That's a concern of the insured.

Those, I think -- I think that gets to a part of the reason why we see the difference in prices between HMOs and PPOs, at least historically we saw those. As Dr. Ginsburg mentioned, the networks are getting broader, the prices are converging. So, I think, in a sense, we may have -- certainly, we're trying to factor it in. Whether we've done a good enough job or not, I'm not sure.

MR. BERLIN: Dr. Feldman, anything you'd like to say?

DR. FELDMAN: I think the analysis of quality should be part of any potential antitrust proceeding. I agree with David. It's very difficult. I want to just mention quickly. It's probably a little bit easier to study quality in the Medicare program than in private insurance because in Medicare, we see variation in the benefits that M+C plans offer. And some of these benefits, like drugs coverage, are virtually universally present in private insurance, but they may or may not be present in Medicare.

Steve Pizer, one of the people from this afternoon's panel, did a study where he showed that more structural competition in the Medicare market is

associated with a higher probability than an M+C plan will offer drug coverage. So, at least in this instance, there's evidence which indicates that quality differences are really important.

question that requires a big wind-up, but I have a shorter one that follows on this. That is, what is the role of non-price factors and consumer switching between insurance products and how can we factor in or how do these things factor into a market definition analysis?

MR. LERNER: Because I'm not an economist, I can give an anecdotal answer very quickly. I think if you look at the experience of the CareFirst organization here in the D.C. area recently when they had their big public dispute with Children's Hospital, you saw a tremendous amount of interest in that and you saw a lot of enrollment loss to CareFirst with people switching out. I don't have data on it.

In the federal program, of course, it's a little bit distorted because -- well, people could have switched out of -- well, actually, people switching out

the complexity here is you have two levels of decision-making. The first level is the employers, and anecdotally, we often hear cost seems to be a primary consideration for many of them just because this is just part of the benefits and the expenses to handle. So, once you reach the first threshold of what the employer is willing to offer, then there's a second threshold for the actual employee in terms of their selection and that the whole issue about a pocket cost versus premium contributions all come into play.

So, while quality is certainly -- and quality, I agree, has to be viewed very broadly. It's sort of a value. I mean, is my doctor in the network that that particular plan is offering, et cetera. But what physicians found, actually, is though they might have a wonderful relationship with a particular patient, that if the patient suddenly faced an added cost, that it didn't take much additional cost before the patient said, I'm sorry, I'm going to have to switch because there's a lower cost plan and I'm going to take that lower cost plan even though I can no longer see you under that particular plan.

DR. FELDMAN: Again, drawing on the work of Sherwin Rosen, economists view quality differences, however you define them, as a compensating differential.

quality information that's available today, either the employers aren't or even the patients, even though there's a growing body of information. So, we have a long way to go before people are even aware of what's out there and are making use of it.

I guess the other complexity is when I select my plan, I may not be thinking about what the best cancer center is. But when I'm diagnosed with cancer, my whole life changes. And so, there's all kinds of complexities, I think, in this process that makes it difficult.

MR. MONK: I guess my limited addition to what Roger said is that when you look at the benefit design -- and the benefit design is one place where you capture a lot of the non-price issues in health insurance -- I

factored those in to our logit analysis to try to figure out whether or not those do end up creating separate nests and, therefore, creating separate markets.

MS. MATHIAS: My question goes more to the geographic market. David had a -- one of his slides was asking whether or not the MSA can be a relevant geographic market and I believe at the end he was saying that it needed to be a broader geographic market rather than just the MSA, possibly the state. We earlier had a telephone conversation where he gave the example that Texas might be a relevant geographic market, but Rhode Island might be maybe too small and that you'd include some of the surrounding states as part of the geographic market.

I'm a little confused on that because part of your argument today, at least as I understood it -- and maybe I didn't quite get it -- was the reason why possibly the state should be the relevant geographic market is because the ease of entry expansion was so easy because you had already met so many of the regulations and that wouldn't seem to me to be quite the same when you're doing a greater several state geographic market.

clearly a debate on the panel about whether or not expansion is a supply substitution and, thereby, not relevant in the market definition question. I'll put that aside for answering your question.

In a state like Texas where Houston is an MSA wholly subsumed by the State of Texas, Dallas is an MSA wholly subsumed by the State of Texas, as is every other MSA in the State of Texas, you can look at expansion, you

What will end up happening is then that the insurers that are focusing on Southeastern Pennsylvania are -- that may not currently offer products in New

price increase on products produced within the tentatively identified region only by shifting to products produced at locations of production outside the region, what would happen?

So, what we've got to ask here is, if an HMO with any region, or whatever our product is, raises its price, would buyers switch to products produced outside the region? Would firms introduce a health plan that's located 10 miles away or would consumers switch to a health plan that's located 10 miles away? That's the kind of question we need to ask. And the answer is quite clear, geography matters. It matters a whole lot.

I did a study where I looked at the choices by employees in large Minneapolis companies, about 26 companies with 250,000 covered lives, and I found that a five-kilometer increase in the distance between my home and the nearest clinic, in an alternative, reduced the probability of choosing that alternative by 12 and a half percent.

Minneapolis is a very large metropolitan area. Five kilometers is about three miles. That's a trivial increase, guys.

MR. LERNER: Well, I agree with both of you guys and I would only say, Roger, you sounded a little bit like Judge Posner there with that last comment,

mushing the providers in with the insurance company as being the question.

I think that -- what I was trying to say before is that the guidelines create this discrete border and they say you define the product market by measuring consumer response. And I would agree, if you take Roger's hypothetical in the purest sense, that people who live in Northern Virginia, or an employer based in Northern Virginia, cannot buy an insurance product from an insurance company that's licensed only in Maryland and not licensed in Virginia.

So, by definition, therefore, in that sense, you can say that the consumers of a product in Virginia can't buy a product from someone who's not licensed, nor can they buy an HMO product from an HMO that's only licensed in Richmond and not licensed in Arlington.

But the antitrust analysis, when you're actually doing an investigation, doesn't go in these little clumps, like, well, let's do the product market, and we'll spend a year doing that and now let's do the competitive effects analysis. If, in fact, as David was saying, the companies that operate in Montgomery County could, in a minute, start selling HMO coverage in Arlington County, Virginia, then whether you viewed Virginia as the market would not be particularly relevant

to the question of who are the competitors in that market. You could consider the plans in Montgomery County to already be in that market.

And that raises the question that Roger and I were talking about during the break, which is, how do you then measure market share, which we haven't talked about at all because today's discussion is about market definition. If Barry Harris were here, he would say that absent exclusive contracts with the providers or absent some telling barriers to entry in health insurance, you ought to assign everybody the same market share because today's market share is no indication of what tomorrow's market share is going to be, and he would find some words --

DR. FELDMAN: I say nonsense.

MR. LERNER: And he would find some words in the guidelines to support that and Roger would say nonsense.

DR. FELDMAN: I am not disagreeing that entry into a geographic market might be easy. In fact, entry is a lot easier if you're already licensed in the same state. We found that an HMO that operated within a state can easily go into cities within that state where it's not already present. An HMO going from one state to another is a trickier question.

But I want to make it clear that we should keep these questions very separate and distinct in our minds. What is the market? How easy is it to enter? Who are the participants? What are their shares? They're all distinct questions.

MR. MONK: I guess I would argue that it just isn't that distinct, and this is piggyband Rrnng 1stuwdistArt-5.1 0

MR. BERLIN: Henry, do you have any reaction to the comments?

DR. DESMARAIS: Well, I'm truly getting a little confused because, like Art, I'm sort of agreeing with -- I think you have to look at the facts. We seem to want to focus on an HMO as if they're the only game in town and anyplace in this country and if they sneeze, somehow it has this monumental effect. I mean, quite frankly, most of our members are in multiple states. They're already competing and they may not have huge market share in some places, but they're there. They're selling product, they're available. So, I guess there's a great deal of competition. There could be more in some places, certainly.

But I guess I'm having a little trouble when we focus so narrowly on this one HMO and we want to make an issue out of that when, in fact, the employers in that area and even the employees and individuals there, have other options within that geography. What they're looking for, I think, is health benefits. And if they can obtain them in a variety of ways -- I'm not sure I'm following the issue in the same way.

I'm not so cavalier about this, you know, well, it's just a license, anybody can get it because our members dutifully choose, make business decisions, they

HMO was established under the -- it wasn't the first HMO but the first HMO that was established under the HMO Act of 1973 and it started to do business wherever it started to do business, you could say, well, it was the only HMO and it had all these different attributes and it was a very clear distinction. But if you said, well, who are you trying to steal business from, it was pretty clear who they were trying to get business from. It was from Blue Cross and the indemnity organizations.

Later, you could go through a period of sort of the HMO heyday and you could look at HMO planning documents, if you got your HMO planning documents, and you'd read who they -- and they would only be measuring the market share of HMO competitors. And I would go to them, to the senior executives, and I would say, well, you know, you're being investigated by the government here and all your planning -- and we're saying that there's these broad markets and all your planning documents only measure the market shares of other HMOs. And you'd find out, well, why is that? Well, it's being

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sense. Obviously, if there's some irrational consumer preference -- lawyers might say it's an irrational consumer preference, economists generally would say, well, it's a consumer preference, so it's a quality factor. So, if the employers in Portland don't want to be self-insured, it must be because self-insurance isn't good in their way of thinking of things and, therefore, it's different.

So, I think you do have to look at these differences. But I don't think you can go for this notion that there's -- you have to look at each situation tempered by some sense of anomalies about that local market that if the price went up, maybe they'd change their mind.

MR. MONK: I was just about to say the same thing, just on your point about the data. The data aren't just HMO data, they're just fully insured HMO data.

I think one has to look -- when you're looking at a specific market, you do have to factor in what the characteristics that are in that market at that time and whether the characteristics changed because there was a change in -- either the market was currently in balance or out of balance. Let's take, for example, Texas in 1998. Almost all of the insurers were losing money.

for it to be an HMO? First, Roger?

MR. BERLIN: Do you mean for licensing purposes?

MS. MATHIAS: Licensing purposes.

MR. BERLIN: Or for market definition purposes?

MS. MATHIAS: For market definition purposes is what I'm going to do first for Roger and then --

DR. FELDMAN: I'm glad I wasn't asked the licensed purposes question. I think that question deserves a multi-part answer because it really gets to the heart of what we've been discussing this morning and you know my view, that there is a product continuum and you could think of one end of the continuum -- in fact, the slide that David put up earlier -- as being the conventional fee-for-service insurance, and the other end being the pure staff model HMO. And, originally, that was all there was. There was a big empty space in the middle. Lately, the space has been filling up with all of these hybrids. Recognizing that as a fact, however, is not the same as concluding that all products are equally close substitutes.

In logic, if A is better than B and B is better than C, then A is better than C. But in product substitution, A and B can be substitutes, B and C can, but that doesn't mean that A and C are. So, I still

think there is room for multiple products along that continuum.

The way that you define them is back to the old Smith-Barney way. You work at it. For example, Ann Royalty and Neil Solomon did a study of employee choice at Stanford University. The question there is whether PPOs competed with POS plans, which are the hybrids with some degree of choice that HMOs offer. There, they concluded that POS and HMOs were, in fact, close competitors. You have to -- I'm just going to give you the economist's answer here. You have to go out and look at the substitution between these different types of products.

While price differences don't necessarily mean there are different products, I think that price differences among these options are interesting and important. For example, HMOs are still about 20 percent cheaper than conventional plans. David, I don't agree with your evidence, and it might be right, but it was, first of all, 1998 and, second, selective to one region. According to the latest Kaiser Family Foundation survey of national employers, the average difference between HMOs and conventional plans is still close to 20 percent. Now, there's got to be something different about those plans or else they couldn't charge 20 percent more for

the fee-for-service plans in equilibrium. It doesn't necessarily mean they're separate products, but it certainly means that they are compensating along some dimensions that are still important to consumers.

MS. MATHIAS: David?

MR. MONK: On the price issue and the cost issue, the -- it was one region, it was 1998. The Mercer studies -- Mercer has done this study every year for at least the last 10 or 12 years. Their current 2002 study says that, in fact, the converging trend continues. It was just in the Midwest, although the evidence in the southern region was virtually the same as that in the Midwest. The Northeast, for some reason, there are much broader differences in price. But I don't know that you can -- I don't think that you can look at that difference in price, and Roger just said, you can't just look at that difference in price, and absent any other information, conclude whether it's one market or whether the same market or not.

But I think the evidence that I've seen does seem to suggest as the products have -- the lines have blurred, the prices have converged and that certainly should be factored in.

MS. MATHIAS: I have a quick follow-up question just as to those two surveys. Earlier somebody said that

you cannot -- you have to look not at the list prices, but at the actual prices that are being negotiated and I was wondering if either of you know whether those two studies that you're referencing, are they looking at the list prices or are they actually looking at what the negotiated price was when all was said and done at the end of the day.

DR. FELDMAN: Gee, that would make the HMOs even cheaper because they still have less cost sharing.

MR. BERLIN: Changing gears here a little bit, Dr. Ginsburg first highlighted what I think he called the key role of employers in these issues and I think several of you, Roger, you, in particular, I remember followed up on that point. And I'd just like to get, you know, perhaps starting with Art and Dave, your reaction or your view to the role of employers in defining health insurance markets, particularly given their role as an intermediary between the plan and the consumer and the patient, and also now that we're also hearing things about, you know, consumer-directed plans, maybe let's bring this back in that direction. So, what are your views on that?

MR. MONK: When I was referring in my talk to the employee contribution strategy, that's, in fact, exactly what I'm talking about. How does an employer choose how much the employee is subsidized for its care? In a very quickly dwindling number of cases, some employers do, in fact, cover 100 percent of the insurance. In those cases, changes in price have no effect on the employee. They may well have an effect on the employer, and that's why you'd need to look at employer response and employee response in looking at the

marketplace.

On the other hand, there are some employers that are more and more pushing the employee contribution towards -- kind of asking the employees to cover more and more and so, they might be faced with a 5 percent increase in the cost of the HMOs or the PPOs, but the employee might see a 15 or 20 percent price increase because the employer has changed its strategy.

So, it certainly adds a complexity to the whole

The other thing I was going to mention, and I think it goes back to this distinction that David isn't so sure how important the distinction is and Roger says, of course, how central that distinction is on this question of, you know, being the market as opposed to a competitor being in the market in terms of what is the market versus who's a supplier that's in that market. If you view a managed care provider, whatever kind of license it has and imagine it as exercising market power in some way other than tying up the provider community with exclusive contracts or something; in other words, if you view it as exercising its market power over consumers and employers, but not, for purposes of discussion, depriving others of access to the provider community, then if they raise price and are notably seen as being a monopolist or perceived as being one even if they're not, the employer community, in some places, has responded by, A, setting up their own HMO, years ago, setting up employer coalitions that basically say, well, gee, this HMO has got -- or insurance company, whoever it is, has this huge mark-up, why don't we go direct to the hospital community and to the provider networks and cut our own contracts.

Some of these programs don't work very well because they find out that what they thought were

monopoly prices maybe weren't so monopoly prices and there's really not all this fat that they think they can cut. But certainly the employers in those areas -- and I think Paul's studies show that in those communities where there's a very active, in particular, sometimes large employers with a vested stake in this, do constantly remind the plans that, you know, we could do without you, we could go direct in one form or another.

Paul's studies also show that in some communities where there's a lot of smaller employers, maybe, or no particular leading employers or no history of it, the employer community is rather passive about some of these things. But I think that bears -- I think it does bear on market definition, but it bears also, and perhaps more centrally, on competitive effect analysis.

DR. FELDMAN: I just want to make sure it gets read into the record that the best published study in this area is by Jessica Visnis and co-authors, who found that total premiums, that is the employer plus the employee paid a portion, are lower in firms that offer multiple choices and structure the employee's premium contribution so as to make them sensitive to the price differences between those choices.

In my study in the Twin Cities, the employer that offered those two restrictive plans didn't drop the

choices, multiple options for their employees. They use, what I call, the employee contribution strategy. What they're asking the employees to pay, they jigger those, thereby, changing the incentives of the employee. And you can measure, as the employee's incentives change, do they switch. And if you find that they switch, then I think you've got the two products in the same market. If you find they don't switch, then maybe they are complements.

MR. BERLIN: Okay. I'll throw out what I believe we'll call our last question, although we'll see how many responses we get. We've heard Dr. Desmarais say that there's 16 million individual purchasers of health insurance in the United States versus the group market and my question is, should we consider this individual market or should this be treated as a separate product market or, perhaps, as another dimension of the continuum in determining this.

Art, I think I understood you to say no in your presentation and --

MR. LERNER: No, I was only saying that one wouldn't want to concede it off the bat.

MR. BERLIN: Okay. Well, why don't you just start off and then we'll go around?

MR. LERNER: Actually, I don't know because

I've never actually thought about that a whole lot, and that ought to make me not say anything right now at all. I don't know.

DR. FELDMAN: That 16 million number seems sort of high. I thought it was like 5 percent.

DR. DESMARAIS: The numbers are 16 million and that's 16 million people under the age of 65. So, it's not picking up Medigap or anything like that.

DR. FELDMAN: Oh, okay.

DR. DESMARAIS: But the number does vary depending on who you look at. Sometimes it's 12 million and so on.

MR. LERNER: You go through the merger guidelines or the courts to the extent that they don't use the same test.

DR. FELDMAN: Under some proposals for tax credits, the markets would become much more similar and the employer might even disappear as an agent. But the way things are set up now, I'd probably argue they're separate because the decision to get one or the other is essentially an employment decision. Do I work for an employer that offers a group policy and I would argue that that decision is fairly insensitive to the price of insurance since it depends on so many other things.

MR. LERNER: And I think it will probably make

the supply-side substitution issue critical, which, depending on how you look at it, may not be relevant to the market definition question but would be relevant to a competitive effects question. If a carrier is offering one or the other of these products, if they didn't offer both already, could readily jump back and forth, even though the consumer couldn't jump back and forth. So, those questions about whether the group carrier could jump into the individual market or the individual carrier could jump into the group, I think would be important to assessing the competitive -- to the competitive effects analysis.

MR. DESMARAIS: What I would say is there's certainly differences on the part of the consumer. They're paying the full cost, so there's no employer subsidy. So, that leads to very different dynamics between the consumer and the seller in this case. The products are also very differently regulated at the state level than group coverage and that also, I think, has

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purchasing for different reasons, have different options available to them about whether to get into the work force and get a group coverage. So, there's a great deal going on.

I will say that there are a number of insurers who are not in the individual market because they do not view it as good a business climate to be in and they are in the group market. In other cases, the same insurer is in all these markets. So, again, there's a lot going on.

MR. BERLIN: David, you get a chance to get the last word on this issue and on the panel.

MR. MONK: So, unfortunately, I don't really have much to add to it. It's not a question that I've looked at, so I really don't have an opinion as to whether -- what the answer would be. But I agree with Art that it seems more likely that it would be driven by the supply side as opposed to the demand side, which means, depending upon your view of how the merger guidelines should be employed, it may or may not be relevant to the market definition question.

MR. BERLIN: Okay. We will reconvene at 2:00 today with a panel discussing competitive effects for mergers in these markets that we've discussed this morning.

Before we go, if we could give a hand to our

panelists for coming today.

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AFTERNOON SESSION

(2:04 p.m.)

MS. LEE: Good afternoon. Welcome back to the Department of Justice and Federal Trade Commission's Hearings on Health Care and Competition Law and Policy. I'm June Lee, and David Hyman, Special Counsel at the Federal Trade Commission, is co-moderating this panel. This afternoon's session is Health Insurance Monopoly Issues: Competitive Effects.

I would like to thank each of the panelists for speaking and look forward to hearing their insights on this topic. I will give each speaker a very brief introduction and refer the audience to the handouts for complete biographies.

After the speakers are done, we'll take a short break and then Dave and I will ask questions of panelists and I also invite the panelists to ask questions of each other.

There are a couple of absences on the panel. Helen Darling will be joining us late. Mike Mazzeo, on the advice of his doctor, was unable to travel from Evanston, Illinois. He will give us his presentation by phone, though fortunately, his PowerPoint slides are here.

We're first going to start with Lawrence Wu,

who will give us a general introduction to the topic of competitive effects and health insurance monopoly. Lawrence is Vice President at NERA. Lawrence?

MR. WU: Well, thank you for inviting me to speak on this very important issue. Over the past three decades, the health insurance industry has seen dramatic changes both in terms of the products that have been offered and the nature of competition in the marketplace. And we've come a long way from the time that economists were concerned that competitive health insurance markets may not even be possible due to factors such as adverse selection and imperfect information. Today, I think there's little doubt that competitive health insurance markets are not only possible, but also likely.

My comments today will focus on three questions. First, what is harm to competition? Before we start talking about competitive effects, we ought to define it.

Second, when evaluating allegations about the exercise of market power, what kinds of dynamics should we consider? Put differently, what are the conditions that keep health insurance markets competitive? I think this is important because part of an evaluation of competitive effects of a merger or business practice is an articulation of how that merger or business practice

changes competitive conditions.

And, third, what are the measures and methods that can help us evaluate harm to competition and are they useful in identifying changes and competitive conditions?

So, let's begin with an overview of what constitutes harm to competition. Competition has been harmed when the process of competition has been distorted in a way that leads to prices rising above competitive levels or quality falling below competitive levels for a sustained period of time. Thus, to evaluate whether a merger is likely to harm competition one would determine, for example, in a merger matter whether the merger would enable the merging parties to raise price above competitive levels for a substantial period of time.

An important part of this analysis is to consider whether the forces that are driving competition prior to the merger will remain, and therefore, continue

So, in the U.S., health insurance markets are generally viewed as being competitive, at least that's the consensus among the health economics textbooks that I glance through, and I think that's a good starting point for a competitive analysis because if we can identify whether and how a merger or business practice has changed or is likely to change competitive conditions, then we can begin to articulate a theory of competitive harm.

So, let's start at the beginning with an overview of the conditions that I believe generally make health insurance markets competitive and these are the seven -- there are seven I'll discuss today and we'll go through those seven. Again, I want to think about those seven because I think they will help us evaluate the indicia we typically look at when evaluating competitive effects and exercise of market power.

Now, each of these elements can be put together by insurers on the supply side or by employers on the demand side in any combination they choose. And what this means is that many of the services provided by an insurer can be unbundled and combined again. So, for example, on the one hand, there are HMOs and PPOs that perform all of these functions in-house, and at the other extreme, there are health plans who outsource all of these functions.

So, for example, there are employers who choose to be self-insured, thereby bearing the financial risk, but contract with a third-party administrator for claims processing and other administrative services. Of course, there are all the permutations that fall in between these two ends. For example, many health plans choose to perform the claims and benefits processing and they do the utilization review, but they also contract with a third party to obtain access to a network of providers.

And, in fact, there are companies that specialize in each of the functions that comprise health insurance coverage. There are scores of third-party administrators who specialize in claims processing and benefits administration and a fairly large number of companies whose primary business is to create a network of providers that they then sell or rent to other

insurers or employers.

I think if we think about health insurance as the business of putting together the various contracts and functions that are needed to pay for health care services, then I think it's a little clearer why many view the industry as being fundamentally competitive.

Number two, the ease of expansion. The business of health benefits coverage is primarily about the contractual relationships that a carrier has with its health care providers and with its customers. And because of this, capacity constraints don't have much meaning for health plans and that is because, with

That's number two.

Number three, in health insurance markets, buyers generally are informed and sophisticated customers and this is -- there's one important reason why the insurance market is competitive and that is because most of the shopping is done by employers. Now, employers are informed and sophisticated because they also rely on a whole other industry to help them stay informed, that industry being comprised of brokers, agents and consultants. They help employers devise a solution that best fits the company's needs. They give companies advice on designing a health benefits plan, and in so doing, they can facilitate the entry and expansion of insurers, large and small.

Consultants here play an especially important role in the facilitating substitution from one insurer to another. So, for example, consultants can help employers develop a request for a proposal which is then sent to competing health plans, and because consultants also help employers design the proposal and select the winners, they facilitate the process by which substitution can occur among the various insurance solutions in the marketplace, and that substitution is at the heart of competition.

In health insurance markets, competition takes

place in bidding contests. When employers make decisions about the health benefits plans that they offer their employees, they typically put it out to bid. For large firms, it's typically a more formal process where the consultants might actually survey the firm's employees about their preferences and then follow up with a design for a health benefits plan. It's not just the large firms that can benefit from that, but small to mid-size firms as well who rely on brokers to do the same thing.

Brokers might also design and develop a request for proposal, and it could take place on a formal basis, but again, it could also take place on a less formal basis. But, again, they might go to individual carriers, get the rate and benefit quotes and bring it back to the employer.

Again, once we recognize that competition takes place through bids and RFPs, the role of brokers and consultants in facilitating substitution and in facilitating the entry and expansion of a smaller carrier becomes clearer.

The next condition, the willingness of individual consumers to switch health plans based on price. Even after a health plan is selected to be among the plans offered to employees, the competition has just begun, and that's because the empirical evidence suggests

employers, and with the help of their consultants, determines the premiums to be paid by its employees for each plan. In other words, the employer has tremendous bargaining power because it can essentially dictate the nature and terms of competition among the health plans, not just only competition to be among the plans offered to employees, but dictate the terms of competition that drives consumer choice.

And the last condition I want to talk about is entry as an effective source of competition. Now, this is the subject for a hearing that will be held tomorrow. So, let me just show you one picture, one picture that basically tells 1,000 words.

In 1994 in the Atlantic City, New Jersey, area, the leading health plan was Blue Cross/Blue Shield of New Jersey, which had a 38 percent share of HMO/POS enrollment in that metropolitan area. In just four years, there were eight new entrants. As you can see, they did well. In 1998, the entrants, which is the party of the pie that's blue, collectively had a 47 percent share of HMO/POS enrollment in the area. These are plans that did not exist in 1994 in Atlantic City/Cape May.

What happened to the share of the largest plan in 1994? That's the pink slice of the pie which belongs to BCBS of New Jersey, and that share shrunk by 17

percentage points. Among the new entrants is AmeriHealth, which in three years time became the leading

competitive conditions.

There are a number of indicia that are commonly used to evaluate harm to competition and health insurance markets, but three stand out and they will be the ones I talk about today. One is market shares and share-based market concentration statistics, like the HHI. Second, medical loss ratios or profits margins. And, third, elasticities of demand which measure the degree of consumer price sensitivity.

Let me start with the usefulness of the market share information because market share data are so commonly cited and relied upon. But I think we really need to be cautious when we think about market shares because they really tell us very little about a health plan's market power and I want to tell you why I think that's the case.

First and foremost, an analysis of market shares is typically a restatement about one's conclusions about market definition. So, a person who believes that the relevant market is comprised of HMO enrollment in a particular city is likely to calculate shares on that basis. And someone who believes that the market includes all health insurance sold across the state is likely to calculate market shares that wayy I think

what I want to point out is that even if there were no dispute about market definition, there are still many reasons why a snapshot of market share data would not provide us with much information about the degree of competition in that market.

First, market share is not a useful indicator of a firm's ability to compete when expansion or entry is accomplished easily, and that is because market share is a measure of a firm's historical success rather than the ease with which it can expand in response to an attempt to exercise market power. And this is especially true for a smaller insurer whose enrollment could easily double or triple if it wins one or two accounts. And in this way, an insurer's enrollment could change dramatically from year to year. So, in other words, market share can under-state a smaller firm's ability to compete just as easily as it can over-state a larger firm's ability to compete.

Second, in a bidding environment, aggregate market shares tend to be a poor indicator of competitive viability. With one competitive bid, a health plan can get a lot of business right away. Thus, a carrier's market share, if it is based on past enrollment, is a poor indicator of that firm's capacity to compete in the future.

Next, it's hard to interpret high market shares even when they are stable or when a health plan consistently has a high market share. Now, why is that? One issue is that data on market-wide enrollment and shares hide a lot of competitive activity and churn, and with consumers so sensitive to price, this is not surprising, but something very important, something we need to continue to be aware of when we evaluate market share statistics.

There's a lot of enrollment and disenrollment, so even though aggregate shares may appear stable, there is still a lot of switching by individual consumers.

Fourth, market share is also an indicator of relative efficiency or quality; that is, firms with high market share may be the more efficient, higher quality and innovative health plans in the market who are being basically rewarded for the services they provide.

Fifth, enrollment and shares often do not account for all the ways that health insurance can be arranged. Data on HMO and PPO enrollment, for example, do not account for the ability of employers to develop self-insurance plans or the ability of another health plan to reposition itself.

Six, there are frequently issues related to the data that are available and this is very similar to the

previous point. Data are generally available for HMOs, but data on PPO enrollment is much poorer. Part of the reason is that PPOs are less regulated than HMOs and thus lack many of the reporting and operating standards that HMOs have. So, it's hard to get accurate data on PPO enrollment. It's even harder to get data on indemnity plans. But these are all important health care insurance solutions.

Now, I don't want to sound too dismal, so let me offer some suggestions on the indicia that might be helpful in evaluating competitive effects.

If we are to focus on enrollment and shares, I think it's useful to study shifts in market shares over time and I think this would be a great way to test whether entry and expansion, in fact, is easy. The problem, as I mentioned earlier, is that with a static analysis, it's possible that the market might be served by a handful of large firms and many, many small firms, and although one might want to conclude that small firms stay small and big firms stay big, this is typically not the case and definitely not a safe assumption in an industry where we have seen big health plans fail and many small firms rising to the top.

Looking at profit margins or medical loss ratios are also frequently done. In the case of health

insurance, one commonly computed statistic is a medical loss ratio which is the ratio of medical expenses to premiums. If a health plan has high and persistently low medical loss ratios, which may correspond to higher profits, that could be one indicator consistent with the proposition that the plant has market power.

But even here, we're not all the way home because there are still issues of measurement and interpretation. For example, medical loss ratios tend to vary widely by product and the medical loss ratio may fall if the health plan is doing many of the things employers really want health plans to do, like take on responsibilities to assure quality, profile providers, review utilization, and these are all functions that reduce medical cost, yet require administrative resources. And so, these are responsibilities that might lead to lower medical costs and lower medical loss ratios.

And the last one I'll mention, the last statistic I'll mention is the elasticity of demand, which is a concept that has found its way into many studies of market competitiveness in health insurance markets and a high elasticity of demand, which is typically the finding, would suggest that consumers are willing to switch health plans in response to changes in price and

this would be a finding consistent with competition. Such an analysis is likely to involve an econometric study and there are numerous approaches that can be taken.

So, in the end, conclusions regarding the competitive effects of a proposed merger or business practice are likely to rest on a number of facts. For example, evidence of harm to competition could include a demonstration of high and sustained prices and/or high and sustained profit margins. And to corroborate the analysis, a study of the relevant elasticities of demand might also be helpful.

Also, an analysis of competitive harm should include a clear articulation of the ways in which a merger or business practice would result in higher prices for a sustained period of time. And to do this, what we really need is an explanation of how competitive conditions have changed or are likely to change as a result of a merger or business practice.

I have an open mind, but, in general, health insurance markets do have many of the features that help to ensure competition. And to paraphrase the title of a song written by Paul Simon, that is because there are probably more than 50 ways to leave your health plan. So, I'm going to use that to summarize the competitive

dynamics that I think form the start of an analysis of competitive effects. Now, again, I focus on the competitive conditions because what we want to focus on is how a merger or a business practice changes those conditions.

Just slip out the back, Jack, and turn to another health plan, which is made easier by the willingness of individual consumers to switch plans.

Make a new plan, Stan, because with the help of brokers and consultants, health insurance can be arranged a number of different ways.

You don't need to be coy, Roy, because employers are informed and sophisticated.

Just get yourself free.

Hop on the bus, Gus, because health plans can expand easily across geographic and product space.

You don't need to discuss much because competition takes place in a bidding environment.

Just drop off the key, Lee, because the key is effective entry.

And get yourself free.

Thank you for the opportunity to speak today. I appreciate that.

(A a .)

MS. LEE: Our next speaker is Mike Mazzeo,

who's a Professor of Management and Strategy at the Kellogg School of Management at Northwestern University. He is joining us by phone, so I'm going to adjust the microphone. Let me know if there are any problems listening to him. We do have his Power Point slides, so Julia, can I ask you to move those along as he's going.

DR. MAZZEO: Good afternoon and thank you for giving me the opportunity to present to you today and, in particular, for the opportunity to present remotely.

I want to talk today about some recent research that I have done regarding the question, how does product differentiation affect competition in HMO markets.

What I will discuss this afternoon are the highlights of a paper that I have co-written along with my colleagues at Kellogg, David Dranove and Ann Gron. The title of the paper is Differentiation and Competition in the HMO Markets, and it will be published later this year in the Journal of Industrial Economics.

I've left most of the technical material out of this presentation, but have submitted a copy of the

differentiation has the potential to reduce competition among HMOs, particularly if consumers -- and here I mean employers -- of HMOs don't find the products offered by differentiated firms to be perfect substitutes. Unfortunately, as was previously described, given the nature of the HMO industry, some of the standard techniques used to evaluate competition and differentiation are not feasible.

Lawrence talked about calculating demand elasticities. It's problematic for HMOs since prices are determined often by individual negotiations between HMOs and employers and because the specific services included can be different on a contract-by-contract basis. However, more simple competition metrics, such as concentration ratios, can be misleading to the extent that they don't explicitly account for the effects of product differentiation.

Therefore, we have utilized a different framework for measuring the effects of additional competition on HMO profits, one that specifically distinguishes between the impact of competitors based on whether they offer differentiated services or whether they offer similar services to the other HMOs in their market.

As I will discuss more below, we compared two

types of HMOs in this study, ones that operate only locally and ones that have a regional or a national network available throughout the United States. The results that we found, using geographic scope as the basis for classifying differentiation, were striking. However, other forms of differentiation could be examined using this framework as well.

We estimated our model using data from a cross-section of small MSAs and other large rural counties in the U.S. These markets varied considerably in their demographic characteristics and in the market structure of the HMOs in the area. The HMO data that we used for this study came from the interstudy data set for the year 1998.

Just a note on the geographic scope product differentiation of HMOs before we get started. The histogram in this slide indicates that most of the operating HMOs that we identified operated locally. So, there were a total of 137 HMOs in our data set and 112 of them operated in areas that represented less than 5 percent of the U.S. population. In contrast to those, there are a handful of HMO firms that operate over a very wide geographic area, some approaching a national network.

National HMOs may be more attractive to certain

employers, ones that have multiple establishments spread across the country, as they can offer one health plan to all of their workers by contracting with this national HMO, provided that they're available in each local area.

Other employers may value local HMOs more highly, particularly if these HMOs have ties to particularly local service providers that are prominent in the community.

So, our empirical framework is based on the concept of entry threshold ratios, which were introduced into economics by Bresnahan and Reiss in the early 1990s and which have helped guide policymakers since.

This methodology is based on the following basic insights. Firms will enter markets only if the costs of doing so are less than the profits that can be earned once the firms have entered. These post-entry profits can be divided into the profit margin earned by operating firms and the quantity that they sell. How does competition enter this framework? Well, if it turns out that markets with more operating firms are also more competitive, which results in lower profit margins, then the quantity that firms need to sell post-entry must be larger to make up for the lower margins and to still offset the entry costs. A priori, we don't know the extent to which additional competition reduces margins,

but we can infer this by comparing market size per firm, a measure of quantity, across markets of different sizes.

So, let me explain a little bit more about that. Such a comparison is done by calculating entry threshold ratios in a cross-section of markets in a particular industry. So, markets are grouped based on the number of firms that are operating, then the average market size, composed mainly of population, but also weighted by other demographic characteristics, the average market size for markets in each group is then calculated. So, the entry threshold ratio that coincides with the Nth competitor in a market is the ratio of the average market size per firm in markets with N firms over the average market size per firm in markets with N minus one firms.

If this ratio is greater than one, then we can infer the following: The entry of the Nth firm reduces margins for operating firms in the industry. The logic is straightforward. A larger market size per firm is associated with markets that have that one additional Nth competitor. The fact that this extra quantity is needed suggests that competition is more intense once you have that extra firm in the market.

However, if the entry threshold ratio equals one, indicating the same market size per firm in markets

with N firms and markets with N minus one firms, then we infer that the presence of the Nth firm does not reduce industry margins. The quantity needed to support one additional entrant has remained the same.

So, Bresnahan and Reiss calculated their entry threshold ratios for a number of relatively homogenous service industries and I've graphed the pattern here on this slide and the pattern that they found, looking at these homogeneous industries, was very consistent. The entry threshold ratio for the second firm entering these markets was significantly greater than one, indicating that moving from monopoly to duopoly reduced margins substantially.

As the number of firms in the markets increased, the entry threshold ratios in these industries converged toward one. This was interpreted to indicate that a competitive market was achieved once these industries had four or five operating firms since the

as you can see from the raw data, we had a total of 263 markets included in our data set and most of these markets had between two and eight operating firms.

Once we matched these markets with their market sizes and calculated the entry threshold ratios for HMOs, we found a very striking pattern. Now, it's useful to compare the HMO findings by super-imposing the ratios on the same graph as was shown on the earlier slide. So, here, in contrast, we see that the second operating HMO has an entry threshold ratio that's very close to one. Now, remember, this indicates that the second HMO in the market does not cause profit margins to fall. Only when a third HMO enters do we see the entry threshold ratio rise to above one, and there, it is comparable to the second firm in the other industries that are listed on the graph.

After three firms, the entry threshold ratios for HMOs follow the same pattern, reducing toward one, albeit a little more gradual than the other industries.

So, it appears from these data that there's a fundamental difference between HMOs and the other industries studied using this technique, and the presence of competition reducing product differentiation can help explain these striking results. If there are, for example, two distinct types of HMOs that don't compete

are grouped for this analysis based on the values of the ordered pair. Second, we estimate an underlying economic relationship for profits of HMOs using the cross-sectional data.

Parameters in the model incorporate two types of effects. Market effects, such as population and other demographic characteristics, are allowed to have a varying effect on the profitability of local HMOs and national HMOs, and the competitive effects reflected on the profits are reduced by the entry of another competing HMO. Importantly, these competitive effects are computed separately for same type and for different type firms. So, a key comparison that we can make is the following: How does the presence of one local HMO competitor affect the profits of a local HMO and how does that compare to the effect that the presence of one national HMO competitor has on the profits of a local HMO?

Now, here is the slide with the list of the product type configurations in the data set that we've put together here. The histogram presents the raw data across our markets and the ordered pair of operating firms for each type are on the axis and the number in the table reflects the number of markets that have the corresponding prior type configuration as their market structure.

So, for example, there are seven markets with the 0/1 product type configuration, that is zero national firms operating and one local HMO in the market. Before reviewing the empirical results, it is useful to note the striking pattern of product differentiation in HMO markets that is reflected in the numbers in this table. This is evidenced by the relatively large numbers on the diagonal of the table as opposed to the edges.

For example, let's look at markets with exactly two HMOs operating. We see that 24 out of the 31 such markets in the data set have the 1/1 product type configuration. This pattern continues as the number of operating HMOs increases. This provides further evidence that product heterogeneity is important in HMO markets as evidenced by the patterns of entry that have emerged across the markets in the U.S.

If there is one operating HMO and that HMO is part of a national network, then the next entrant into that market is very likely to be a local HMO and vice versa. So, along with the evidence from the entry threshold ratios, this appears to indicate a strong relationship between product differentiation and competition reduction in HMO markets.

Now, I only want to briefly mention the estimated parameters in the model. The key results,

again, are outlined in more detail in the paper. On the competitive effects, the important finding is that the effect of same type competitors is much larger than the effect of competitors of the other type, which are negligible. This is true for both the local HMOs and the national HMOs in the markets that we studied. Such results are clearly in line with the differentiation pattern in the raw data, which were seen on the previous slide.

Now, in addition, we have the market effects and the interesting fact to note here is that some of the demographic characteristics of markets affect the profitability of local and national HMOs differently, thus attracting each of these to their markets in greater proportion.

I highlight one difference here, the share of a market's residents that are age 65 and above. In markets with more older residents, national HMOs were found to be more prominent than local HMOs, which may reflect advantages that national HMOs have in serving elderly patients more efficiently. Either way, the difference in these estimated parameters suggests that the connection between market structure and competition would be potentially different depending on the particular characteristics of the markets in question.

research that I'm going to be talking about and also acknowledge my colleagues, Austin Frakt and Robert Coulam, with whom I worked on some of this research.

When we were contacted about testifying or presenting today, we were given a number of questions to think about. So, in a different order I've reproduced them here. The one that really struck me the strongest was when should the agencies be concerned about coordinated effects arising from a merger. So, that's the question that I kind of have in the back of my mind when I'm talking. And there are some answers to that question that were suggested by some of the other discussion points. One is, when products are close substitutes. So, if two firms are merging and the products that they supply are substitutes for each other or there's lack of product differentiation, there might be a reason for concern.

When demand for the products is inelastic, and that could be because of brand loyalty was one of the reasons that was suggested, but there are other reasons that I'll suggest later. And one that wasn't suggested in the discussion points is, when industry concentration already has demonstrable effects on price and on quality. And I'll -- the results that I'll present today will really focus on that area.

Why focus on Medicare? There's less group purchasing and self-insurance in the Medicare market than there is in the broader market for the working population. It tends to make markets more local, I would argue. Product differentiation is constrained by regulation of the products, so there's more homogeneity of products. And demand for insurance, at least in our experience, seems to become less elastic with age; in particular, as Medicare beneficiaries get into their late

charge a premium. Plans may offer benefits above the standard Medicare package. The most attractive of these benefits is prescription drug benefits, outpatient prescription drug benefits and there's quite a variety of the generosity of those benefits that are offered.

Just a little bit of background about competition in Medicare Plus Choice. There's been a lot of concern about it. There have been attempts to introduce competitive pricing as a means of setting payment rates in Medicare Plus Choice. For a number of years, those attempts have not been successful. So, payment rates continue to be established through an administrative mechanism with Congressional input.

Since historically many of these plans have charged zero premiums, competition often is limited to competition on benefits. This is a little less true in recent years as premiums have become more common. As I'll show you shortly, the Herfindahl Index and the actions of other plans do affect premiums and they also affect benefit decisions.

And, finally, there's a new type of plan that just came into being in the last couple of years. It's called a private fee-for-service plan. It's different from traditional HMOs, much more like a fee-for-service indemnity plan and there's two plans right now I'll be

talking about. One of them that has recently entered a number of markets where HMOs exited and it might represent an important source of new competition, but it's still very small right now.

So, I'm going to be talking about two studies. The first was engendered by the passage of a new payment law in late 2000, which created a natural experiment and this was valuable for us as researchers because it gave us the opportunity to separate the effects of payment rates and of competition variables like industry concentration from the effects of unobservable costs, and then we could compare the effects of payment rates to the effects of competition to get a sense of how important our competition variables were. That's the first study.

The second study focuses on the private fee-for-service plan that began enrolling beneficiaries in June of 2000. And this gave us the opportunity to study market entry and to learn a little bit about how the same competitive variables that we were looking in the first study affected the probability of market entry.

So, just talking about the first one, Congress passed the Benefits Improvement and Protection Act -- the acronym is BIPA -- in late 2000 and what that did, among many other things, was to mostly increase payment rates that had gone into effect in January or were set to go

into effect in January of 2001. So, ordinarily in Medicare Plus Choice, there's sort of an annual ritual dance where data is collected, payment rates are established, plans made decisions in response to that in terms of what benefits they're going to offer and what premiums they're going to offer and what markets they're going to play in. And then in January, all these plans take effect and the process starts again for another year.

Since the underlying costs change over the course of the year, it's a little hard to separate the effects of the changes in underlying costs, say changes in prescription drug costs, from the changes in the payment rates. But in the wake of BIPA, a set of payment rates and a set of benefits and premiums and market entry decisions went into effect January of 2001. Then the effect of BIPA hit and everything changed as of March of 2001. So, we had an opportunity to isolate attention on the effect of the payment rates without having much underlying change in cost.

I'll run very quickly through the data. We had data for January and March of 2001, which is the key time period, and we merged data from a number of different sources, which I won't really go into.

The sample, we had about 1,100 planned counties

for whether or not the plan charged a premium, that other premium variable would reflect whether any other plans in the county charged a premium. If the equation was for what the premium level was, then that other premium variable would be what the average premium level was for other plans in the county.

Actually, let me emphasize that on both the Herfindahl variable and the other premium or other benefit variables, those variables are lagged by one time period. This is a bit of a technical concern, but one that gets at something that Lawrence mentioned earlier. We want to make sure that we get the causation right and there's a little bit of concern about endogeneity about these variables, so we lag them one period to address that.

This is just the list of the supply variables and the demand variables. Things that you might expect like historical Part A spending for an idea of what the geographic -- the historical geographic costs are in the area, the number of physicians per capita, urban/rural status, hospital beds per capita, some risk score data that we got from CMS, per capita income, proportion of population over the age of 65. We also included plan level fixed effects in this specification because the unit of observation is the planned county and we

recognize that a lot of plans don't naturally make all their decisions at the county level. There's a certain amount of stickiness in their decision-making because plans typically want to make the same decision for the same plan, at least in a region. So, there are plan level fixed effects in these equations to account for the fact that plans try to make decisions across county lines.

These are some selected results with respect to the Herfindahl Index and there are four rows in this table, and I would call your attention to the second row and the fourth row. These are efforts to kind of standardize the regression results to make it a little bit easier to understand and to compare. The second row is the predicted effect of a 10 percent change in the payment rate. So, if the payment rate were increased by 10 percent, the probability of a plan charging a premium would go down by 35 percent. That's a big effect.

To compare that, if the Herfindahl Index were increased by 10 percent, the probability of the plan charging a premium in that county would go up by 7 percent. That's a smaller effect than 35 percent, certainly, but it's a significant effect nonetheless. And if you look across the entire table, you see that, in general, the effect of the Herfindahl Index was smaller

than the effect of the payment rate, but it's significant and it's of meaningful absolute size.

In the one case of the probability of offering drug coverage at all, that's the second column, the Herfindahl effect actually is strong and significant and the payment effect is not significant.

Here's some selected results for the so-called other variables and, again, the second and fourth columns make for easier comparison. And, again, the payment rates are -- have strong and significant effects and the other variables also have significant effects, but they are substantially smaller across the board than the payment effects, with the eqs, p/on of the equap/on the-lj-5.7 0 TD(

and those firmly establish that industry concentration and what other plans in the county are doing have strong effects on what a given health plan in a county will decide to do with respect to benefits and with respect to premiums.

What about with respect to entry? We looked at the entry decisions of the first private fee-for-service plan. Private fee-for-service is a new option. The way private fee-for-service works under Medicare Plus Choice is they function under the same payment rates, they have the same risk bearing, the same risk adjustment rules as other Medicare Plus Choice plans, but they have much lower entry costs than traditional HMOs because they don't have to establish or maintain a network.

However, they're more potentially vulnerable to adverse selection. This is because, as has been mentioned before, traditional HMOs tend to get favorable selection because of the restrictions that they impose on utilization, choice of doctor. But fee-for-service plans don't benefit from that. So, it would be reasonable for the private fee-for-service plans to be concerned about experiencing adverse selection and that might influence their market entry decisions.

The only private fee-for-service plan that was in existence in 2001 and early 2002 was offered by

Sterling Life Insurance Company. They entered in June of 2000 and they were in 25 states. By the spring of 2002, they had about 20,000 enrollees and they offered coverage similar to Medigap Plan C, which is one of the regulated Medicare supplement indemnity plans. They don't offer any drug coverage.

One of the questions or some of the questions that we were thinking about that I think are relevant to the discussion here is, does private fee-for-service compete with HMOs in the Medicare Plus Choice Market? What about with Medigap plans? Should these products be thought of as existing in different markets? We had data on all the counties in the United States. Again, our unit of observation is the county. Sterling entered about half the counties as of December of 2001. But they were very small. The average number of enrollees per county that they entered was six.

We estimated an entry model. What are the factors that influenced entry? And an enrollment model simultaneous with the entry model to see what factors influence enrollment. Here are some selected results. The first line is the HMO market penetration rate. So, Sterling was clearly attracted to markets where HMOs were established, where there was market penetration on the part of HMOs, which was kind of interesting, since

they're not an HMO plan. It had a significant marginal probability effect, which is that second column, but a negative enrollment effect. So, they were attracted to those markets, but they weren't terribly successful in enrolling people there.

They tried to avoid markets where Medigap Plan C premiums were high. That's the second row. But they were successful in enrolling people there. So, this isn't a big surprise. In counties where the alternatives were expensive, they were successful enrolling. I should say, Sterling, at this time, had one national premium.

The third line is the number of HMOs, Medicare Plus Choice HMOs. If there were a lot of Medicare Plus Choice HMOs, they tended to try to avoid that county and in counties with a lot of HMOs, they weren't very successful in enrolling people.

But in counties where the number of HMOs changed and, in particular, in this time period the changes were negative because HMOs were pulling out of the Medicare market, so where the numbers of HMOs were declining, Sterling tended to enter. Since the change in the number of plans was negative, that negative .14 results in a positive effect on entry and they were very successful enrolling people.

So, in this time period, one of the main

findings of the study is that as HMOs pulled out of the Medicare market, Sterling targeted, either purposefully or inadvertently, those markets and enrolled a lot of people.

The last row there is the Herfindahl Index and there's no significant result there, which we didn't look at all that carefully at the time. But I went back and looked and this is why. The way we defined the Herfindahl Index was, if there were no HMOs in the market -- since we originally built it thinking about the HMO market -- the Herfindahl Index was zero. We could have just as easily made it missing.

If you look at that graph, you see that there is an interesting effect and it's an effect where the Herfindahl Index, that second bar there is where the Herfindahl Index is between zero and .5. So, those are markets where the HMO market share is not heavily concentrated or relatively less concentrated.

So, while Sterling was about 50 percent likely to enter most counties in the country, they were less than 25 percent likely to enter counties that had less industry concentration in the HMO market, and that makes sense. If the Herfindahl Index is a good measure of competitiveness in the market, Sterling avoided competitive markets because the opportunities there would

be less attractive.

So, in summary, the main findings are that industry concentration affects premiums, benefits and market entry. Medicare Plus Choice plans adjust premiums and benefits in response to other Medicare Plus Choice plans in the county. The effects of competitiveness variables, industry concentration and such are smaller than the effects of payment rates, but they're still quite substantial. And private fee-for-service competes with both Medicare Plus Choice and with Medigap plans.

Some points of interpretation, I think these findings suggest that the markets for Medicare Plus Choice insurance are small, probably bigger than counties. Maybe MSAs are the appropriate market size. Again, HMOs, private fee-for-service and Medigap all do compete with each other for enrollees within these markets. So, that would tend to argue for grouping them together in a market. Arguing against grouping them together in a market is the well-known fact that HMOs experience favorable selection and private fee-for-service, fee-for-service and Medigap plans tend to experience adverse selection. So, that's a very important difference in the way that they make their decisions.

Finally, it's pretty clear from the evidence on

with 100 religions, there is peace." And we will have -- today, we have peace.

This is what I care to present today. I want to review recent trends in health care costs. I want to examine the underwriting cycle in recent years. This is important because I believe the underwriting cycle is largely determined by patterns of exit and entry. I want to examine the pattern of entry into local insurance markets and I want to assess why insurers have not entered markets in recent years.

This is the history of health insurance premiums since 1988. The survey is now the Kaiser Family Foundation Health Research and Educational Trust Survey, earlier done by KPMG and HIAA. I've just given you my resume.

Let's just very quickly go over it. We hit a peak of 18 percent in 1989. During this period of time, indemnity insurance was about 70 percent of the market. We have a growth of managed care during this period of time. We hit a bottom of eight-tenths of 1 percent in 1996. This is the high water mark for HMOs, for heavily managed care. At this time, HMOs had about 33 percent of the market share, but not only did they have the 33 percent market share, they had narrower networks than we have today. They had capitation, they had

come down now due to three-tiered cost sharing. But you can see they were in the 15 to 20 percent range for many years.

Inpatient hospital expenses are most interesting. During this period of very low inflation from 1994 to 1998, we actually had nominal decreases in hospital expenses per capita. If there's one thing managed care was good at was keeping people out of the hospital, and at that period of time, getting large discounts from hospitals. You can see in recent years there has been a big increase in hospital expenses. This is due to both utilization. It is due very heavily -- as a result of increased utilization, you have a shortage of nurses, and we can see last year that the increase was about 7.5 percent.

Now, this line right here, this is outpatient hospital expenses. This actually includes ambulatory surgery centers, which makes the numbers bigger. But, again, you can see, we've had a very large recent increase. This is also -- this is largely driven by volume. The point again being that managed care, which was able to control costs during an earlier period of time, does not show the ability to control costs as we had in that mid-1990s.

Now, let's go to the underwriting cycle.

Now, of course, when insurers start losing -- when they enter these new markets, they compete very fiercely through price. They price below the rate of the increase in claims expenses and they all end up losing money, which they did right here. Then they start exiting the market. With fewer firms in the market, they're able to raise their premiums and they're able to start realizing underwriting gains. That is the health insurance underwriting cycle, an underwriting cycle which is also seen in other types of insurance, such as property and casualty.

Now, how about the managed care companies? These are the ones that are publicly traded. This data are, actually, I think, from Lehman Brothers. I will have to look again on that. You can see, in the last four years, this was actually supposed to be 1.1 percent. You can see the growth in profitability among the publicly traded managed care companies, up from 1.1 percent to 4.4 percent. So, we do have a more profitable industry after going through some pretty hard years.

At the same time, though, the managed care companies are not earning as much on their investments. They are like everybody else and the interest rates are lower and you cannot obtain the same rate of return for bonds and bills, et cetera, let alone if you invest in

the stock market.

Now, I'm going to very quickly summarize the literature about HMO market structure and performance. I talk about HMOs in subsequent slides, not because I don't consider other lines of business important, but simply because as I think was noted earlier by Lawrence, I believe, there's more data available on HMOs.

Well, number one, we see through the literature that greater numbers of HMOs and local markets leads to lower premiums. There are economies of scale -- see, I've got all my footnotes in the audience just to flatter them, Ruth, see -- of 115,000 and we believe there are economies of scale up to that point, but then after that, they decline. Roger Feldman, he's in all these other three.

Despite the many national mergers which took place during '94-'97, this period of time was characterized by increased competition in local markets, which is one reason why we had that underwriting cycle. Concentration of the HMO industry is growing nationally, but it's local markets that determine the level of competition. Now, given that as background, let's look at the entry patterns in the last couple of years.

These are new figures. Again, it reflects the underwriting cycle. You can see during the 1980s, we had

a period of time in the 1980s, around '84, '85, '86, I believe, where there was profitability and there's a lag effect and a little -- but you can see the big entry that took place. Then we had a shake-out as the insurance industry lost money in '86, '87, '88, the industry lost money. You can see with the lag effect there was very little market entry.

The industry now is earning money and you can see that there's a little bit of a lag, but they start earning in '89 and here, by '91, we're up to 11 and you can see, during this period of time, the entry of new HMOs in the nation. And now, as we go into -- the HMO industry is losing money. There is no entry. And now, we're starting to earn money again, but we will have virtually no entry during the last couple of years. That's national statistics.

Let's just say, why should we be expecting HMO entry at the local level? Number one, we've had four years of underwriting profits, although there's a lag -- at this point, I would expect historical patterns, we would find some entry. There's growing profitability among the publicly traded MCOs and there's a limited number of competitors in many local markets. There's low-hanging fruit. For example, Norfolk, Virginia, which had about 10 effective competitors back in the 1995-1996

period, as of about two years ago, there were two effective competitors. And so, again, low-hanging fruit.

So, let's look at it on a per state basis. Look what happened in 1996 compared to 2001. You can see in all the states we have a decline in the number of licensed HMOs. Look at Illinois. What a sharp decline it had. Maryland, sharp decline. Maryland has a big HMO penetration.

If we look at Massachusetts, big HMO state. You see a big decline in the number of HMOs competing. Minnesota, a slight decline, big HMO state. Big decline in New Jersey. We looked earlier at how we picked up market share in Atlantic City. I wonder how many of those HMOs are still in business. You can pick up market share and lose a lot of money. That's one thing we know about the underwriting cycle.

Ohio, look at the very significant decline. Virginia, I'm aware of. Norfolk, for example, a very significant decline in the number of HMOs. And a big HMO state like Wisconsin has far fewer licensed HMOs. So, here we have fewer firms competing. The result is, according to the literature, we can expect premiums to go up more than they would if we had more firms competing, and we have had premiums increase.

Now, this one I have -- in this graphic, I have

put the entry of new commercial HMOs alongside of the Blue Cross/Blue Shield underwriting gains and losses. And you can see there's generally a little lag. Historically, we have a little lag, but they do tend to follow one another. If you're not earning money, you get out of the market. If there's opportunity to make money, you go into the market. There was, historically, sort of a free -- a relatively easy -- ease of entry.

Now, we have a recent increase in underwriting profitability, yet we have no indication of any entry into the market. And I have talked to a number of large national plans and they do not indicate any interest in entering local markets.

Now, let me say this, what might be different today? Why not? Well, I think, first of all, many of the insurers got badly burned in the 1990s and they have long memories now. Wall Street is leary of MCOs with an aggressive entry strategy for the same reason. Now, this is what I think is most important. I think the cost of entry is greater today than it was 20 years ago or 10 years ago.

Let's go back 20 years ago. Twenty years ago you had an indemnity plan, all you needed was a license. You didn't have to have a network. You didn't have to worry about quality assurance, utilization management, et

cetera. Ten years ago, you could enter a new market and you only had to sign up one-third of the hospitals. That's good enough. That's all you needed to do.

Today, employers want a wide network. You essentially want to have to sign up everybody, or at least come close to that. And this requires greater purchasing power. So, if I try to enter a new market, unlike 10 years ago, I don't have the purchasing power and one-third of the hospitals isn't good enough and I think there's provider push-back. The provider push-back, I think, makes it more difficult to secure the substantial discounts, and I think many of the health plans are making big capital investments in information systems, which is making entry a little more difficult, also.

Conclusion. Again, I depart with a question rather than an answer. I say, why now, after four years of profitability, why is it we see almost no movement whatsoever into local markets. And, of course, if HMOs do not enter new markets, the last round of inflation is -- the current round of inflation is likely to last longer, we'll have less innovations as new firms enter markets and we'll have less aggressive behavior on the part of health plans to control cost.

Now, as I started with Voltaire, let me end

with two quotes, also. The first one is from Adlai Stevenson. He once observed, "Man does not live by words alone, although sometimes he does have to eat them." I hope I will not eat mine.

And, number two, I have given you many statistics. I ask you to think as your very last thought of the day, think of what George Bernard Shaw once said which was, "Only a truly educated person can be driven to tears by statistics."

So, I ask you to look on your left and look on your right and I thank you.

(A a .)

MS. LEE: Thank you. Fred Dodson, who is Vice President of Network Management at PacifiCare of California. Fred?

MR. DODSON: June, since I don't have Power Point, do you mind if I just sit here and work off my notes?

MS. LEE: No, please do whatever makes you most comfortable.

MR. DODSON: Well, in answer to Jon's question, where have all the insurers gone, my response to that would be, “Do you know the way to San Jose.” But I'll get back to that. My name is Fred Dodson. I'm Vice President of Network Management of PacifiCare of

California. In insurance speak, that means I manage the relationships with the provider community most prominently, but I spend probably the other 50 percent of my time working with large employers and working with medical management issues.

PacifiCare of California is the largest operating entity within a company of PacifiCare Health System. We have about three million members across PacifiCare Health Systems, operate in a number of western states, Washington, Oregon, California, Nevada, Arizona, Texas, Oklahoma and Guam. I think I got them all right.

In that three million members, we have approximately 700,000 M+C lives. Additionally, we've got about nine million members nationwide in specialty products, pharmacy benefit, vision, dental and behavioral health.

The comments I have I'm giving to you from a large insurer's perspective and I'll address them in four general areas, those being market concentration, the purchaser product preferences, market tensions and the provider issues, and the regulatory and political impacts.

In terms of market concentration, very clearly, where I spend my life, there is a lot of competition. And I think it's important to note that while there are

multiple insurers, when you look at information on HMOs, that speaks only to HMOs. In the markets I have broadly broken out, there are HMOs, there are PPOs, there are point-of-service plans, there are now consumer-directed plans. But within each one of those categories, you might have five, 10 to 20 or 30 different opportunities. Just within our HMO offerings in California, we probably now have at least three or four very major differences in the plan types, and then you can get down to smaller differences in terms of out-of-pocket co-pays and other variables. And if you take that to the PPO arena, you only expand upon it.

So, there are numerous options out there to the employer level of purchase and the employer level of purchase is an important distinction that I'll get back to.

The other thing is many large employers simply can self-fund if they desire to. So, that's an additional choice.

The other thing we've seen in California, that when we find competitive advantage, when we enter the marketplace with a new product, that competitive advantage is usually fairly short-lived because our competitors will respond meeting employer expectations and come up with a product that is comparable.

One other thing worthy of note as you look at this is most employers can purchase differently across different geographic areas. So, I may opt to have PacifiCare as an employer in Northern California, Aetna in Southern California, somebody else in Arizona. It doesn't force me to make a decision across multiple markets when I make an insurer decision.

So, when we look at it, you know, we haven't seen that mergers really have resulted in a unilateral competitive effect. That's not where we've seen this play out so far. In fact, we've got some real life experiences in PacifiCare as a company and we did a little looking. We went back and looked at the Lehman study. Only three of the 32 mergers or acquisitions we've seen in recent years were even within the same geographic marketplace. And it's important to understand that health care as a product, which I'll get into a little more in a minute, is purchased locally and the consumer of the health insurance is purchasing a health care product much more than they're purchasing insurance.

Our examples, FHP was a merger of essentially equals. When PacifiCare and FHP merged in 1997, we subsequently, at that time, faced a number of challenges that I think we've finally worked our way through. But we had to compete in a very active marketplace in all

those areas in the midst of putting together a merger and we learned that mergers are not easy work.

In Northern California, we've lived with a couple of experiences in the last year with our competitors. Health Plan of the Redwoods was a health plan, predominantly HMO, some Medicare business, operating in Sonoma and Napa, Mendocino and some of the other Northern California counties. They were the most successful, from the consumer standpoint, and profitable health plan. They didn't have the highest profit margin, but they were profitable in that market until they faced significant provider pressure on the premium equation. Basically, the provider community came back and said, we need more resources.

The ultimate effect of that was Health Plan of the Redwoods closed about six or eight months ago. Any one of the insurers in the marketplace could have bought that health plan for essentially nothing. No one did. The plan simply closed. The only effect of that closure was the premiums have increased in that market with all the competitors. There's at least five significant health plan competitors in that market. Premiums have increased almost identical to what the payment rates of the provider community have increased. It's simply what has happened in the cost equation.

Down in San Jose, Lifeguard, another regional health plan, had 150,000 members, was actually one of the dominant health plans in that marketplace, closed its operations about six or eight months ago. Same situation. No one stepped up to the plate, no acquisition. It was simply allowed to dissolve. And the premium rate increases in that marketplace essentially mirror the premium rate increases in the rest of the market area.

Let me transition and take you through the purchaser product reference. Clearly, the employers set the expectation for us on what the product is. So, we design products to meet employer expectation and a big piece of our product is what is the provider network.

State of California -- in terms of what happened with the major purchasers. CalPERS covers about 1.3 million lives in the State of California. About almost a year ago now, Blue Shield became the sole major insurer for CalPERS in the State of California. That became effective on 1/1 of this past year. But that business was put out to bid.

HealthNet and PacifiCare were both major insurers with CalPERS. The result of the lower bid with Blue Shield was that CalPERS went to Blue Shield. HealthNet and PacifiCare no longer became insurers for that population of employees. That affected about 300,000 lives who were with PacifiCare or HealthNet. And

and physicians, let me describe for you that large health system and the reality I face every day. A single health care provider system in Northern California receives 40 percent of the dollars we pay out in health care services in Northern California, approximately $500 million a year and we influence that marketplace with approximately 400,000.

Now, the logical assumption would be that that would give us, the insurer, significant purchasing power. Reality is absolutely the opposite of that. That supplier, that health system, has 26 hospitals, 13 medical groups, a number of ancillary services, lab, home health, the whole array of health care services, that they offer to us on an all or none basis. If we want one of their hospitals, we take all 26. If we want one of their medical groups, we take all 13. And the bottom line is, we simply cannot offer a product in that marketplace without that organization. We're not in business without that.

And the reason for that is the consumer transaction is a transaction of is my doctor, is my hospital in your program. The consumer of the product looks at this differently than the employer. The consumer goes down and says, I want my doc, I want my hospital, that's how I make my decision. So, we face

both an employer expectation that you must have this health system in your health plan or we can't offer you product and an individual consumer expectation of, is my doctor in the program.

So, it plays out to an interesting provider strategy to manage in this environment. The provider of the large health system knows that. They approach us on an all or none basis. Want one part of us, you have to take all of us. Can't break it up. We're required to offer them in all geographic areas and they cover multiple markers across Northern California. So, if I want them in Sacramento, I have to have them in Oakland.

They also recognize that there's a regulatory requirement upon us that we are required in our HMO products, at least, to provide adequate access. In many places, we don't have adequate access to physicians and hospitals without this organization. So, you can leverage one market area where you have to have adequate access now across multiple cities in Northern California in an all or none approach.

One of the more interesting and insidious things that this system has done -- and this is not the only system we face this with in California, but this particular system approaches us in a concept that we lovingly call equal treatment. They state that they must

be equally treated, vis-a-vis all their competitors. It seems innocuous enough. Take that to the level of the individual consumer. That means if this health system is paid twice as much by us as their competitor health system we cannot have the individual consumer see a higher co-pay for that system than for the lower priced system.

Think about that. We're trying to put into this industry some consumer transparency to cost and quality. That contracting strategy has removed that transparency. It's obscured. And at the point of the individual consumer, they see no price difference between a high cost health system and a low cost health system.

Interestingly enough, the same system attempted to do that on quality, but they probably weren't forward thinking enough. PacifiCare now has a hospital quality index published in California on 50 publicly available measures. Generally, in the hospital community it presented some interesting challenges because the industry had concerns about that type of information being out there. This one particular system wanted originally to be able to approve the information before we distributed it.retafbutcy tarlremovedally, iefore2213

these health systems have consolidated, if I am the lower priced competitive health system in those markets, what benefit is there to me? I, as the insurer, have no way of passing that lower price benefit through to the consumer because the larger more dominant system says you can't show that to the consumer. The less dominant system goes, well, there's no reason to be more price competitive with the insurer than the big guys, I will just move my price up. And, in fact, that's exactly what's happened now in those markets and the less dominant system has said it wants the other guy's rates without using their name.

So, it's become -- we jokingly describe it as kind of the rising tide raises all boats phenomenon. The weaker systems rise to the higher price. There's no reason not to.

It's fairly recent, actually, in health care -- if you go back a few years in this industry, physician organizations influenced the market on the hospital side and helped in the purchasing decision, but as the systems have not only aggregated hospitals but aggregated physician organizations on their behalf, the doctor now no longer is influencing the cost equation. They are very much married up to the health system that they are an employee of or represented by in contracting. So, our

ability to use the physician to shift behavior and move care is significantly limited by this contracting structure. And, in fact, we are prohibited in contract language from even encouraging physicians to direct care to the lower cost facility.

Let me move on. A couple comments on the regulatory and the political environment. Certainly, mandated benefits, that is something that's commonly a factor we deal with, has driven some of the similarity of health plans. Now, that's not all bad by any means. But there's a balance in this that you can tip the balance in the regulatory and political environment to result in unintended consequences. Let me give you an example of one.

The Department of Managed Health Care in California now regulates the HMO industry. They are compulsive about access and quality and the types of things you would want them to be compulsive about. But where it plays out as an unintended consequence is, if we wish to move members from a physician group as part of this big system to someplace else, we weren't able to get a contract, whatever reason, there's a quality concern, we're unable to do that without the approval of the state's Department of Managed Health Care. Why? Because we have to ensure access and quality, et cetera.

Well, it plays right into the hand of the dominant health system who says -- they contractually tell them they can't move. They've also got a regulatory prohibition. So, that regulation has made it very difficult for us to work in a marketplace. I'm sure that was not the intent of the Department of Managed Health Care when the reins were put out there, but that's how it plays out.

Other states we've seen, we live and operate in Texas where over the past few years seven managed care plans have left the M+C program in Houston. You know, that certainly isn't desirable from the standpoint of the government. A lot of that is just due to the business and regulatory and political and other environments that have existed in that state.

In closing, you know, let me say I come from this from a perspective of having lived all sides of this life. I don’t want you to think that I've made comments about the provider system and I've never spent any time in the provider system. I spent half my life as a hospital CEO, health care system exec, et cetera. I understand the system from that perspective. I think it's a wonderful thing that we have done what we've done in health care, we can transplant organs, we can do things that we never even imagined when I got into this

business 25 years ago.

But it's now a system with a lot of subtle issues that sometimes it can be missed, and I think a very clear shift in the balance of power of many markets that are driving health care costs, that may not be seen unless you're living them on a day-to-day basis. With that, I'll conclude. Thank you.

(A a .)

MS. LEE: Helen Darling is President of the Washington Business Group on Health.

MS. DARLING: I'll stay seated, too. I think you'll hear that Fred and I didn't plan this, but I pretty much see the world as he's described it from the national perspective. We find that our large employers find vigorous competition among health plans and most employers feel that the health care system falls short on many dimensions, including competition, generally. But health plans and insurance and that piece of it works better than other parts of the system, which is not to say they're perfect. But at least in terms of the question at hand, there's plenty of competition from the point of view of especially large employers.

In general, as Fred said, large employers, first of all, in any market they're in, they have a lot of options. I have enormous respect for Jon Gabel's

research and data, but it's also true that we look at a given community and HMOs are a relatively small part of the community and we have more people in PPOs and other things than HMOs. So, you can't imagine the geography of a given region and not think of all the things that are there and there are point of service plans, there are HMOs, there are PPOs, there are all these things that we haven't even named yet, but will undoubtedly emerge. There are consumer-directed health plans.

It is a very, very complex collage of options and most employers are, in fact, moving in those directions pretty quickly. If you look at just the data on HMOs alone, real HMOs -- and then, by the way, I would say, again, not to, in any way, Jon's data, but I know those markets, I used to run the benefits at Xerox Corporation. I had people in every one of those markets. I can tell you there were states there that, in my mind, I wouldn't count them for having a single HMO. Certainly not any real managed care.

Now, they may have had a license, but they were basically what I call fee-for-service in drag. They just were prepayment overlaid on an existing crazy system. And you had a little prepayment and you -- maybe if you were lucky, there was a little bit of pre-certification or something, but there wasn't real management. These

weren't integrated systems. These weren't systems that had sort of the kinds of things that PacifiCare has, where you have actually people who are sitting there trying to figure out what works, what doesn't, what should we encourage people to get, what information we should provide for them.

So, in most places in this country, even when we had managed care all over the country and even when we had people in HMOs, we really didn't have a nation full of real managed care. So, I think that's important to keep in mind. It's even getting more complicated. But for my large employer members -- and we are a business

successful ones, in fact, go in and do a market-by-market analysis and they use information about what the options are to figure out what they want to do. So, there's a lot of competition.

In addition, if you will, as sort of a last straw even today, our large employers can just decide to get totally out of the business of dealing with health plans. They can self-fund. They don't even have to buy stop-loss. They can self-administer and there are companies who do that. They can rent networks. They can rent anything they want to rent. So, if they got really unhappy, you know, they could basically put it together.

Now, most of them don't do it, but I can assure you that when you're sitting down every year looking at what your costs are and some of the carriers come in and semed.e2eeverytSnfl5.7 0 TD(11)Tjbymoeno rentomarkup 18 percy wato s

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But, for example, in Connecticut through CBIA, which is the Business and Industry Association, you can get actually a lot of plan options as an individual and a small employer because they happen to have a pool that does it that way. And the rates are very good because I had to check out the rates, too.

So, I think there's more competition out there at the plan level then there is probably in many other areas.

Now, large employers' biggest concern in all of these areas -- and this is a message and fortunately I think PacifiCare generally does a certainly much better than average job in this regard. So, I would exempt them and a few others from this. But as large employers, we have looked to health plans to be our partners in helping to drive the transparency and information agenda forward so that we have the information, that everybody has the information, not just purchasers but consumers as well.

And partly for some of the things Fred talked about, the power of the hospitals and the physician groups, there has been a kind of stonewalling of information. We've known for 30 years how to actually put information out that's useful. In fact, for those of you who have been around this town for a long time, you know it was the '70s when the federal government, in its

wisdom at the time, actually passed a program to collect and report health information on utilization.

Today, the QIOs, their grandchildren and great grandchildren, whatever we want to call them, actually have online a lot of information that's simply not available to the public, partly because they don't know how to get to it. So, we hope the health plans and the insurance companies would work with us more to allow us to have information. We have an imperfect asymmetric information market. Transparency is a critical ingredient in everything we're all trying to do.

And one of the nice things about transparency in the system is it doesn't matter which side you're on, everybody will benefit from transparency and information, whatever the philosophy, whatever the position, whether it's a consumer-directed world or purchaser-directed world or even a physician-driven world, whatever, transparency will work. So, we would hope that we could all together drive the agenda forward and make certain that we all have the information we need.

We also, I think, as an organization, as a group of employers, we want to applaud the FTC and the Department of Justice for what they're doing in health care. It is about $1.5 trillion as I'm sure everybody has said. It's soon going to be 2.8 and I think it's

going to go up no matter what, by the way. Most of the things that are driving it are underlying forces to do with medical treatment and utilization. And while all of us, including I could do this, too, and would love to have the opportunity to nitpick about a lot of things about what's going on in the health system, the fact of the matter is, even if we got everything solved and did it very well and we had great competition, we had great other things, we have a system that is being driven by forces that have to do with utilization of health care.

And until, as far as we're concerned, until consumers have information about that and a financial incentive -- and it breaks my heart to hear what they do in California -- a financial incentive to pay attention to what these things cost and make decisions accordingly, we're going to all be sitting up here looking at probably a $3.8 trillion economy and half everybody's pay package in America will be for their health care benefits and the other half will be what they try to live on.

So, with that, I look forward to some questions.

(A a .)

MS. LEE: Let's take about a 10-minute break before we start with the questions. Thank you.

(W , a a .)

(M [illegible] a Q&A [illegible].)

MS. LEE: Jon?

MR. GABEL: I just want to make the point that for -- as I indicated earlier, I showed HMO data because HMO data are available. The other point is that most POS plans have HMO licenses. So, it really shows -- if you add HMO and point of service, you've got about 44 percent of the market or something like that. So, it would be indicative of, at least, 44 percent of the market and, of course, most of the national players, if they have an HMO plan, they have a PPO plan, et cetera.

The other point I just want to make is about barriers to entry. There was much discussion about being self-insured. The problem still is the network. Where do you get the network? You need the network and you need the discounts. So, maybe you end up having to rent a network which is able to obtain big discounts. So, you might end up, rather than having Aetna risk business, Aetna self-insured, where you still are entering that Aetna network.

So, if you are in Norfolk, Virginia and you only have two real carriers who are getting big discounts -- this is what the brokers that I work with say. It's very difficult, even in the self-insured business, to

enter that market.

MS. LEE: Helen?

MS. DARLING: Yeah, just on that point. There are a number of PPO discount networks that are independent and are not connected with an insurance company. So, you can do that separately. If what you want is a -- you know, if you want to have a PPO plan or you even want to have a discounted fee-for-service plan, you can do that by buying the networks independently.

MR. GABEL: Such as Beech Street.

MS. DARLING: PHCS.

MR. GABEL: But generally they don't get as substantial discounts.

MS. DARLING: Oh, I disagree.

MR. WU: Well, I just wanted to comment, Jon. We really do have peace on this table. But what I was going to say, that does mask a lot of churn.

I found your data interesting because it really did seem to show that there was a lot of entry and exit and fundamentally, it shows that the conditions for entry and exit are in place. It seems to me that -- and this is more a question for you. It seems to me that where we probably disagree is when we expect new entry to begin again because it sounds like historically we've seen health plans respond to market conditions and enter new

and their market capitalization -- I mean, just to give you one example, the total market cap -- there may be somebody in the room that knows the exact details -- of Aetna, probably today, but certainly last year, was lower than what they paid for U.S. Healthcare alone.

So, you've got giant companies sitting on very weak assets and reserves and their ability or their interest, therefore, to go into markets that are -- you know, where there's any chance of losing more money is just completely different. Not only is it not venture capital, but everybody is financially risk adverse today in a way that they weren't just a few years ago.

Now, you would argue that there were a lot of bad business decisions made a few years ago, and some of us are on the record of having said that numerous times, but the fact of the matter is, today, they're in a very difficult position regardless of what they'd be buying into. Financially themselves, they are not strong.

MR. WU: Plus, in terms of new entry, I'm not sure that we might actually see it with the HMOs. As Fred said, PPOs are really what consumers are preferring. I'm not sure whether we see more entry there.

MR. DODSON: The product request of the employers right now are not heavily focused on HMOs. We're in that cycle where we're into choice and

flexibility and all those other dynamics you showed, and that is the PPO product or other new products rather than an HMO. So, in fact, we're entering a number of markets for PPO, but there's no way we would enter those markets for HMO right now because that's not what we're being requested to do.

MS. DARLING: Right, exactly.

MS. LEE: I want to ask -- well, let me just follow up a little bit on what the discussion has been about. This question of new entry and when and how entry will begin again, there seems to be diverging opinions on the panel as to how easy entry is. I guess my question would be, well, there may be lots of competition now.

you have four or five really big carriers around the country. If United, Aetna and Cigna all merged, that would be one thing. If, you know, HMO X down in River City in rural Texas merges with something, it wouldn't matter at all.

So, it's really important who it is and this is no surprise, but there will be markets where you have five and six and seven large plans already operating, and if anybody was doing well, there may be more that come in. But they are going to all be pushed by the same provider pushback that Fred talked about. So, they're all going to have fixed costs that, in our judgment, is too high to start with.

MS. LEE: Lawrence?

MR. WU: I guess my answer would involve a summary of some of the points that other people have made. If I looked at John's charts, what I would conclude is that there really has been a lot of entry and exit, which would suggest to me that the costs of entering and exiting a market are relatively low. So, it's not really the likelihood of entry that would be an issue in evaluating a merger.

I would also -- and then in terms of the study or the graph that I showed, I also think that entry is likely to be effective in disciplining an incumbent

guess. The first question really is, how big does an employer have to be to have unbundling of the insurance product as a credible threat to deal both with the insurance company and downstream purchasing from health care providers? And the overlay on that is, does the availability of the services necessary to unbundle vary across geographic markets? I mean, is it easy to get in New York City and hard to get in West Texas?

I mean, I think a number of the panelists can take a whack at that. I actually think it's Fred, Lawrence and Helen, but everybody else can chime in.

MR. DODSON: Well, if you're going down the path of the self insurance alternative through the --

MR. HYMAN: Well, I mean, it's not limited to self insurance, but that's the sort of endpoint of the continuum. I mean, Lawrence, I think, outlined a range of unbundling options that, you know, start at one end of the spectrum as buying a state-regulated insurance plan and at the other end is self-funded and anything where you administer it yourself.

MR. DODSON: Well, in my experience, most states have a number of different options available for that, whether you have a purchasing coalition of like type industries, a state option, you're big enough to self-insure and re-insure and you can go out and find an

administrative services firm or one of the entities like PHCS or Beech Street that will get you a network. So, you don't have to be particularly large.

MS. DARLING: Five hundred is the usual number, 500 employees.

MR. DODSON: Yeah. And if you can find a few of your friends and put together something to go approach in terms of some type of buying coalition, you know, you can structure it that way. There's actually a great deal of flexibility out there if you are willing to take a look at it and that's where people work with brokers and consultants towards that type of solution.

MS. DARLING: This is also where -- a lot depends on what you want to give your employees. I mean, if you look at the data, it's the large employers who actually have the richest benefits and the most comprehensive plans many times. There are lots of employers, the smaller ones, that do provide a health insurance product and you may pay all the difference between what's reimbursed and what the doctor charges. We still have people in those kinds of plans. I mean, we've all gotten caught up because we talk about HMOs, but the fact of the matter is there are lots of people with just regular health insurance out there and more will come.

So, a lot depends on what you, as an employer, want to provide to your employees and whether or not -- what's the labor market. I mean, if you go back just three years, we still had people wanting to be an employer of choice. We've had a recession, we've had 9-11, we're in terrible shape right now. So, nobody's sitting around saying, I've just got to give more benefits to people to keep them here because the economy is completely different. So, this is also a time when there's going to be much more likelihood that an employer -- if they're looking at a 10 or 15 percent increase, they may say, well, you know, I may take either -- not even a PPO, maybe I'll go back to an old fee-for-service plan and just simply buy an insurance product.

It's just so different today than even two or three years ago.

benefits. States such as California and New York, the Northeast, have less self insurance than the rest of the country. In our survey, we are down to 5 percent of the nation of employees now being enrolled in indemnity plans.

MR. DODSON: Oh, I can actually give you a personal example of taking it down to five people. You know, my option was, to buy with a small consulting group a plan offered by one of the insurers. I looked at it and said, I don't like that premium price. It created for everybody MSAs with catastrophic coverage and it was substantially cheaper and a wiser business decision than buying insurance. It's a very viable alternative for small entities if they wish to go down that path. So, you can take it down to fairly small levels if you understand the industry and know what your choices are.

MS. DARLING: If I just may build on that because I was just in some conversations with a group of people who are selling large corporation health insurance, and one of the things they're seeing is you could -- I'm sure the terminology is something like a hollowing out of the benefit, that basically if you're sitting across the table and you've got 15 employees and you've just had presented to you per employer $250 is what it is roughly, and somebody's just come in and said,

is that in a lot of these markets, you see growing total enrollment, and so, in this environment, even though market shares may be changing, it doesn't mean that the new entrants are actually taking customers away from the incumbents. So, market shares may not be so informative about the competitive state or the competitive positioning of the health insurance companies or HMOs.

So, in addition to your own criticisms, I'd like you to address this. And then I'd throw out a more open question to the other economists and everyone else. Certainly, we all know the problems with market shares and Herfindahls, but often, it's the best we can do. And are there other things that we should be looking at in order to evaluate the competitiveness of markets.

MR. WU: Well, I guess I have two general responses. One is, in some of these markets, you know, there has been an increase in market size, meaning total enrollment has increased in the marketplace. But still, whether you are a new entrant or an incumbent health plan, there still is competition for that new business. So, even if it were the case that the leading firm in the marketplace basically lost share because it stood still and did not increase its enrollment and let new entrants just carve out a place in the marketplace, one, that seems to me unlikely; and second, my sense still is that

there is still a lot of competition for that new business. That business had to come from somewhere. So, I'm not sure that it's really the case, that the new entrants got to be 47 percent of the market just because it's brand new business. So, if the numbers are small, that might be a more valid criticism, but these entrants really do have -- received 47 percent share.

Now, I guess my other point is that, again, when you look at shares, it does hide a lot of churn that's underneath all that. And, again, that goes to all these studies that show that consumers are willing to switch on a dime. And it's that kind of churn that you don't see with market share numbers.

MS. LEE: Steve.

MR. PIZER: Let me just comment. I'm not going to disagree with some of what Lawrence is saying. I think there's -- but I'd make some distinctions. There's pretty intense competition -- and the markets that I know the best are the Medicare markets -- for the younger and healthier risks. And that's where the churning is, also. So, market shares may not be moving that much, but there's a lot of competition for the younger folks. And, in particular, in the Medicare markets, there's the supply of younger folks coming in. So, a plan that isn't being successful competing for younger risks, even though

those are just sort of the marginal new enrollees, is going to have trouble over a period of a few years. So,

the reasons that were brought up earlier about individual negotiations between employers and health plans. I think that if you're going to have any hope to do a really careful demand elasticity study that would be useful policy precedent, you'd have to have a good stable set of prices and product characteristics.

As was discussed earlier, if prices are going to go up, then employers have the opportunity to negotiate with providers to change the characteristics in the product such that maybe prices don't change, but the plans that are offered are going to be different. So, it's very -- you know, I think it would be very difficult in practice to calculate the effect of a change in price that held plan characteristics constant in any meaningful way, which is what you would need in order to do a demand elasticity kind of study accurately.

So, you know, for the reasons that were discussed earlier, even the HHI and the concentration ratios have difficulty because that's why in our study we fell back to just this basic idea of firm count and trying to incorporate some of the differentiation to that as well, but when it comes right down to it, the number of possible choices that firms have -- that employers have is going to ultimately determine the negotiating power.

Now, having said that, I think that there is potentially an opportunity to incorporate auction theory into the analysis of merger and other kind of policy analysis for the reasons described earlier, that essentially, firms are bidding against each other for employers' business and if we think of the competition like that, there may be potentially some new economic theory that we can bring into the policy evaluation.

MS. DARLING: Just two points I'd like to make that tie back to several of the comments. One, I believe that if an individual does not have to change his or her physician, they will move on very small dollars. So, you have to disentangle that. It is true that if they have to change physicians and that they have to sort of start over, the combination of inertia and other things come into play at all age groups. Inertia probably affects the younger more than any. So, that's one point.

The second is, as I'm listening to the discussion about the competition and everything, the geography is really important because I think about, as this discussion was going on, California. If you go back about 10 years or so, you had the Kaiser Permanente. They were not growing. In fact, they were probably shrinking and one of the reasons they were shrinking is because they were tied to certain relatively

disagree with what you're saying at all. I think we're just coming from different backgrounds. When I am thinking about these issues, I'm thinking about individuals who are making their own arrangements, either buying Medigap plans or signing up for Medicare Plus Choice plans and I think, generally, you're thinking about employers --

MS. DARLING: Right.

MR. PIZER: -- getting plans for -- and multiple plans which employees will choose and those are just totally different marketplaces.

MS. DARLING: Right, right.

MR. PIZER: The other marketplace that we haven't talked about at all is non-group or individually purchased insurance. And I'm not aware of any literature on premium elasticities there. What Mike said is certainly true about the shortcomings of doing premium elasticity work when you can't see what the prices are. And, again, you know, my head is just in a different place.

But individually purchased markets are much thinner and would be another sort of corner of the marketplace that might merit some attention.

MS. DARLING: There's probably a lot more turnover, too, because you see a lot of people going on

and off individual policies because that's -- you know, they come off COBRA and then they have maybe six months before they get another job or something and so you see a lot of turnover there.

MR. GABEL: When we were discussing employee choice, I think we just need to remind ourselves that not all employees in the country do have a choice of health plans. My statistics are higher than everybody else's statistics. If I were to go with Steve Long's statistics, it would be only about one-third of the

different providers in the same market, whether that might change the dynamics so national firm entry would enhance competition with local firms rather than only against other national firms?

MS. DARLING: But national firms have thousands of benefit packages. So, they have so much -- you know, they're basically almost like a continuum of options and there's never -- I mean, once in a while, you'll stumble on a company that will have a very limited repertoire, but the repertoire is becoming more extensive, not less extensive.

MR. HYMAN: Although, I mean, if that's a complete description of what's going on, it's hard to explain Mike's results because then each new national firm entrant shouldn't compete with each prior one, whereas his results indicated -- I'm actually not sure you were here for that presentation.

MS. DARLING: No, I wasn't.

MR. HYMAN: Okay, well, then I won't tax you with his results.

MS. DARLING: I wouldn't want to let data get in the way of my opinion.

MR. HYMAN: Just more generally, I guess the question is, how do you see state regulation as playing out in this context? Is it market-enhancing? Is it

market-replacing? Is it just bad news all around?

MS. DARLING: Well, our view is it is certainly not market-enhancing. It is very harmful to the markets working in a couple of ways. First of all, the state regulation almost always tends to be something that ties people's hands and because it is always driven by narrow special interests wanting not just -- well, give me eye care instead of something else. It's give me everything you're giving me and give me eye care. Give me this. So, it is always accretive to whatever's happening because every time something new comes in as a mandate, every other narrow special interest that hasn't had their mandate has to come in. So, it is really dysfunctional. That's number one.

Second, you know, in a way, some of the companies -- in a way, mandates essentially also get them off the hook for competing and using wisdom in selecting benefits and managing. So, it's not just sort of blatantly dysfunctional in our minds, it also makes it impossible for health plans and insurance companies and anybody in that business to compete on combining and re-combining the best packages to serve -- you know, with as much diversity as possible.

So, I mean -- and the other thing is that they are almost always not thoughtful in the way they come

through. That is, for example, it will always be a lot of something as opposed to -- usually because it's a political process, not a scientific process. They don't look at the scientific evidence about whether something is effective before they mandate it. They mandate a lot of things that are not only not effective, they're certainly not cost effective.

So, there's -- anyway, you can tell, sorry, I feel deeply.

MR. HYMAN: Tell us what you really think, Helen.

MR. MAZZEO: June, can I answer this question also?

MS. LEE: Sure.

MR. MAZZEO: I think it's a pretty interesting idea the fact that maybe state regulations could, in fact, make markets more competitive because by mandating a certain set of characteristics that HMOs would need to include that makes the individual competitors more alike. And so, you might imagine that if what these firms were competing on was a list of things that they offered to the employees, then a state regulation that mandated a greater list of things would reduce the potential for product differentiation and then, in turn, promote additional competition among firms that did exist in the

market. So, I think that's a potentially interesting idea. We did not look at that issue in our study, but we did find that national firms were less likely to enter into states where there were more state regulations, whereas that effect did not seem to matter as much for the local firms. You know, potentially, they were lobbying their local state regulators to mandate services that they were already providing that would be more costly for national competitors to provide.

MR. GABEL: Well, I think it's noteworthy that Alain Enthovin always advocated standardized benefits packages. Standardized benefits packages promote price competition. That doesn't mean it makes it better, that that's a better policy choice, standardized benefit packages, but I think it does promote price competition.

I also want to note that, I think, Helen, there's good mandated benefits and there's bad mandated benefits, and let me give an example. Most of them are bad, but let me give you a good one. A good one would be mental health benefits because what we know from history is if we do not -- if we do not require all employers to offer -- well, let's back up.

If we look at the mental health market, you will notice that it does exactly what insurance isn't supposed to do. It does not protect you against

catastrophic cost. People have done all kinds of caps on it so they cannot cover those costs. Without mandated benefits, many firms would purposefully not offer those benefits so that they do not have those high cost employees. There would be an erosion of those mental health benefits.

So, in the case of mental health benefits and maybe certain other benefits, I think they probably are good, I think they probably promote price competition rather than by preventing competition to hire healthy employees.

MR. WU: My reaction really is a follow-up to Helen's reaction, which is unless we think that competition will lead to benefit packages that are sub-optimal or extremely poor, it seems to me that we're almost always better off having firms compete on as many dimensions as possible as opposed to constraining competition to being limited to price or only a few dimensions. So, that would be my comment.

MS. DARLING: And could I just build on that and tie it back, there is a difference, in my mind, between mandated and standardized. We actually have standardization driven by the labor market and -- I mean, it's interesting because what Lawrence said is correct and what's happened is that almost all companies provide

very similar sort of benefits. Maybe there's a little bit of difference on mental health, but if you look at the -- I mean, I used to do this for a living.

If you look at benefit packages, there's sort of the average that you expect to have. You could almost predict, you know, it's X number of chiropractic visits, it's prophylaxis of this and, you know, scaling of teeth and all this stuff, they're all very standardized, but they do compete on certain things and I don't think that -- mental health, by itself, is not what they compete on. That's a whole other subject.

We should have a session on this. I would take issue with most of what Jon said, I'll just say that for the record. Love to have the chance. But to get back to the point, I think we do actually and it's particularly true, if you will, in a good job market that, in fact, if anything, some of us in the business, I've jokingly said, because of the job market, essentially corporations gave away far more health benefits than they should be doing for purposes of having an informed consumer and things like that, but we shouldn't have made it so easy. And now, we're having to undo some of that.

But it became very standard, I mean, almost to the penny what you would get if you went to work in almost any of the regular places, you know, government

jobs, think-tank jobs, large corporations. Very standardized.

MR. HYMAN: As a professor, it's a thrill that people want to go past the allotted time, let alone suggest an additional class as Helen has. I must say, in 10 years of teaching, neither of those things have ever happened to me. It's clearly June's beneficial effect. But it's 5:00 and we need to wrap up and we're going to pick up tomorrow morning at 9:15 and we've heard about a number of different songwriters, so we'll close with Fleetwood Mac, don't stop thinking about tomorrow.

(W , a 5:00 ., a .)

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

MATTER NUMBER: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW

DATE: APRIL 23, 2003

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

DATED: MAY 12, 2003

SONIA GONZALEZ

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

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

ELIZABETH M. FARRELL