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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. ELIASBERG: Good morning. Welcome to the joint Justice Department/Federal Trade Commission health care law and policy session on entry and efficiencies in the health care insurance industry. My name is Ed

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anticompetitive in any relevant market.

The format this morning is going to be slightly different than what you saw yesterday and in the last few

task force and numerous working groups. She tells us that her presentation is going to be health insurance 101, and we are very much looking forward to hearing it, Mary Beth.

To Mary Beth's immediate left is Ruth Given. Ruth is Health Care Director for Deloitte Research, the applied research arm of Deloitte & Touche, where her work has explored numerous issues in various segments of the health care industry. She has been an expert witness on a number of HMO and insurance industry merger cases and has written several articles about the economics of HMO mergers.

To Sarah's left is Jay Angoff, he is of counsel to Roger Brown & Associates in Jefferson City, Missouri. Jay served as the Missouri Insurance Commissioner between 1993 and 1998 where he approved, disapproved or conditionally approved more than 10 insurance industry mergers, including the United Care Metro Health merger, Principal/Coventry and the Traveler's/Citicorp merger. He has been an antitrust lawyer with the Federal er'vnigNfy3.7 0 TD(

enough to be one of our panelists on yesterday's sessions about competitive effects in the health insurance industry, and as became clear then, he has analyzed mergers and competitive issues in a wide range of health care markets, including, most importantly, the health care health insurance sector, and indeed was heavily involved in the Aetna/Prudential case. Prior to joining NERA, he was a staff economist in the Federal Trade Commission's Bureau of Economics.

With that, I would like to ask Mary Beth to start off. We will then proceed in the order in which folks were introduced. Once everyone has had an opportunity to make their presentation, we will take a quick break and then move to the moderated roundtable. At that time, again, let me repeat, I will introduce the other two individuals who are going to be participating in the roundtable.

Let me finally just ask all the speakers and panelists to try to speak into the microphone, because this is being both recorded and we have folks listening in by telephone.

So, Mary Beth?

MS. SENKEWICZ: Thank you, Ed. Thank you for inviting me and the National Association of Insurance Commissioners to participate in this hearing.

As an introduction, I do want to note, in preparation for today's hearing, I was reading through various literature, looking at your web site, and I must admit that while insurance has a language all of its own, I must say antitrust truly has a language all of its own. And in fact, we probably are not speaking particularly the same language today.

I'm here to talk a little bit about how state insurance regulators operate and how it happens that a health plan can come to be and what types of requirements the states will put on health plans to operate in their state. And I know that you guys, the antitrust lingo is, you're talking about barriers and all sorts of things like that and I was trying to think, what kind of barriers exist.

I think that first of all, I would like to say as state regulators, we don't consider any of our requirements barriers, but rather good, sound regulation of a market and of an industry that when you think about it, for one reason it's regulated is because it's not, generally speaking, you're not in an arms-length transaction when you're dealing with an insurance transaction, as you are in many other contractual types of situations. So, I think there's really good public policy reasons for the insurance industry to be so

heavily regulated.

Let me briefly just kind of give you an overview of how regulation works. As we all know, states are generally the regulators of insurance products, although since they're in health, there are three main, I don't know if you call them exceptions or incursions by the federal government into the regulation of health insurance, beginning with ERISA back in 1974, and then with OBRA90, began the kind of the dual state federal regulatory authority over Medicare supplement insurance, and then in 1996, HIPAA, the Health Insurance Portability and Accountability Act put certain requirements on both group and -- both the group and the individual market.

But first things first, how does a health plan or how does an insurance company get to operate in a state? The first thing you have to do is obtain a certificate of authority to do business in a particular state. And let's say it's a new company, someone that doesn't exist. If you don't have a certificate of authority to do business in Missouri, Jay's old state. Well, they would have to fill out a very complicated, long license application, certificate of authority application, giving a tremendous amount of detail about their finances, their background, who these people are that are putting it together, a business plan, plan of operation, what types

of lines of insurance are they going to sell. It's obviously a very -- to some extent, arduous process, but also a necessary one to make sure that these people are legitimate, that they have the finances. Remember, the essential promise when someone is selling an insurance contract to you is that they will pay and they will have the ability to pay claims when the claims become due. And it is that promise that insurance regulators want to ensure that the insurance company can deliver on at the appropriate time.

So, one of the principal areas of regulation is over the solvency of an insurance company. So, you have to go through an application process, you have to obtain a certificate of authority to do business in a particular state. So, assume that that's all done and you get your certificate of authority to do business. Then, what's next?

Well, you can begin to sell, but before you sell, the products themselves have to be approved by the state insurance commissioner. And there are a variety of ways that is done. There are as we know, 51 jurisdictions, and 51 perhaps different ways of doing it, but generally speaking, they have to file a product approval form.

Now, what has to be in that product or what has to be in the product in order for it to get approved?

That's going to depend on the line of business, for example, but let's just say it's a major medical policy, a group major medical policy. Some of the things that would have to be in the products in order for it to be approved are the things that are required by law, both state and federal. Because of HIPAA, and I would just note that most states had already done what HIPAA did in 1996, so it was kind of the Feds were doing a little bit of catch-up there.

For example, all policies have to be guaranteed renewable; the insurance companies have to renew the policy, with certain exceptions. The classic exceptions in the insurance context are fraud, misrepresentation, nonpayment of premium, or if the insurance company is leaving a market, things like that. They have to be guaranteed renewable.

They have to have a certain amount of consumer protections within the product form, within the policy, to protect the consumer that a state might require. And, for example, most states require that each health insurance contract have a grievance process, if the consumer has a complaint, there has to be a set of internal appeals processes available to a complainant to make sure a complaint is known and for it to be heard by the insurance company.

That can get and even involve two different levels of appeal within the insurance company. They have to have, if there are any type of managed care arrangements or utilization review requirements; i.e., you have to get permission before you get certain procedures done, there have to be processes in place by the insurance company, by the health plan, to ensure that that utilization review is done on an objective basis, and that due process is given to the insured.

If there are still disputes, many states, it's up to 41 now, require what's called an external review of a claim that's been denied in the case of medical necessity. So, the complainant, the insured, gets to go to an outside, outside the insurance company, that is, objective panel to have its -- his or her claim heard.

There are things that a managed care plan must have in place, such as network adequacy requirements. If you are selling a product that is restricted in the payment it will make based on the service provider; i.e., you know, our classic, you know, you get 80 percent if you go in network, you only get 60 percent if you go out of network. The states will require that the health plan have a network that is adequate to service its policyholders. I mean, if they're being restricted, there have to be enough doctors, providers, all types of

service providers to allow the insureds to have instant or reasonable access to the services that are provided.

This is just a little bit of the types of things that you will see in managed care plans in particular, quality assessment and improvement, again, because of kind of the perverse, I call not perverse, reversal, some would say perverse, reverse incentive in managed care; i.e., the doctors are only getting paid X amount per month, versus old fee for service, the money kept flowing in, so they kind of have a reverse incentive, perhaps, not to treat, there is -- there are requirements about quality assessment, that they continuously assess the quality of their services and quality improvement. So, there are requirements that are in place in those regards that are set by the states.

So, the policy form would have to be approved by the state before it can be sold.

The other continuing aspect of state regulation that is crucial is the continual solvency monitoring by the state insurance commissioners. All licensed insurers, and that includes HMOs, et cetera, will file on a quarterly and annual basis their annual statements with the state insurance commissioners. Anyone who has looked at insurance company annual statements know that there's a lot of information in there. The states, the 51

jurisdictions have in place infrastructure to do this, and have been doing this for many, many years.

So, they will file on a quarterly and annual basis, and then the insurance department of kind of the state or domicile of the insurance company will actually physically go to the insurance company and examine its books and records once at least every three to five years, depending on the state. So, that is a full fledged audit examination that a insurance department undertakes.

Literally in some cases, the insurance examiners are moving into the basement of the insurance company for months, and believe me, the insurance companies don't particularly like that, but that's what we do. And we monitor their solvency to ensure that everything that's in their annual statements is actually there, and reflected in their books and records.

The other type of examination that will occur for a health plan and insurers in general is what's called a "market conduct examination," and that is when these market conduct examiners go in and examine not necessarily the financial books and records, but the practices, the books and records of the practices of the insurance company. In fact, because of HIPAA, are they renewing all of their policies, do they have too many

we do understand that perhaps a little less in the health context, but because of Gramm-Leach-Bliley, and the barriers that have been broken down between insurance and banking and securities, right now the focus there is perhaps on the life industry, but are they able to trickle down to health eventually? Are there things that states could do with more uniformity to make it a little easier for insurance companies to compete globally?

And so, through the NAIC, the state regulators are embarking on several initiatives that will enhance regulatory uniformity, including right now we do have a system that was initially set up through the NAIC, but it's a separate entity now called Surf, the system for electronic rate and form filing. Essentially that acts as a central clearinghouse for the filing of these forms that I was telling you about, these product approval forms. Rather than necessarily filing them in 50 states, the insurance company will only have to file them with Surf and from Surf they will be disseminated electronically to the states that the insurance company wants those forms approved in.

We have -- there is a uniform certificate of authority application, the UCAA that all states are using now, so again, at least that certificate of authority application is somewhat standardized rather than having,

again, to file in 51 states when a new company is starting up.

We have an interstate compact initiative which will eventually, we're starting with life and annuities

the context of that, that's sort of negative . This was January 1997, it was very cold. I was in town with my boss, who was the executive vice president of the California Medical Association, who at that time was on the short list to be surgeon general. He wasn't obviously picked, but we were here, and I thought, well, I'll drop by the Federal Trade Commission and raise some issues I have with the pending merger that we have in California. And that, of course, was the PacifiCare/FHP merger. And I had some current concerns about the competition in the Medicare risk market in California for that merger, because it was going to allow two of the largest Medicare risk plans in the country to combine.

And the people at the FTC, I think, thought I was a little bit crazy, because there were a lot of competitors at that time in the market, probably all 20-plus HMOs in Southern California which was a major area that the merger was going to affect, had Medicare risk products. And I tried to explain to them, well, do you understand about the APCC and how it's very, very high now in Southern California relative to what people can get for, you know, commercial products, and that very soon, probably HCFA is going to reduce the rate of increase in the APCC across the country, and I don't think they took that very seriously.

And I think we all sort of know what happened

think, are more important, and they are, I would say, less definitely robust than an economic analysis, but I think important and actually very important, because it's just about all we have to go on.

And the two types of nonacademic evidence that I am going to be presenting are really two types, qualitative, which is based on my discussions, really over the last month or so, since I was asked to do this presentation, by people I know in the industry. These are people at HMOs, they are academics, they are purchasers, Wall Street analysts, who I think are very important, even though there's a certain credibility issue there in some cases, and potential entrants who I have actually talked to about their problems of get se nney are, I w

operated by the states, and I just don't think that they're relevant competitors. And what we're left with is the green line, which is what I would say are total new commercial HMO competitors.

And so, this just gives you background about, you know, is there entry, there has been in the past, there doesn't seem to be very much right now, as you can see up to the year, that goes to January of 2002. And, I guess the questions that we should have are: why is this happening; and what should we make of it; and what should we expect the next 10 years to look like?

I mean, as someone suggested the other day, if we have seen insurance cycles, maybe we'll just keeping seeing these ups and downs over time and it shouldn't be a problem. So, let me just go to the next slide.

And what I've done here with this slide, I've just taken that green line from the previous slide, which is the number of total new commercial plans, and I've superimposed it on some information about -- relative information about profitability. And what you have plotted there on the red and blue lines are the percentage change in premiums and the percentage change in costs. And John didn't quite present this yesterday, he presented something similar.

And what you can see for the period of time where

influx of HMOs in the mid-90s is there was a huge market that still had not enrolled in managed care. I think that's pretty much taken up now, it's pretty well penetrated, maybe not HMOs, but PPOs, so I don't think there's a huge market growth opportunity that there was in the mid-90s.

Also, and I hope we get to talk about this a little bit more later, I don't want to go into it a lot now, is I think the HMO industry is changing substantially. I think, at least based on analyst reports and the analysts that I talked to, I don't think the HMOs are going to want to go in and compete as heavily in the general commercial market as they have in the past. They're differentiating themselves, and not just in the ways that we heard yesterday, and not just in different types of insurance products. They're differentiating themselves in providing services, again, at United Health Care, talking about WellPoint, very different things that they're going into. So, I just don't think we're going to see that kind of competition in the future for a variety of reasons. But, you know, I think it remains to be seen. And that's, you know, like I said, this is about as far as we have.

Just one more graph I have here, just in case people are wondering if we're actually profitable now.

This is just sort of showing kind of maybe not that the numbers are so correct but the trend that this has been going up. We sort of came out of the trough when the industry was in trouble.

So, that's the quantitative information that I have. In terms of the academic information on barriers to entry, I just want to say that as far as I can tell, I haven't found anything that specifically looks at it, and maybe Lawrence will be able to come up with stuff. There were a few studies that were done looking at competitiveness of HMO markets. There's one that Mark Pauly and his colleagues at Wharton did a few years ago that was published in Health Affairs that sort of looked at whether markets retained their high margins over time, which could provide evidence that there weren't barriers to entry. It also could mean that as he even admitted in the article, there could be monopolistic conditions dealing with some cost tracks. So, I think there's really no academic evidence out there.

What I would really like to focus on most, though, is the qualitative evidence that I got talking to the various individuals in the industry over the last couple of weeks. And the story that I was really told by most people, the consensus was, really in the past, entry was easy for indemnity plans, because all you really

needed was a state license or fulfill the State requirements, as Mary Beth mentioned, and all you really needed to do was collect premiums and pay claims.

And what I've heard is that really managed care has changed that in a couple of ways. In the early 80s, the name of the game was selective contracting, so you actually had to have a lot tighter relationship with the people in your community to select plans, to select a lead contract with. And that's the way that managed care saved money.

Interestingly, in the years of the managed care backlash, that really changed, and even though things got more open and you didn't read as much about selective contracting, and employers and employees were demanding broader networks, that actually made things worse because you really needed a bigger critical mass to get your competitive rates. Before, you could channel it all to your little selective provider partner, but as the market got big, that was even more important to be large. And I don't want to read the quote, because it will take too

saying, even, you know, with a 400,000 member health plan in that area, they had a hard time getting rates.

So, I think this is actually pretty well documented. So, I guess the reasoning about barriers to entry is, I think, tightly related to scale, and that, you know, the evolving form of managed care has really created barriers to entry related to scale, and possibly even created what economists would say is a minimum viable scale to actually get competitive rates in a market.

Now, there are some counter arguments, and I want to recognize these. And one of them is, of course, something that was brought up a lot yesterday. That was: what about self-insurance, you know, at least for the large employers? Can't they get around this issue by just going out and self-insuring? I think that that's definitely a possibility. There are questions about, well, it depends on who you're going to go to for a third party administrator. There's been some information in the industry that I read in the analyst report saying that there's a switch away from the smaller TPAs who represent only about 35 percent of the market to the bigger TPAs and the bigger TPAs are, guess what, they're the health plans.

So, maybe you're doing self-insurance, but you're

move into these markets. It's a little tricky looking at Blues buying Blues, because they're kind of restrictive, but for example, WellPoint recently bought Rush Hospital Plan in Chicago, I guess that was a couple of years ago, and recently bought, I think, Methodist Plan in Houston or Dallas, and I was just noticing that they were paying $385 per member to buy thisdorf, Maorfh umoi vTepnddddpnddddpnddd

scale. These are things based on the costs of the health plans. And there are maybe two things that are changing that would make these results be somewhat biased low in the present situation.

Number one, the production function for HMOs may be changing somewhat so that it actually requires a lot more fixed cost to compete in a market and provide the type of services that employers want with disease management, utilization management, maybe more sophisticated underwriting, and so fixed cost may be higher, therefore minimum efficient scale may be a little higher.

Another situation that's changed in the last few years that's been talked about a lot is the increase in the market power of the providers. To the extent that you think that these efficiencies or these scale economies are related to what we call pecuniary economies of scale, and that's really the bargaining power that these plans get with the providers, the plans maybe have to be bigger to deal with a greater concentration in the provider market that we're seeing now. So, those are two things that could increase it. I don't know how much they could increase it. Roger said that he's actually done some research on more recent data and he doesn't see that it's increased too much, but that's something to

look at.

The other thing, the other caveat I have with our research is it doesn't look at what I call demand side economies of scale. These are things that are really the benefits of scale to the customer related to size that improves the value. It doesn't have anything to do with the cost, but if you have a plan that's bigger and for that reason it's more valuable to the customer, they're going to pay a higher price.

And kind of the classic example is industries that have network externalities, you know, where the size of the network actually improves the value that the people get from purchasing that product. That's not the case here, but there are some things where scale might be important.

And finally what I would like to talk about is dig a little more into what are the sources of economies to scale in the HMO industry, and what I've done is kind of put together a matrix looking at the two types of economies of scale, as I just mentioned, supply side and demand side, and look a little bit on what's happening for local markets and national markets.

Like I said, the supply side is really conventional scale effects that reduce average cost, and demand side are those that improvey -2 Tcm0uceorage cost, and

customer. And I wanted to look at the local and national level, because there's an interesting interrelationship on the demand side between the local and national level that's starting to kind of become shown.

What we've pretty much focused on in the past for antitrust is really what's in the red box, in the upper left quadrant, which is the supply side effects, and the major things. Technically, these are things in the production function that you can just become more efficient, high fixed costs, spread it over a larger number of enrollees, so local administration, utilization, state regulation, reserve requirements, and then as I mentioned, there are the pecuniary things, and these are things that you can actually get lower prices by being more aggressive, bargaining with your local competitors.

And then the other ones are, you know, a little bit different. But what I would like to do now as I finish and wrap this up is really just try to tie these back to barriers to entry. On the supply side, I think, you know, as I mentioned, one of the problems with, you know, small size and de novo entry is getting in and getting a large enough critical mass of bodies, of lives, to be able to shift to a provider group to get a reasonable discount. And that's sort of the pecuniary

issue.

So, that's the connection between economies of scale and barriers to entry. What I think is getting to be equally important, though, is the barriers to entry related to scale on the demand side, and one of the things that I've been hearing, talking to purchasers over the last few weeks is they really want to deal with large HMOs. I think Helen Darling said a little bit of that yesterday, the PacifiCare person mentioned that.

One of the things when I was talking to people So, th

couple of their HMOs a couple of years ago, partly because I didn't get the premium that they wanted, but they specifically said we want large plans so we can do population health. You really can't do this credibly, you know, with smaller plans, we really want plans that are big enough to do so. So, they have explicitly said that. I do think that PBGH feels that way as well.

So, just to kind of wrap up, you know, hopefully I've kind of convinced you that there is a connection between scale and barriers to entry, and I think, I just want to, in closing, kind of point out the implications for antitrust. On the one hand, for merger, I guess evaluation, one of the things about bigger economies of scale is that that might translate into greater merger efficiencies. If I get asked later, I'll explain why that may or may not be the case. You know, that's pretty dependent on a bunch of things. So, they might be able to justify a bigger merger, a bigger market scale by saying, we can get greater economies of scale and this is beneficial.

On the other hand, I think to the extent that barriers to entry are linked to greater economies of scale, that's going to make a potentially anticompetitive merger more difficult to defend to say, we want to get big, but it's going to be hard for anybody to come in and

compete with us if they aren't immediately of this size.

So, thank you.

(A , .)

MR. ELIASBERG: Thank you, Ruth.

Jay?

MR. ANGOFF: And I don't have slides, will I be messing anyone else up if I close this?

I'm very pleased to be here because we've all been on panels or we've been in the audience, and we've seen other people on panels, particularly for lawyers, where everybody talks about the cases that they've won, and all the things that they've done right. And what I would like to do, I'll talk a little bit about that, but I'll also talk a little bit about the cases that I lost and the things that we did wrong. And I may also talk a little bit about some things that I think some other people did wrong.

I was the Commissioner of Insurance in Missouri between '93 and '98 when there were a lot of HMO mergers nationally, and a lot of these mergers had significant impacts in the St. Louis market, so I would like to focus on that.

And I would first like to give a little background on the structure of the St. Louis market, or the St. Louis HMO market when I became commissioner, that

was in early '93. There were four big HMOs, each with more than 12 percent of the market, General American, which was a local St. Louis company, big health insurance in St. Louis, United Health Care, Blue Cross, and Coventry. And then there were a half a dozen or so smaller HMOs, one or two local ones, but mainly the big national carriers, which each had just a few points in the market: Met, PRU, Cigna, the pre-U.S. Health Care, and Aetna.

And in '93 when I started that, coincidentally, that's when the merger wave, the HMO merger wave started. And the first merger we were faced with -- we had was a proposed merger between the first and second biggest companies in the market, Gen Care and United Health Care, which together would have a market share of -- depending on how you define the market -- at least in the thirties. And it was a close case, but we ultimately decided to approve that merger for a couple of reasons. One of the reasons was that there were plenty of other competitors in the market, even though they had relatively small market shares, but these were big companies that obviously, or one would think on their face, were strong potential competitors. I mean, there was a good possibility that they would expand.

So, we approved that merger and there wasn't a

whole lot of discussion about the entry issue, even though it did involve the merger of the first and second biggest companies in the market.

The second merger we looked at was the acquisition by the second -- what was then the second biggest company in the market, Blue Cross -- of the biggest PPO, a company called Health Link, which also had a small HMO.

Now, again, depending on how you define the market, the combined market shares of the two companies could vary significantly. Ultimately, we decided to approve it, because if we defined the market as HMOs, as only companies that take risk, Health Link didn't have much of a market share, it only had a small HMO, so we approved that merger, too, despite the fact that it created for ASO business really a dominant carrier, because Blue Cross is -- so much of Blue Cross's business is ASO business, and so here Blue Cross was acquiring the biggest PPO. It really created a dominant ASO carrier, nevertheless we approved that.

The third big merger we were faced with, and we really didn't get to the entry issues. With the third big merger we were faced with, we did reach the entry issue, because this merger was a proposed merger of the combined Gen Care and United Health Care, which we had

approved in '94, which was by far the biggest carrier in

were 320 insurers, and that any of these insurers could quickly and easily compete in the managed care sector, and said that we really should -- that because it would be so easy for these companies to enter, we shouldn't have concerns about the high levels of concentration on their face.

They particularly emphasized two companies that would be particularly strong competitors, one was Humana, a national HMO, and another one was Great American West, which was a major life health insurer in St. Louis. And said that these companies in particular were very strong potential entrants.

And then the final argument that he made was this: That even though United might have 40 percent of the market, and several other carriers might have a percent or two of the market, there are 10 carriers in the market, and in this market, because entry is easy, and in particular because each HMO has little or no effective capacity constraint, that in doing the Herfindahl calculation, what we should do is not square the actual shares of the competitors, but instead, assume that there are 10 companies in the market, assume that each company has 10 percent of the market, because each company can very easily lose or gain market share.

And so, even though done by traditional

calculation the Herfindahl would be very, very high, and the increase in the Herfindahl index would be very, very high, his calculation assumed each company had 10 percent, therefore each -- therefore the total Herfindahl is only a thousand and the increase in the Herfindahl is only 100.

That was in '95, I believe. Eight years later, let's see what has happened in the St. Louis market. With the 320 insurers who arguably could enter quickly and easily, how many of these have entered the St. Louis market? Ten percent? Five percent? Maybe one percent? Well, the answer is zero. None of these 320 companies that could quickly and easily enter the market have entered.

In particular, what about Humana, the big national company that could particularly easily enter the market? Humana, according to the latest statistics from the Missouri insurance department, has 16 people insured in St. Louis.

What about Great American West? Well, really, they have an HMO, but their only market is their own employees. They -- it's really a self-insurance plan, they insure their own employees.

What about the calculation of Herfindahl figures based on the argument that each insurer is equally

capable of losing or gaining market share? Well, no. The big have stayed big and the small have stayed small. Actually, the big have gotten bigger, the smaller, in general, have gotten smaller.

So, those predictions didn't come true, and one of the things I think we did right was we disapproved this merger. We didn't think this economic testimony made sense then, I certainly don't think it makes sense now. So we disapproved that merger, and not only did we disapprove it, but we ordered that the company sell off -- that United sell off -- its St. Louis HMO to a procompetitive purchaser, and I think that worked out very well. It sold to one of the smaller companies, Principal, so it created a much -- which was fifth or sixth in the market, then it became fourth or fifth, so it created a much stronger smaller competitor.

So, I think that was a very, very procompetitive outcome in that case, and as I say, that was one of the good decisions I think we made. Unfortunately, though, it was followed by a very bad decision, and I would like to take this opportunity to publicly recognize that Ruth Given was right, and I and all of us at the Missouri Insurance Department were wrong, because what happened right after -- soon after the United Health Care/Metro Health merger was turned down and Principal bought the

relatively small St. Louis sub, Coventry and Principal proposed to merge.

And all of us at the insurance department took the view, and so that was the fourth and fifth -- actually third and fifth biggest or third and sixth, somewhere around there, I believe third and sixth biggest HMOs in the market, and all of us at the insurance department took the position that, heck, we approved a merger just a few years ago of the first and second biggest companies. There's no way that we should disapprove this of two much smaller companies. But Ruth argued that that was not the case, that the market had changed, and that we should really look into it.

Well, we didn't, and the market now because of all these mergers, is a very, very concentrated market with three very big companies, United, still by far the biggest, Blue Cross, and Principal/Coventry.

How much new entry has there been since I was at the insurance department? There's been none. There has been no new entry. There has been no entry by start-up HMOs, there's been no entry by big national HMOs that are expanding into Missouri. There have been acquisitions, for example, Aetna and U.S. Health Care, obviously, and Aetna/Prudential, but there has been no de novo entry in the St. Louis market.

particularly, as the HMO industry becomes more mature, and more and more people are in HMOs, it becomes tougher and tougher to get into the business. And I think, here's why: HMOs make money in two ways, they make money either by reducing cost or by selecting out risk. And by selecting out risk, well, one way to select out risk is to attract predominantly good risks by doing things like trying to sign up members in health clubs or doing certain types of advertisements that are going to appeal to healthy people. There are various other methods that they become quite expert at, but another part of selecting out risk, of maintaining a good risk pool, is disenrolling people in subtle ways. And I mean, obviously, they can't do it too heavy handedly, but by making it difficult for high cost people to get treatment. And particularly, with HIPAA, with no pre-existing -- with people not having to worry about having to fulfill another pre-existing condition exclusion clause, people now can more easily switch between plans.

So, I think it's quite possible that the new HMOs that come along now are going to have a worse risk pool, and that's another thing that makes it tougher for them to get into the business profitably. Again, that's just speculation. It seems to make sense to me. I don't know

from auto insurance in the following ways: And I think when the carriers started up HMOs, they thought it would be more similar to auto insurance for this reason. In another insurance, there are a couple of dominant carriers, obviously State Farm, AllState, they've got a huge percentage of the market. Now Progressive and GEICO are moving up, but the national agency carriers, carriers like Travelers, Hartford, SafeCo, which are higher cost because they use independent agents, not a salaried agent, they are nationwide, they only have a couple of percent in each market, but they do make a profit that way. They do very well only having a couple of percent in each market.

I believe when some of these companies went into the HMO business, PRU, MET, Cigna, the pre-U.S. Health Care Aetna, they thought it would work the same way, that they could make money nationally if they just had a couple of percent of each market in the HMO business. But that's not how it's worked, there are obviously different fundamentals of the HMO business, and so it's much tougher for the national carriers to make a go of it at a 1 or 2 or 3 percent market share in the HMO market than it is for them in the auto market.

Let me just say a couple of words about efficiencies. As I said in the St. Louis market, in

those merger cases, the merger proponents didn't really argue efficiencies too strongly, but one of the things I guess that I would like to emphasize about efficiencies is that it's a question of fact. It's a question for a fact witness, it's not a question for expert testimony.

And on the issue of efficiencies, the language in the merger guidelines, I think, is very good. If the agencies are going to buy an efficiencies argument, the guidelines say that the agency must be able to verify by reasonable means the likelihood and magnitude of each asserted efficiency. That means that the companies must come in and explain exactly what it is that they can't do now that they would be able to do after the merger. That they've got to have fact evidence of those kinds of things, and I think if they can come up with those types of things, that an efficiencies defense ought to be allowed, but if they can't, it should not be.

We talk a lot about efficiencies, but what we don't talk about are I guess the term, the more fashionable term now is synergies, so we talk a lot about efficiencies or synergies and economies of scale, but we talk very little about inefficiencies or negative synergies or diseconomies of scale.

And I guess I would like to end up with this: For the last 25 years, antitrust has been focused on

demonstrating that where a merger on its face, based on the market shares involved, would be anticompetitive, let's look hard at entry barriers and efficiencies, and where there are low entry barriers and the merger is going to create efficiencies, we should allow the merger anyway.

That may be fair, but let's look at it also from the opposite point of view. What happens if a merger -- if the entry barriers are high, and clearly there are no efficiencies created by the merger? Well, I think in the next version of the Merger Guidelines, there should be something said about what happens when there are high entry barriers. And what happens when there are no efficiencies? In those cases, maybe there should be a presumption that the Agency challenge the merger, and maybe the Agency should even go a step farther and say, even when a merger does not meet the Herfindahl thresholds, in a market, where entry is particularly difficult, and efficiencies are clearly not going to be created, maybe mergers ought to be challenged even when they don't meet the concentration thresholds.

(A , .)

MR. ELIASBERG: Thank you. Lawrence?

MR. WU: Well, thank you for inviting me to speak on this subject. As I considered the presentations that

were made yesterday at the hearings on the product market definition and on competitive effects in the health insurance marketplace, it is clear that entry and expansion is a central story line in the analysis of competition.

It comes up in the debate on product market definition because the ease of entry and expansion affects how one counts and identifies the participants in a marketplace. And it comes up in the debate about competitive effects, because entry and expansion is one of the most important sources of competitive constraints on existing health plans.

So, what I want to do today is evaluate two questions regarding entry that often arise in the context

events but part of something more systematic. So, let's start east and move west.

1994, in the Atlantic City, New Jersey area, the leading health plan in 1994 was Blue Cross/Blue Shield of New Jersey, which had a 38 percent share of HMO POS enrollment in the metropolitan area. And in just four years, there were eight new entrants, and as you can see, they did well.

In 1998, the entrants, collectively, had a 47 percent share of all HMO POS enrollment in the area. What happened to the largest health plan in 1994? That's the pink slice of the pie which belongs to Blue Cross/Blue Shield of New Jersey, and the share of that firm shrunk by 17 percentage points.

Among the new entrants was AmeriHealth, which in three years time became the leading HMO in the city with about a 30 percent share.

Let's take a look at Houston. In 1998, about 23 percent of all HMO enrollment in Houston was accounted for by 11 entrants, that is 23 percent of the shares in 1998 were accounted for by plans that were not in business in Houston four years prior. And what happened to the largest plan during this period of time? It lost share, and the share of the largest plan, which again is in pink, fell 32 percentage points.

Now, the obvious question here is whether the experiences in these two cities are merely anecdotes and isolated events or whether they're part of something more systematic. And my conclusion is that the data shown on these two slides are not unique events, but rather experiences that reflect the more general phenomena that, one, entry or expansion can be relied upon to take share away from the leading firm; and two, entry or expansion is an effective source of competition.

To test these experiences, and to test whether these experiences in these cities yield more general conclusions, my colleagues and I analyzed four years of information describing the effect of entry or expansion in 46 cities. So, for each metropolitan area, we collected information such as the number of HMOs that serve the area, the enrollment and shares of each HMO,

plan; and two, making service areas less concentrated over time.

So, let's start with some numbers. In 1995, the average share of the leading plan in each metropolitan area was around 37 percent. In 1998, the average was 30 percent. So, in three years, the average share of the leading plan dropped by seven percentage points.

So, one question is whether this has anything to do with entry or expansion. And when you look at the data across these 46 cities, the answer seems to be yes.

business away from the large plans? Well, our analysis of the data found that they did. And if we define a small plan, as any health plan with 10,000 lives or less, we see that in aggregate the small plans did constrain the leading plans, and when the total share of these small plans increased, the share of the largest plan decreased.

It isn't one-to-one, of course, because small plans did take business away from the number two plan and other larger plans, but the data show that the leading plans lost disproportionately more.

So, not surprisingly, these results explain why service areas have become less concentrated over time, and service areas that became less concentrated because there was entry of new plans, and declines in the share of the largest plan.

What's not so evident, though, is that the drop in HHI was greater in more highly concentrated service areas. And this is important because that says that the process of entry and expansion is an important onergest plan. of th06

And both types of switching are important, so let me just discuss each of them briefly. Let's start with switching costs for individual consumers.

For individual consumers, there are costs in switching health plans. I think one of the ones we hear most frequently is concerns by consumers that changing health plans may require them to change physicians. And I think in many cases, and in many cities, this disruption is overstated, and one reason is that many competing carriers have broad and overlapping provider networks. Now, this may not be true in all markets. We consider it to be an empirical fact that could vary from market to market.

The second reason why these costs are often overstated is that employers can and do take steps to minimize the disruption costs to subscribers. So, to facilitate switching, an employer can offer its employees multiple health plans, and in fact, this is the case for the majority of employers in this country. According to the 2002 Kaiser HRAT survey on employer-sponsored health benefits, 62 percent of covered workers had more than one health plan option. Moreover, the majority of employees, around 61 percent, worked for firms that gave them a choice of more than one HMO.

Now, of course, the availability of another

health plan does vary by the size of the employer. The percentage of employees in the smallest firms, that is firms with three to 199 employees who had more than one health plan option was 24 percent. And in general, the percentage of employees who have more than one health plan option rises with firm size.

So, in the category of firms with 200 to 999 employees, 61 percent of employees had more than one health plan choice. The percentage was 75 percent in the category of firms with a thousand to almost 5,000 employees, and 86 percent in firms with more than 5,000 employees. Now, these are national figures, of course, the specific figures will vary from city to city.

In addition, health plans can and do take steps to minimize the disruption costs to subscribers. Health plans engage in marketing and advertising, which we see during open season. They give discounts on pricing to get new business, they build broad provider networks to reduce the disruption costs to consumers who might be concerned that switching a plan would also require them to switch doctors. And they continually improve their products and customer service.

And for a health plan, this is a cost of doing business. This is part of the ordinary course of business, whether the plan is a new entrant or an

existing plan. And because it is a cost of doing business, whether the plan has a high share or a low share in the market, or whether the plan is an existing firm or a new potential entrant, it is a cost that is incurred by all plans, and so those costs do not rise to the level of being a barrier to entry.

So, let's turn to switching costs for employers. The potential disruption to employers is often overstated. Although you'll hear benefits managers complain that switching a health plan might tend to lead to long lines outside of their office door. And clearly some employers may have reservations in dropping one current health plan for another. But in practice, dropping a health plan is probably not what most employers tend to do if they want to switch health plans.

For instance, there's probably -- it's more likely that an employer would keep his current health plan and offer a lower priced alternative plan as an additional option for employees who may be willing to switch. And that's the option that's usually done rather than a complete replacement.

Now, there are some administrative costs, of course, to employers who do this. The ability to form enrollment and other administrative tasks electronically is reducing the administrative burden on employers, where

Why don't we take a 10-minute break and then come back for the moderated roundtable discussion. So, why don't we reconvene at 10:50. Thank you.

(Whereupon, a brief recess was taken.)

MR. ELIASBERG: Welcome back. Now we're about ready to start the moderated roundtable. Let me first introduce the two other participants on the roundtable. The first, sitting to Lawrence Wu's left, is Stephen Foreman who is an economist and a lawyer and Director of the Pennsylvania Medical Society Health Services Research Institute. He's also, I might add, submitted written comments last September on behalf of the society to the FTC's Health Competition Law and Policy Workshop, touching upon some of the topics that we're going to be exploring this morning, and you can access those comments through the FTC's website.

And to Steve's left is Art Lerner, who is back with us again. As many of you know, Art is an antitrust lawyer with the Washington, DC, law firm of Crowell & Moring, and he has represented numerous clients in health plans and insurance company mergers, and before going into private practice, he was head of the Federal Trade Commission's Health Care Division.

What I am going to first do is just let each of

our four presenters from this morning have an opportunity to make any comments, if they would like, on what they have heard this morning, seeing how it's been a while and there's been a lot of information that has gone around the table since we first started.

After we do that, we'll ask our two new participants if they care to make comment on what they've heard this morning and then we're going to open it up to questions among the roundtable participants. We hope all of them will feel free to ask questions of one another, as well as answering questions that Sarah and I may be asking.

As a procedural matter, if a number of people are interested in answering a question, or you wish to speak, we appreciate if you would turn your name tent over so that we will know to call on you and keep things going in an orderly fashion.

So, with that, let me turn to Mary Beth, any thoughts or points you would care to add or make?

MS. SENKEWICZ: I probably just want to say thank you, and I probably need to have a conversation with Jay at some point. The one thing that occurs to me, the one thing we do hear within particularly the small group market for health insurance is that we're losing -- they're losing competition. And there was kind of a

little thread with Jay's in St. Louis is down to three, and St. Louis perhaps is not the best example, but at some point, though, because of critical mass, and I was

we're down to 25. Well, how many does New Hampshire really need? How many does Wyoming really need?

So, I just think as a risk-spreading issue, that's just something that I would like to consider. Thank you.

MR. ELIASBERG: Ruth?

MS. GIVEN: Yeah, I would just like to make a comment about Lawrence's presentation. I'm very interested in the first part of it, and maybe we can talk about that a little bit more, the study of the different cities, but I also just wanted to comment that I totally agree with the second part. I don't think there are any switching costs and I don't think switching costs create any sort of barriers to entry for the HMO industry. Especially where there are broad markets where everybody just uses the same providers. Kaiser sort of being the

MR. WU: My question, this is really a question, I think, for Mary Beth, which really has to do with the regulations, and I know there are -- putting aside the important issue of solvency, I know health plans compete at many levels, they design their benefits packages, they set their prices and so forth. What concerns you the most about health plan benefit design, and what I'm wondering is whether you view some of the work of the insurance departments as being insuring a minimum standard, or whether you're really shooting for something

them in turn if they have any comments or thoughts they would like to -- or observations they would like to make upon the presentations that were made. So, Steve, why don't you go first.

MR. FOREMAN: Thanks. Well, from the perspective of the question, we have the data. It's just sort of a starting standpoint. In 2001 and 2002, we did a study of health insurance markets, there is study data, and in point of fact, the story is a whole lot different now than it was in 1998.

I'll give you an example of Houston, in our latest edition, there are only four firms left in Houston, they have 91 percent of the market. The Atlantic City situation I studied for the New Jersey Medical Society, and what you caught in 1994 to 1998 was a very large shift in competitors there. AmeriHealth, which is one of the firms that's a subsidiary of Independence of Blue Cross, it has a 76 percent market share in Philadelphia, and it was using that to expand into New Jersey, which is right down the road. In fact, the Atlantic City market is one of the most concentrated in New Jersey right now. There are only two firms left, Blue Cross and AmeriHealth. So, that market is now concentrated.

We would like to have St. Louis' problems in

firms with high shares and high profits? Why aren't we seeing the entry?

From my own experience, and it's actually getting too long now, I suppose, but over many years in this industry, from wearing a lot of hats, I see four key barriers to entry in health insurance market, and some of them haven't really been discussed here. Ruth talked about one, she called it pecuniary economies of scale, I actually call it monopsony power, Ruth, sorry. You know, if there are not other efficiencies tied to it, I just think that's raw bargaining power, and I wonder whether it should exist to begin with.

So, that gives you an advantage, and the real advantage from that is, you can guarantee yourself, if you're a downstream seller, as an insurer, of the lowest input costs in a market. And you can use that to exclude entry.

The second item here that people haven't discussed a whole lot, is what about the issue of very large reserves and high levels of capitalization required for firms to compete effectively in new markets? We have a carrier, for example, that has a $2.3 billion surplus in reserve and they have indicated, I suppose, tied to it is what are they willing to do with it to keep entry up? And we have seen instances where people are willing to

use those reserves to make sure that they reduce price for any new entrant and, you know, so why would anybody want to come in there and just lose a lot of money? So, that's the second one.

Third, fully formed networks are an advantage to existing health insurers. New entrants can come in if they can run a network, but if you have one dominant carrier that's not willing to enter a network, you're faced with the task of putting together a new network from scratch. That's going to take you a lot of time, at a minimum, and there may be a number of key providers who don't want to actually provide services to you for one reason or another.

Just as a parenthetical, UPMC tried to go into the business dealing with Highmark. It took two years for them to get physicians credentialed, and they already employed about half the physicians they wanted in their network.

Next, the broker system matters. In many of these areas, lots of the health insurance is sold through broker systems, firms that haven't had brokerage systems or have had pro-broker systems have found out to their chagrin what the importance of this is, and in some of the major areas in this country, in effect, the large dominant insurers have an exclusive broker network.

I was in a case in Indiana last year where someone tried to argue that the rental PPO network client that I represented had market power in some sort of a rental PPO network market definition, and their expert came in and testified that there were substantial barriers to employers switching, especially for smaller employers, because for larger employers, blah, blah, blah, but for small employers, which, of course, tended to use PPO products and tended to use rental PPO products through

decrease in HMO POS concentration, but there was also a fourfold increase in enrollment. In other words, it looked like there must have been a substantial shift out of indemnity and PPO into some sort of HMO product over that period of time.

And I would agree, that tends to be indicative of what happens when HMOs are in their growth spurt period in particular parts of the country. And so you will see in Texas, which may be a little bit behind St. Louis and Boston and Philadelphia and maybe some other communities, that you will have this period of rapid shifts where a lot of people are jumping in in one sort or another.

Subsequent to that, I don't have the data to talk about Atlantic City or data to talk about what's happened in Texas, but certainly in markets that are more mature managed care marketplaces, you're not going to see that kind of new entry, and you're also likely to see some departures from plans who came in and got beaten out.

What none of the discussion has today gotten into, though, I think, is obviously the important question, which is even apart from entry barriers and how high they might be, what is the level of concentration, Herfindahl measured otherwise, at which we can expect to get viable, vigorous and strong competition in managed care markets. What are the barriers to collusion or

barriers to single firm exercise of market power? How much do we need to worry about a merger of number one and number three in a market with five meaningful players? I mean, where should we be on the Herfindahl scale in terms of level of concern? I think that's an important question. There is some research that's been done, and not a whole lot, but there's been some literature, I would say, if not a lot of research, that suggests that there's not a lot of potential for collusion in managed care markets. If you look at the history of antitrust enforcement, you know, I can't remember finding a case, bringing a case or finding a case where you could successfully prove collusion among health insurance companies, in contrast to others. I'm not saying it can't happen, I'm just saying I think it's an important topic, because there may be barriers to new entry in a mature market, but that doesn't suggest necessarily that there's a competition problem, unless you have concerns about the level of actual performance.

Finally, on barriers, I think just from my experience, I think an attempt by existing carriers to rip off the public with high prices is more plausible if they have a way to lock up the provider community than if they don't. That the markets do have a way of fixing themselves if the inputs are readily available to

expanders or new entrants or the smaller fry in the marketplace.

And so if the larger plans do not have exclusionary practices going on with the provider community, I have less concern about size. I do have some concern about in certain circumstances the use of MFN clauses, the use of exclusive contracts, the use of tactical contracting practices that would obstruct the ability of new entrants to get access to a viable network.

I would note that mere size does not necessarily seem to be an obstacle to other competitors coming in and getting good prices from providers. For example, if it were true that dominant payers could expect somehow automatically to extract bigger discounts from providers than the smaller competitors, why have some of the larger ones been tempted to use MFN clauses in the first place? Because if they could simply by their size extract better prices, they wouldn't need to use the allegedly punitive MFN clause to try to keep the providers in line.

In fact, from some experience I've seen, the providers in some cases are more desperate to keep prices up to the larger payers because those are the ones they have to cover their fixed costs with. With the smaller new entrants they will sometimes have, I can pick up a

something to be thought about. And that's another reason why I think the Agencies should be very sensitive to market power aggregations on the provider side, not only because of what they do to the consumers directly, but conceivably also to how they might influence the structure of the payer market as well.

MR. ELIASBERG: Thank you. I guess the prerogative of the moderators is that we do get to ask the first question. So, with that, I'm actually going to turn to Mary Beth and, Mary Beth, thank you for the Health Care 101 course, as you put it. I'm afraid, though, I need to ask you a bonehead health care course question here.

At the session yesterday, an example was given of a hypothetical that was given of, well, gee, if an HMO -- the example given was in Florida. I don't mean to limit this to Florida, but the example was given that, you know, an HMO has license and can offer services in Orlando. If prices were to go up, if the incumbent suppliers in Miami where this particular HMO was not participating would try to raise their prices, the Orlando HMO could simply start offering services in Miami, seeing how they had the license by the state.

Just how accurate or precise is that characterization in the real world?

MS. SENKEWICZ: Generally speaking, Ed, the HMO just couldn't kind of pick up from Orlando and start the next day in Miami. As part of the license or process for HMOs in particular, insurance commissioners typically allow them to operate within certain service areas, they have to have the adequate networks, they have to have everything set up. So, I believe, generally speaking, that HMO would have to go back to the insurance commissioner, come up with a new business plan, you know, demonstrate that it could adequately serve any, you know, essentially come up with a new business plan for Miami before that would be approved is my general understanding.

MR. ELIASBERG: And I guess one thing, just to follow up, and part of that business plan would be that there are -- could you say a little bit more perhaps about what are in the -- you mentioned network access requirements, just in general descriptive terms, what would be involved in those sort of requirements?

MS. SENKEWICZ: Well, network adequacy, just simply put, is that the HMO, the health plan, has sufficient numbers of providers and sufficient areas of services to deliver on its promise to the insureds. I mean, very simply put. So, that means they have to have, you know, X number of specialists, most states keep it

fairly general like that, rather than get into formulaic type stuff, at least in the laws and regulations. They may, in practice, when reviewing those types of applications, get into that. The NAIC model on this subject, as I said, is pretty general. But, I mean, that's it in a nutshell. Adequate numbers of providers to deliver the services promised in the contract.

MR. LERNER: Ed, if I could just comment and then also mention one point that I forgot to mention. Generally, as a lawyer who has advised plans and gone through that process, in general, that process would not seem to require much more in terms of substance in terms of your network than what your customers are going to demand, generally. So, it's not -- I wouldn't view it as adding in normal circumstances. It's more of a consumer protection safety thing, but in -- for most employers that you would be approaching, if you didn't have that kind of adequate network, you wouldn't get very far to sell. So, it doesn't really impose an extra market requirement, other than some additional lead time. And that usually is a couple of months to go through that process.

The only other thing I was going to mention since NAIC is here, I was going to just mention this, I've mentioned this before, that the NAIC has its own

insurance holding company act which imposes antitrust scrutiny or antitrust type scrutiny to mergers of insurers and HMOs, and most states have adopted some form of that model holding company act, as Missouri has.

And the process that it uses is a very sort of similar to the Hart-Scott-Rodino type practices, but it also creates certain presumptions, and unlike the antitrust laws which talk in broad terms like substantial lessening of competition, the insurance holding company actually does that, but then actually has numbers built right into the model law, which many of the states have adopted. That actually creates statistical presumptions, that a prima facie case is made out with the following numbers.

So that, for example, in a nonconcentrated market, if one carrier has 19 percent of the market, and merges with another carrier with 1 percent or more of the market, it is prima facie illegal. And then there's, you know, if it's 5 -- if one has 5 percent and the other one has 5 percent, it's prima facie illegal.

For those of us that have been operating in the federal antitrust standards for many years, these are remarkably 1960s-like figures. And I think, frankly, it's a disservice to the insurance commissioners because it puts them in an awkward box of operating -- you can

rebut these, it's a presumption that you can rebut them, but it helps them because it gives them leverage, because they have very low numbers to start with, and putting the burden on the merging parties, but it puts them in an awkward spot to be administering the statutory framework that doesn't really seem to conform with current antitrust jurisprudence, whether one agrees with it or not.

And I noticed that, for example, when Jay talked, he talked about reviewing these mergers and how they stacked up against HHI standards. He didn't talk about how they stacked up under the statute that supposedly he was charged with enforcing. I don't blame Jay for that, I'm just saying that the statute is sort of frozen in time. And I think that's something that NAIC might want to at least look at.

MR. ELIASBERG: Sarah, if you would indulge us, I think that Art has engendered some other interest, and Steve, why don't you go first.

MR. FOREMAN: Back to the original question, I think there's another concern here that I have from the original question, and that is if the Orlando HMO and the Miami HMO that have dominance in those markets have a side agreement that they won't compete in each other's territories, that creates another barrier to entry that

ought to be of concern to us, and I think those kinds of agreements do exist in a number of areas of this country.

MR. ELIASBERG: Okay. Jay?

MR. ANGOFF: Yeah, Art's right about the state insurance holding company acts. The way insurance regulation works is the NAIC drafts model laws and the states typically adopt those model laws or a version of those model laws. The model insurance holding company act has codified the Department of Justice guidelines, but they're not the current Department of Justice guidelines, they're the 1968 Department of Justice guidelines.

So, at least the theoretical power of an insurance commissioner is huge. We, if we wanted to take the statute literally, we could go back to Von's Grocery, or ALCOA-Rome. We could prohibit mergers which today, you know, no one gives a second thought to.

And I would hate -- I mean, I understand what Art is saying --

MR. LERNER: It's not the public policy, Jay.

MR. ANGOFF: Well, there's certainly an argument --

MR. LERNER: Leverage.

MR. ANGOFF: It is true that it is not consistent with current antitrust jurisprudence, but I would also

say it's just not consistent with the current fashion in antitrust. And things may go back the other way, and on the one hand it is anomalous, on the other hand, I would hate to see the NAIC now codify the new justice guidelines because by the time they did that, and the states adopted it, probably antitrust jurisprudence would have swung back the other way. But Art is absolutely right about what the statute says, in addition to the antitrust, the substantial lessening competition standard, there are five other standards, and one is a catch-all, prejudicial to policyholders' standards.

So, I guess what I'm saying is, if the commissioners really wanted to exercise the authority the statute gives them, they could do a heck of a lot, but in general, that authority has not been exercised.

MS. MATHIAS: I actually wanted to go back to Jay and give him an opportunity, because I think when Steve was making comments, you kind of made a note to yourself about a response to a question that it was either Steve or Art raised that I thought you wanted to respond to relating to the St. Louis market. Was I wrong about that?

MR. ANGOFF: Okay, sure. On the issue of the profitability in the St. Louis market, and Art's point is correct, the point that I didn't make was that

profitability and pricing in St. Louis is higher than it should be, based on some measure. We don't have data, I don't have data now as to the entire commercial HMO market in St. Louis. We do have data, though, for the Missouri consolidated health plan, which is like CalPERS in California, which, when I was commissioner between '93 and '98, functioned as what I think is the closest model in the country to a pure HPIC. What the state did was to standardize the benefit package and require companies and community -- and establish community rating in effect, and require the HMOs to bid on a standardized package and to give us one price at which they would assure -- they would insure each state employees, any state employee that elected that plan.

And the state paid the entire cost of the low-priced plan. So, there's a tremendous benefit of being the low-priced plan, because you got that insurance for free. If you wanted to elect the prior-priced plan, you had to pay the difference.

And every year I was commissioner, those prices were very, very low. Since I left, the prices went up way, way more beyond any measure -- whatever measure you use, the increases in the Consolidated Plan have been far above that measure.

Now, does that prove that concentration or the

lack of entry has driven those prices up? Not necessarily, because among other reasons, prices in the Consolidated Plan were artificially low during the five or six year period that I was there. But there is some evidence and we can argue that, but I do agree with Art that in order to close the loop, you need to demonstrate what the existing price level is in St. Louis.

And just one more comment and then I'll shut up, but just look at what a great issue entry is for defendants. On the one hand, they can say, well, if a merger is challenged, no matter how big the market shares are, we don't have to worry about it, because there's going to be new entry. And if there's no new entry, then they can say, well, because there's no new entry, that means prices must not be supra competitive. So, I just think we ought to be a little more skeptical about arguments with respect to entry in general.

MR. ELIASBERG: Do you want to respond?

MR. WU: I think I'll take that cue. I'll take that cue to respond to a couple of different comments that people have raised, and I've got four.

I think, and this is taking a step back and looking at the data that we've seen over the past, say, dating back to 1994, and I guess here are the lessons that I think we've learned: One, that entry and exit

does take place, okay? Now, what does that mean? It means to me that one thing that I think we've all agreed on, which is that switching costs really are not so much of an issue. So that customers do seem willing to -- they are willing to switch plans and that includes accepting new plans into the marketplace.

The other thing that I think we can learn from the entry and exit is that health plans are responding, or seem to respond to changes in market conditions. And in part that's what the underwriting cycle is about, and in part that's why we see a lot of entry in the late 1990s.

But it's comforting that the health plans are responding to market conditions, because that's the kind of thing that we do want to think about when we evaluate a merger and have to look forward. Do we have any -- and it's important because we want to think about what evidence we have to believe that new entrants or potential new entrants are likely to respond to what's going on in the marketplace.

And I think the experience suggests that entrants are responding to profit opportunities and to changing prices. Again, I think that's what the underwriting cycle does.

And I guess the third lesson is that entry does

-- and expansion does take place pretty quickly, and you see large shifts in shares within a very short period of time.

I think that goes to my second point, which is looking at shares, this is something that Stephen mentioned, which is his comment that, well, if I were to look at Atlantic City or some other city today, we might also see a very concentrated marketplace. And I think you mentioned some figures about AmeriHealth in Atlantic City today, but again, I think the point that I would draw from that is the dynamics is exactly why it's -- why we can't look at concentration at any one point in time, because it may be -- there may be a certain market concentration today, but it's probably true that there was a same level of concentration years prior.

The key, though, is that the identity of the firms aren't the same. And I think that's the important point, which is, you know, there may be changes -- in some markets there are changes in concentration, in other markets. Even if concentration did not change, I think it's important if there are shifts in identity of who the leading firm wasjoiokn2-22gdentity of whogdentn.8 that the idenhinke

respond to is this question about why haven't we seen new entry? Now, that's a -- that's a tough question because if you look at the data, and this is basically the beginning of a new underwriting cycle, and after a period of high premiums, which is when people expect to see new entry occurring.

Now, one is, I have to say, it's still pretty early, so I'm not sure that we would expect to see the new entry so far, but again, this is something we should revisit in a couple of years. But the other thing is, that when we think about new entry today, do we really expect to see new entry in HMO plans? And I think this is -- this is more a limitation of the data than it is a limitation of our expertise, and that's really the data that we track are data on HMOs. And that's what we tend to know a lot about, in part, I think, because of the regulatory framework. HMOs are required to report a lot on their finances and enrollment.

So, we know a lot about HMOs. But if you think about what's been happening over the past four or five years, it's been a period where employers and consumers have been turning away from HMOs and turning to PPOs and other less restrictive managed care products. And those are the plans where I think we're seeing the enrollment growth and the expansion.

I think it was Fred Dodson, with PacifiCare, he said yesterday that, in fact, PacifiCare is not entering new markets with HMO plans, but they are entering new cities with PPO plans. And again, that's the dynamic that we're counting on, but again, that's something that we're not going to see in the data.

And I guess that goes to my fourth issue, which is HMO penetration, and your comment that in Texas you noticed the enrollment growth in HMOs, and again, that's -- you know, there was the heyday of HMO penetration, that's in part why there was a lot of entry. In today's environment, there's this managed care backlash and consumers are turning away from it. So, again, this is just another way of saying that I'm not sure the entry would be expected with HMO plans, but I think if we actually looked at PPO plans after that we would see it.

MR. FOREMAN: I think I would like to start out by saying, I take that as a yes, that you are forming a new insurance company in Pennsylvania?

(L - .)

MR. ELIASBERG: Steve, did you want to comment on what Lawrence was saying?

MR. FOREMAN: In fact, I would like to point out that from the data that we have, that concentration has been increasing since 1998. The world has changed. I

level of concentration that we're seeing doesn't seem to be explained by the insurance cycle.

MR. ELIASBERG: Ruth, did you want to comment?

MS. GIVEN: Yeah, and actually, what I wanted to say really kind of echoes what Steve was saying. It's basically by saying that we're shifting out of HMOs to PPO and maybe even to self-insured does not assume -- that shouldn't imply to we're shifting to different companies. Because as Steve pointed out, it's the same company.

As Fred Dodson said the other day, PacifiCare is trying to move more into PPOs. One of PacifiCare's big efficiencies at the moment is ASO; they would love to get into self-insured, they would love to do that. And so in reality you're buying a different product, you're not buying it from a different bunch of competitors. So, that doesn't seem to really increase entry or, you know, intrusive competitiveness.

MR. ELIASBERG: Actually, Ruth, let me sort of follow up on that with a question and if you're not the right person, maybe someone else can jump in. Given what you just said, going back to the example that was given yesterday, and change it just a little bit, in which you have a PPO in Orlando that is not offering services in Miami, and the current providers of PPO services in Miami

decided to raise prices a significant and nontransitory amount, what's to stop the Orlando PPO from simply going in and price disciplining the incumbent firms in Miami?

MS. GIVEN: I'm probably not the best person to ask that of, I don't have any personal experience with it, but I mean, I think it really depends on whether they're able to get the relationships with the provider networks. And, you know, I guess the only experience, I mean, with regulatory issues, I can deal with the regulatory issues from an economic point of view, and the only kind of story that I can tell that's at all related to that is -- I mean, it depends on if you can bring covered lives quickly, if you can bring bodies to people and get a big discount. But the only experience I can talk about is a conversation I had with Lee Newcomer who, as I mentioned, used to be the medical director of United, and is now at Vivius, talking about how his new plan, he is sort of trying to move into new areas of the country, any areas of the country, actually, and discussing the problem they had moving into the Spokane area with another health plan, which was HealthNet. And it's interesting, because it also brings up an issue that Art raised about potential barriers to entry problem when there's one dominant plan, I guess in the Spokane area, it's Primera Blue, and having a real difficult problem,

it could mean a number of different things.

You could mean, and we talked about this a little bit yesterday morning, it could mean a vertically integrated insurer with its own proprietary provider network, let's say Aetna offers an insured or self-insured product administered by Aetna through a Aetna contracted delivery network.

So, let's say there's Aetna and two or three companies like that and they all tried to raise price. But you also often sometimes have a PPO network that is a substantial, for example, the company that Jay had referred to in HealthLink prior to its affiliation with Blue Cross, where you have a network organization that rents itself, that may have various -- it may have to undergo utilization management and claims various other capabilities, but it doesn't provide the insurance function and it rents itself -- it may have an insurance license on the side, but its principal business is to rent itself out to carriers, in which case if the carriers selling that product were to raise their premium while maintaining the same price they pay to the provider network, it would be that PPO's incentive to invite into town an insurance company from Orlando to come in and happily do business with them.

So, you have to focus on what you're talking

about, and therefore Ruth's comment was shorter and correct, that it depends on access to provider network. If you can get access to a good provider network, and you're an insurance company with a brand name, there's not a lot of barriers to entry to competing with, you know, with Aetna. I don't think that really just because it's Aetna and you're Humana and you're right down the road and you can get the exact same network at the exact same price or a better price, that, to me, seems pretty competitive.

Take a market where I've heard complaints about in Utah, where you have a dominant payer who is also the dominant provider, and you've got problems, okay? So, I'm not saying that they've broken the law, I'm just saying that I have gotten a lot of complaints, because it's a small state, I've gotten a lot of complaints about Utah.

Stephen raised a question. There's been a lot of discussion today, a number of speakers have talked about the insurance underwriting cycle. I understand that to mean, in practice, that profitability in the managed care industry and the health insurance industry swings, and you'll have a trough and then you'll have a higher and then you'll have a trough. That you would normally, as Lawrence was just explaining, that you would expect

during a period of a downswing across the country, irrespective of particular local market areas, you wouldn't expect to see a whole lot of entry, and that you would expect to see relatively more entry in a period of up if it looks like the period is going to be wrong. But it's like market timing, you don't want to jump in too soon and all that stuff.

I guess the thing I found interesting was Stephen's question or comment where he said he thinks the very existence of these underwriting cycles suggests the existence of a competition problem. Or the existence of market power or at least barriers to entry, which suggests a competition problem.

And I've also heard about this insurance underwriting cycle on the property and casualty side, with malpractice insurance, with liability insurance, with tornado insurance, all sorts of things. It's everywhere. So, I guess my question to Lawrence and Ruth as economists also are, what are your thoughts on Stephen's observation about whether the existence of these underwriting cycles somehow suggests the existence of a barrier to entry? Given being, you can go first.

MR. WU: I'll just start.

with Lawrence and then Ruth responding to Art's question?

MR. WU: Yeah, I've interpreted the underwriting cycle much more as evidence plans are responding to profit conditions in the marketplace. So, it's not so much a barrier to entry, but just a normal market process at work. And especially if it's something that we see in insurance generally, it seems to me the insurance cycle is, you know, unless we think there are barriers to entry in all of insurance generally, then I think it's probably not evidence of the barrier to entry in health insurance.

You know, I guess the more -- the question that I think this raises is, what do we make of exit from the marketplace, which is so let me sort of translate what I think Steve is saying, which is there has been exit, and so a question is, is that exit a -- does that exit represent the failure of an entrant to get into the marketplace, or is that exit representing a rational response to market conditions, for example, prices falling and profits falling?

And I think it's, you know, given the general phenomenon, I think it's part of the normal market process, because I think if you were to look at barriers to entry, I think that's something we need to look at market by market as opposed to something that's much more general that goes across the industry.

MR. ELIASBERG: Ruth?

MS. GIVEN: I think my comments would be first, I think, in general, the policy and we're also seeing the insurance cycle is flattening out, which is interest, it means it's not a persistent thing that goes on forever. So, that may be something to think about.

I don't think it's necessarily a sign of lack of competition; however, I find it kind of peculiar that you don't see it with life insurance, as far as I know, but you would see it more in the property and casualty where you'll get like a big hurricane and something and there will be big losses and you'll have to deal with that. It makes more sense in property and casualty.

MR. LERNER: A plague would help on the life insurance.

MS. GIVEN: Yeah, or major earthquake, I mean, that kills people. But I just, I mean, this is the thing I'm always puzzled about, and this is why I do somewhat agree with Steve, it doesn't seem like it should be there. Why doesn't it exist in life insurance if it's in health 9ecsn't seem like it in lce i2oj7ut ke, I mean,

potential entrants, and I think that is the class of providers, of hospital networks -- hospitals themselves. Most have been failures, and certainly when doctors try to start up these things, like Ruth in the California Medical Association, they've been horrendous failures. But at least there's the potential. The providers hate to see these middle men. I mean, the providers do all the work, they provide all the care, and the executives of CareFirst get a 39.4 bonus, 39.4 million for converting to for-profit status. And here are these poor doctors and hospital directors struggling along on a couple of hundred thousand a year. They hate that.

And so, there have been lots of efforts of doctors -- of providers to start their own HMOs, and most have been failures, and the reason is that in order to make a profit as an HMO, you've got to squeeze the providers. And the providers don't like squeezing themselves. So, most of these things have been failures, but even in St. Louis, there's one hospital network that has grown some, not overwhelming, but it's still in business, and it has grown some. And if they can figure out a way, I think that's the one class of potential entrant that really could make a difference, that is the providers themselves.

MS. MATHIAS: Earlier today Art was talking about

certain contracting practices that may or may not serve as barriers to entry, and I want to discuss a little bit whether, throwing this open to anyone on the panel who wanted to discuss it, whether the MFN clauses, the exclusive contracting, are they -- do they rank as barriers to entry, do they rank as, you know, rank may be the wrong word, but fall into more of a contracting practice that troubles some people? I mean, where should we go with that and what are the concerns that the various panelists members have? And Steve has turned his tent, so we will turn to him first.

MR. FOREMAN: I was thinking about it before when it came up.

We have four carriers in Pennsylvania with market shares at least over 50 percent -- three I mentioned that have 70 percent. They give physicians a fee schedule, it's not negotiated. They give it to you, and you have no choice. And by the way, in some areas, that fee schedule is less than Medicare. They don't need a most favored nations clause. I mean, the physician has the choice of taking that contract or going someplace else.

Now, that's not to say that those carriers don't also have things like most favored nations clauses in their contract. In fact, one of them has an indemnity

clause that they say, well, we never use it, that the physician agrees to indemnify the insurance company against the insurance company's own negligence. That's always one of my favorites. But they can also unilaterally change the terms of the contract without any approval.

So, basically, that should at least raise a red flag when you see those kinds of contract terms, and look at it from the flip side. You know, if you were a physician, why would you agree to a contract clause like that, unless somebody had some level of market leverage. So, that's where I start from.

MS. MATHIAS: Jay?

MR. ANGOFF: Yeah, I would just like to point out that market power of the insurer is not necessarily a bad thing for consumers. For example, I mean, let's go back to the beginning of Blue Cross. Blue Cross, from some of its history, was a monopolist. They community rated, they took everyone, and they really were a benevolent monopolist, at least in some states, at least for part of their history.

And even until relatively recently in Rochester, western New York, even in Pennsylvania, they still, don't they, if they don't community rate, they still have an open enrollment period. I mean, Blue Cross plans, even

state, we had a situation where the state insurance department was saying, we think these are problematic. And everyone has always taken them out in the past when we've asked. And we said, well, we don't want to take it out. And then the situation was we were an HMO, we were signing a contract with a single vision service provider, that's like an HMO signing a contract with, you know, For Eyes, to be our dedicated provider of sort of our preferred provider of vision care services to our members.

That MFN clause is basically saying we're forming an alliance with you in particular, we're one HMO signing an MFN clause with a provider that represented like 8 percent of the provider community. So, we were by no means depriving other health plans of access to whatever prices they could get from anybody or even from equal prices from this provider, but an MFN clause can serve a valuable service, and this goes to Steve's comment about why would you ever sign that if the person didn't have leverage?

An MFN clause in a nonmarket power situation can be a useful tool to say, I want to sign a contract for three years? I don't want to have to sit here and negotiate some very complicated formula to try to predict out exactly what are your costs and exactly what are my

costs and what should the price be over the next three years. You say we're going to come up with rough justice, we're going to negotiate a price, and if the market moves, and you end up having to lower your prices to other people, well, then, your price is going to move to me as well.

That's the classic MFN clause in a nonmarket power situation, and it serves a very legitimate business purpose. Where, however, you have two situations that MFN clause is a problem. If you have a group of providers gets together and forms their own network, I get very, very nervous about MFN clauses, because then while it may be a way of trying to avoid free riding on the network to help make the network more viable, which is a positive aspect, it can also be a creation of a floor and a disciplinary mechanism to prevent the providers from cutting the cartel price.

So, you have to be very careful about MFN clauses in a horizontal network situation. The other, and I think this is the one that Steve is probably referring to, is one that has been used in some circumstances by a very, very strong, we'll just use the word very, very strong payer in circumstances where if you can show that the effect of it is not really to lower the price that they're going to get, but rather to prevent new entrants

from trying to chip away at -- or smaller plans from trying to chip away and pick off a few discounts here and there to try to put together a competitive thing. Where that's the case, then I think the Department has expressed concern in the past on those things, and I think that's rule of reason, something that ought to be looked at. But I would be very wary about adopting some sort of overarching no MFN clause.

MR. ELIASBERG: Lawrence, did you want to comment?

MR. WU: Yes, on the most favored nation issue, I'll start my comments in theory, theoretically, and practically. The theoretical issue really follows on what Art is saying, which is if one looks at the economic literature, my reading is that the procompetitive benefits of most favored nations clauses is mixed. In some cases, there are obviously procompetitive benefits associated with MFN clauses, but it could also raise concerns, too. Among the benefits are the ones that aren't mentioned, which is price protection over time, which is important, especially with long-term contracts, and especially if one is concerned about rising costs.

And of course, the anticompetitive potential is that a plan that -- say a health plan that has an MFN, may have less incentive to discount in the future if it

knows that it also needs to grant that same discount to other providers.

So, it is mixed. I would say, you know, this is something that we ought to look at, market by market, as opposed to something more broadly, and I think it also matters who, you know, it matters who wants the most favored nations clause. And, you know, a lot of customers do like it. And if customers like it, and want it, I think it's useful.

The practical issue with MFNs really has to do with enforcing an MFN clause, and I think it's difficult to do that. You know, an MFN clause that relates to prices is especially difficult, because contracts are very complex with providers, whether it's a hospital or physician, and so it's one thing to see what's in the contract, it's another thing to see what the actual payments made were. And I think that's why I think if I were to summarize the history here, there was a time when health plans and providers really jumped on the MFN bandwagon, because it was -- everyone thought that it was a very good thing, everyone wanted price protection, and maybe it was just plain the fashionable thing to do, because it was the subject at many conferences.

But in practice, I think very few firms really enforce it, because it's just very difficult. And so

economies of scale doesn't mean you have merger-specific efficiencies. I think those are entirely different things and that's what you need to demonstrate. And I just wanted to kind of give some advice about looking at merger-specific efficiencies.

One of the things that I think we've seen in HMO mergers in the last few years is firms that have merged, promised major economies of scale, major efficiencies. I think we've had a lot of trouble, not necessarily their own fault, and this is in integrating information system. In fact, that's actually one of the things that the Wall Street people have been talking about are the major economies of scale in this industry. But meshing these systems together is very complicated, and the more complicated systems get in the future in the industry, the more difficult this is going to be.

And I have to say, this is sort of a plug for my firm, Deloitte Consulting, this is what we do, we integrate these systems. It's difficult for banks, it's difficult for HMOs. A couple of, you know, examples, PacifiCare and FHP had a lot of trouble meshing their systems. Even Harvard/Pilgrim, I don't know if people remember, about the time that Harvard/Pilgrim was going bankrupt, they discovered that they had two separate accounting systems that they never merged. Not because

they didn't want to, I think it's very difficult.

So, if you're looking at a merger, I would like to get some accountability here and say, how are you planning on doing this? And then one other thing I just wanted to raise, and this is getting back to the issue of entry in the self-insured market. And this is actually a question for Art, because Art, I just found a quote from you recently about this recent Supreme Court decision, about any willing provider, and basically anyways, you were saying that this is a major step in the progression of the Supreme Court's decision staking out a new approach to ERISA preemption analysis, and then talking about how, you know, there might be an impact of this decision on, you know, what ERISA plans would be able to do in the future.

So, do you think that that's going to make self-insured?

MR. LERNER: Which important Supreme Court case was that?

MS. GIVEN: Well, this is the --

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requiring that HMOs and other health insurers let any provider who is willing and able to meet the terms and conditions of the plan participate in the plan, which all other things being equal, would make it harder for a plan to assure a particular selective provider of extra volume of business. So, therefore, it makes it harder to get discounts if you think you're going to have to bring everybody in. And the Supreme Court pretty much acknowledged that by saying expressly, this will make it harder for customers to go to an HMO and get a lower price in exchange for more selective networks.

So, it's clearly inevitably, if it has the effect it's supposed to have, will probably raise prices. But what was -- I think what that quote was referring to was a footnote in the court's opinion.

MS. GIVEN: Right, right.

MR. LERNER: Which seemed to suggest that the ERISA preemption would not apply to state regulation of HMO network activity even when the customer was self-insured. That was a footnote, I don't know if they really meant it, I don't know whether they realized the consequences of it, but as I read through the opinion, the rest of it was sort of predictable. It was nine to nothing. I thought it was a good intellectual argument, and if it had been raised 15 years ago, the Court might

have, you know, given it longer thought. But in today's ERISA environment, the result was pretty -- I felt was pretty predictable, but how they were going to come out on this case, not to every line of reasoning.

But I was referring specifically to that footnote, which would be a rather radical change.

MS. GIVEN: Right.

MR. LERNER: To suggest that you could provide these any willing provider laws to an insurance company when it was not selling insurance. That would be a rather big step in ERISA jurisprudence, and a big change in insurance department authority, if the court was really going through.

Now, most state insurance laws are not written to give the insurance commissioners that authority in the first place, even if they weren't preempted, because most laws only regulate the sale of insurance, and not other businesses that the insurance companies do that's not insurance. But anyway, that's what I was talking about.

MR. ELIASBERG: Ruth, I did want to ask you one

And that's really, like I said, that's a demand side, that's something where the customer perceives a higher value, but it's not reflected in the cost. And I think that's legitimate, but you need sort of a demonstration that the customers really would prefer a bigger plan than the technically minimum efficient scale and you just have to get that evidence separately.

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a very substantial literature on the failure of mergers. On how mergers don't work, not for consumers, and also not for the companies. But I don't think there's been anything really systematic where you go back and you look at here's what the companies promised, here's what their expert witness said about all these great efficiencies and all the new entry, and let's look at now what's happened after the merger was allowed.

So, I think that's a very worthwhile pursuit.

MS. MATHIAS: Art?

MR. LERNER: Yeah, just to comment on your question to Ruth. I think that your question was, and Ruth's comment was that those numbers, even if they're somewhat low today, is for the number of members you need at the local level to be competitive. So, the notion would be that maybe you need only 40,000 people or 60 or 80, or 100, whatever that number is, as a population base in Omaha, you know, to do business.

There is a different issue, I think, about the technology that's now required to be competitive with -- to be competitive with the large employers, and large state government entities that basically want you to, you know, be NCQA accredited and to have, you know, HEDIS measures, and to be measuring this and measuring that and all these things.

looked at.

All I can say is, you know, health really is different. You know, it's not like car insurance. It really is a different animal. And in many, many respects, the health is local. You know, all politics is local, but health is really local. And sometimes it makes us state regulators a little nervous when the Feds, you know, try to kind of think nationally about these things, but there are really some very precise and peculiar issues that arise from place to place with respect to the delivery of health care services.

MS. GIVEN: Yeah, just a quick comment, and this is something that didn't come up earlier about a potential entrant in the market which has been suggested a while ago, but I think has kind of died down. And that's there was talk a few years ago about financial services companies coming in and sort of cutting out HMOs and HMOs had sort of, you know, gotten away from the providers, they were not doing anything provider related anyways, and couldn't banking companies, just financial services companies come in and do this? And I think I just want to kind of echo Mary Beth's comments about the localness, the need to deal with providers. I think this is probably not a viable option, but like I said, it was discussed a while ago that they could sort of essentially

fill this function and do in HMOs.

MR. ELIASBERG: Jay?

MR. ANGOFF: Yeah, insurance regulation and antitrust enforcement are two different worlds, and in some ways, they're really almost antithetical. There's a lot of about insurance regulation and the insurance business that involves cooperation, some which would violate the antitrust laws, some which wouldn't. But there's not an antitrust mentality about either the insurance business or insurance regulation, and in most, insurance regulators are not very familiar with the antitrust laws. I think a very good thing would be that the Justice Department and the FTC worked more closely with insurance commissioners and got them a little more up to speed on the antitrust laws.

MR. ELIASBERG: Lawrence?

MR. WU: I think that the data show that entry and expansion is a systematic effect and an important competitive constraint in the marketplace. But again, as everyone else here said, we need to look at each market separately, and each transaction differently, and each practice specifically. And I think that's -- I think everyone here's comments really go to that, which is, you know, in the end, there's 30,000-foot thinking, but there's no substitute for just being at the ground level

greatly appreciate the panelists and the roundtable participants for taking their time and giving us their excellent presentations. This concludes this session. We'll reconvene at 2:00 for the first of the buy side sessions. We ask that when you leave, if you could please take your briefcases and things like that with you, it helps with the security and all, and also any cups and things of that nature. So, thank you very much.

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(2:00 , . .)

MR. DANGER: Good afternoon, everyone. We're going to start here. Welcome back to the health care hearings, and if you've been here before and if you've not, well, welcome. My name is Ken Danger, I'm from the Department of Justice, and with me here is Matthew Bye, he's from the FTC.

This is the beginning of the Thursday afternoon session on monopsony market definition. In my opinion, this issue, monopsony, is quite hot. Congress has recently taken a look at it, and Texas has adopted laws

that establish mechanisms for alleviating monopsony harm when it's found to exist. I believe that Congress and Texas, when they were looking at those issues, were mostly concerned with monopsony power over doctors or physicians; and, however, it seems quite likely that there's a significant portion of folks that are interested in monopsony power being exercised against hospitals.

This afternoon we'll talk about issues that are encountered in market definition when monopsony is concerned. The panelists will undoubtedly talk about product and geographic issues. No doubt we'll also deal with the issue of bargaining power versus monopsony power, something I think that is not well understood in the press. I expect our panelists will also be providing some information on the supply elasticity of physicians, that is, their mobility in response to price changes, and also maybe some evidence on hospitals. I think we'll also be dealing with all or nothing contracts and with the associated implications for monopsony power, and no doubt other issues will come up, as well.

Hopefully when we're done, we'll have a good sense of when monopsony power might be of concern and hopefully our experts will point us to some key indicia that will help us figure that all out. Let's see, in

terms of our panelists, we've got Jeff Miles, he's a principal in the Washington, DC office of Ober, Kaler. Prior to that he worked in the Virginia Attorney General's Office. Jeff wrote and updates the health care antitrust law treatise.

Roger Blair is a Huber Hurst professor of economics and legal studies at the University of Florida. And Roger is the recognized expert on the topic of monopsony.

Ted Frech is a professor at the University of California, Santa Barbara; and an adjunct scholar at the American Enterprise Institute in DC. He served as a consultant and expert witness for the government and for private parties, as well.

Tom McCarthy, over here, is a senior vice president at the National Economic Research Associates, and has offered expert advice in numerous proceedings involving health care issues.

And Steve Foreman on the left over here, is the director of the Pennsylvania Medical Society Health Services Research Institute and my understanding is that Steve is here on behalf of the AMA.

I'd like to start off by asking Jeff to kick us off with an overview of the legal issues on monopsony.

MR. MILES: Thank you. I must admit, first,

having read it for a number of years, it's a particularly interesting case, because although market definition was not an issue in the case, the court just happened to mention an aspect of the case that goes directly toward market definition and got it right.

You might remember the case involved a price fixing agreement among sugar refiners with regard to the price they'd pay sugar growers. And the Supreme Court indicated that, gee, the real problem here is that these refiners are the only alternative these sellers have for their output, and when you cut through all the bull of market definition on the buyer side, that's really the guts of the test that you use, although we can put a lot

situations. The rice growers case some years ago by DOJ and of course the most outstanding example is the Aetna/Prudential case, decided by a consent decree in '99.

There are some, I suppose you would call them Section 2 monopsonization cases involving predatory conduct that excluded other potential purchasers from the market, therefore limiting the seller's alternatives. But usually those cases are a little bit screwed up because the courts have typically analyzed them as monopolization or attempted monopolization, instead of a monopsonization case.

A very interesting case outstanding right now is the case in the Eastern District of Pennsylvania

can arise in situations where payers have monopsony power. The issue there is obviously foreclosure. And there are even some reciprocal dealing cases that also raise monopsony power type issues.

Most of these alleged violations are conduct or violations that are analyzed under the rule of reason and, so, typically, unless there's some type of direct proof of monopsony power, a relevant market is going to have to be defined, both a relevant geographic market and a relevant product market.

And obviously what that market turns out to be depends on the setting or the context of the case, and also the particular type of claim, the particular type of antitrust theory involved in the case. They're not a lot of cases that discuss monopsony power itself in any detail, period, whether you're looking at the substantive legal rules or whether you're simply looking at how to define a market.

In general, I don't think the courts have done a particularly good job in examining monopsony issues, and they've done, I think, probably even a worse job in analyzing the relevant market issues in a monopsony type of case. Some courts seem to confuse the seller and the buyer issue. The case -- the issue may be a monopsony issue, but the court seems to define the market in terms

of the output market instead of the input market.

Sometimes courts just don't recognize that there's any difference between defining a market in a buyer power case and a seller power case. And some cases, again, they treat as monopolization cases, where the real underlying issue relates more to monopsony power. And then in some cases or in some analyses, you'll see that the courts will simply assume there's no difference, particularly with regard to the geographic market, whether you're talking -- whether you're looking into buyer market power or seller market power. There just seems to be a lot of confusion.

I think probably the best case I can think of off the top of my head where market definition was handled in a -- at least in an analytically sound matter is the Second Circuit's decision in 2001 in Todd v. Exxon Corp. And as you might remember, that was a case where it was a class action in which a group of employees in the oil industry alleged that their employers alleged in very, very specific wage surveys, and then the employers would get together and talk about the wage surveys. And the result of this was that the employees wages were stabilized or at least held lower than they otherwise would have been.

It looked like the case could have been alleged

as an out-and-out price-fixing case. At least at the Second Circuit level, it was not; it was more of a price exchange case, and therefore the rule of reason applied. And one of the big issues in the case was what's the relevant market. And the court realized, in effect, that the case was a case involving buyer market power and not seller market power.

If you go back and look at the District Court opinion, the District Court messed up the issue along one of the lines that I just mentioned. In other words, the District Court, instead of looking at the alternatives that the sellers had, treated it as an output market power case and looked at the alternatives the buyer had. The Second Circuit recognized that mistake and moved on.

The issue -- the market definition issue also came up in the Aetna/Prudential merger. There's not a whole lot of discussion in the competitive impact statement on the market definition issue, and I think one reason is it was not -- the issue was not difficult in that case. It was pretty clear that the product market was the purchase of physician services and maybe a little more questionable, it was relatively clear the geographic market was limited to the Dallas and Houston areas. It was not a particularly broad geographic market, primarily because the physicians could not go to more distant

purchasers to sell their services.

I guess the point -- the main point I would make, and I assume everybody in this room is pretty aware of it -- and that is the analytical framework that you use to define a relevant market in a monopsony issue case, analytically, it's the same as it is on the output side. You simply flip the analysis around. In a seller market power case, the issues boil down to what alternatives do the buyers have and how likely are they to turn to those alternatives and in what numbers.

Will there be switching to the extent that the seller can't sustain this so called hypothetical price increase that we use in defining markets? In defining markets on the buyer's side, you simply flip the analysis around and you look at the alternatives the sellers have. And the question you ask is the typical question upside down, and that is if the seller attempts to decrease the price, it pays its input, will it be able to sustain that input or do the sellers have sufficient alternatives that they can circumvent the price decrease and in effect force the alleged monopsonist to raise its price back up. They are the basic issues. And, so, my own feeling is that the so called hypothetical monopolist or hypothetical monopsonist paradigm that we use in defining relevant markets on the output side also applies flipped

over on the input side.

Looking at defining the product market itself, typically the product market depends on the types of purchasers and whether those purchasers are, to use the legal phrase, I guess, reasonably interchangeable with one another. On the geographic side, the question is whether the purchasers are able and will look to more distant sources of purchase or whether they're pretty much limited to a smaller area. If a number of different types of purchasers are reasonable substitutes for the buyers of course and they constrain the ability of the buyers to decrease price, you include them in the market, and the analysis is the same on the geographic side, as well.

One -- another place the courts seem to have some confusion is the fact that the purchasers don't need -- the purchasers of the input don't need to be competitors in the output market to be included in the relevant market for the purchase of the input. Some courts seem to equate the two.

And then from there, I think you can move on and use the normal tools that you use in a market definition analysis. Critical loss analysis ought to apply, for example, just as much in defining a market in a buyer power case as in a seller case. And of course

you need -- one thing you need to consider is whether, from the seller's standpoint, there are switching costs, if there are alternatives out there, what's the cost of switching to those alternatives.

And that was a relatively important issue, it looked like, in the Aetna/Prudential case. The feeling was there were switching costs when physicians tried to switch, let's say, from Aetna/Prudential to some other payer. Switching costs might include such things as an all-product clause that makes it more difficult to switch and even a most-favored-nations clause.

So, I guess my bottom line is from an antitrust standpoint, I don't see -- defining relevant markets is never easy from a factual standpoint, but from an analytical standpoint, and I'll be interested to hear the economists' remarks on this, I really don't see any analytical difference in defining a relevant market, whether you're looking at a buyer power case or a seller power case.

And then I'd like to conclude simply by saying I'm quite happy that the FTC and the Department of Justice are emphasizing the monopsony issue as much as they are in these hearings, because I think to a large extent, number one, there's a lot of misunderstanding about how these issues ought to be viewed; and, number

in case the seller is being abused by a big buyer.

Now, let me -- let's just take a look at an example that we are all familiar with and the reason why this example, trivial though it may be, is useful is because we already know the answer, okay? Think about the market for corn flakes. So, we ask the question, Kellogg's Corn Flakes are a relevant product market. Well, the answer of course is if Kellogg's tries to raise the price above the competitive level, what will buyers do?

Well, some will turn to Wheaties; some will turn to Cheerios; some will turn to Shredded Wheat. And then of course there's always the Cocoa Puffs and Fruit Loops and so on. So, we know from having analyzed this marketplace before that ready-to-eat breakfast cereal is a reasonably decent product market definition.

Now, these things are always somewhat confusing in the real world, of course, because we're combining somewhat imperfect substitutes into what we define as the relevant product market, and we're excluding other somewhat imperfect substitutes, in this case, things like prepared cereals or hot cereals and of course the things that, you know, lots of people eat for breakfast, like, you know, donuts and bagels and, you know, when you're talking to college students, you always have to mention

cold pizza and apple pie and stuff like that. So, we keep some things in; we keep some things out. And, so, that by itself is a little bit confusing.

But, okay, so let's say we know that already that the relevant product market, certainly from the buyer's standpoint, is ready-to-eat breakfast cereal. We've done that analysis and we figured that out. Okay, now let's say that all manufacturers of breakfast cereals are completely specialized, they have completely unique production facilities and Kellogg's can't make anything other than corn flakes. Wheaties, that guy can't make anything other than Wheaties, and so on, okay?

Now, so now let's suppose that we form some buying co-op among us as consumers of breakfast cereals and we decide we're going to pool our purchasing power with respect to corn flakes, and we go to the corn flakes guy and we say you've got to give us a lower price because we're big; and he said, well, I'm not going to do that; and they say, okay, well, we're going to make you give us a lower price. How are you going to do that? We're going to reduce the quantity that we buy, which is basically all that the monopsonist can do. That's going to push you down along your supply curve and the price is going to be lower.

All right, now, Kellogg's has no place else to

week, I'm going to want to eat corn flakes two or three times a week. And, you know, and that -- in effect, I'm going to notify the co-op manager to buy more corn flakes for me, right?

idea that you can just flip over the analysis. And, so, if you're looking for a hypothetical monopolist to see if he can exploit buyers, look at -- by raising the price, you look at whether a hypothetical monopsonist can exploit sellers by driving the price down, so that if the hypothetical monopsonist could drive the price down, that's an indicator of monopsony power and that's an indicator if you have the right hypothetical group that you've got a market, an antitrust market.

So, at that level, it's really very straightforward. Particularly in health care, though, it's very tricky in practice, to say the least. You're always at risk of confounding two major things, and even thinking about it hypothetically, and the two things are monopsony power of buyers versus reducing the monopoly power of sellers. Okay? And it's very hard to know in actual experience and actual data in concrete cases, let alone analytically, which one is going on, especially since we know that provider markets start out as very imperfect and there's lots of room to improve. And managed care plans, in particular, not old-fashioned indemnity, but managed care plans in particular improve competition among providers in a couple of ways. One way is that they perform search, reducing information costs.

So, if you see a provider on the list, you know

that's a low-price provider. The second thing they do is improve incentives to actually use the low-priced provider. And these incentives, with managed care, can actually be stronger than they are with no insurance at all. And people find this hard to see, and it's such an important point. I have a couple of overheads to show about this.

Imagine a situation where there's two physicians -- oh, okay. Okay, I have to sort of commute to the exhibit here.

Imagine a situation where there's two physicians, we're looking at only particular services. The one physician charges $2,000 to do it; the other one charges $1,000. Okay, so there's a high price and a low price one. What we want to do is compare four types of insurance to no insurance. Okay, traditional indemnity that pays 100 percent; traditional indemnity that pays 80 percent.

Both of these were common of course, back in the bad old days of pre-managed care -- than a PPO that pays 100 percent of the allowed bill, if you go in the plan, and 80 percent if you go out of plan. And we're going to set the allowance, just to make it as simple as possible. And it's also pretty realistic, set the allowance at the price of the low price guy, $1,000; so,

if you go see the low-price guy with the PPO, it pays the whole bill. If you go see the high-priced guy you get 80 percent of that allowance towards the bill. A really classic kind of PPO benefit structure. And the and HMO

percent, you get some slight incentive to find out the low-price guy and use him, you save $200 if you go to the low-price guy. Now, skip to the HMO, the HMO you get zero coverage out of plan, so you pay the full 2,000, because you're going to the high-price guy. You go to the low-price guy, you pay zero, $2,000 difference, twice as big as no insurance. A very high-powered incentive. This is pretty recognized, very pro-competitive, high-powered incentives.

Even with the PPO, and the PPOs can be set up more aggressively than the one I just described. This kind of standard, vanilla PPO, the difference between going to the high-price and low-price guy exceeds what it is with no insurance. If you go to the high-price guy, you pay the out-of-pocket $1,200. If you go to the low-price guy, you pay zero. The difference is $1,200. Okay.

So, you can get a huge effect in improving incentives and improving competition with managed care, even with PPOs, even with kind of soft -- think of PPOs as kind of soft managed care. You still can get a huge effect.

Okay, now, this is obviously a good thing, a pro-competitive thing, something that we would -- antitrust if you like, and observing this, observing that

Another problem with applying the traditional hypothetical price analysis just flipped on its head is that the definition of prices is tricky in health care. For one thing, price discrimination is very common. And this is long recognized. In fact, one of the classic early health economics articles, when health economics was in its infancy, was on price discrimination in medicine by Ruben Kessell. This, again, makes it tricky to interpret actual experience and actual data, because we not only get the possibility of reducing provider market power, we get the possibility of reducing or changing price discrimination.

Plans typically have to pay higher prices when there's less competition among providers, so if they can only make a weak threat to drop the only hospital in town, that's not very effective. But that's not price discrimination by the plans; that's price discrimination -- or it's not price -- it's variation in market power by the sellers. Price discrimination by the plans is different. That would occur where they pay less where they're concentrated, not that they pay less where the providers aren't concentrated.

Okay, another complicating issue for particular health care monopsony is that health plan pricing, when they purchase from the providers, is typically

approximately all or nothing pricing. Now, there's a very nice paper on this by Jill Herndon, one of Roger's colleagues, in the Journal of Health Economics, last year, 2002. Providers don't have much option of a little bit reducing their supplies to one particular monopsony seller. It's not like monopsony in grain purchases or something, where the guy growing the wheat can sell it to a different grain elevator down the road, sell some of it.

The biggest reason is contractual. The physicians typically agree to treat patients of a particular plan without discrimination. Okay, and the strength of the contractual language is really striking. And I have a quote from Jill Herndon's article. There's four clauses, that as you'll see they're overlapping, and just leave no room for doubt from one contract between an IPA and a physician. And it says members shall provide services, so long as such services are customarily provided by member. And then -- that's number one.

Number two, member agrees not to reject any person as a patient on the basis of the alleged inadequacy of any payments provided for in agreement with payers, which is the contract itself. Number three, member agrees that all services will be provided in the same manner, standards and time availability as offered

to its other patients. And number four, member agrees not to discriminate or differentiate on the basis of health status or source of payment. That's just contractually just overwhelming.

In the cartel case that I worked on 20 years ago, there was similar language in the Blue Shield physician contract in Massachusetts, although not as strong as this and it wasn't four different places. But it's obvious this is a big important issue. One question is would the plans bother with such language, unless they were planning to pay less than other payers? Well, of course not, so this language itself implies that they were trying to make a better bargain than the other players.

But is this evidence of monopsony? No, because of the fundamental ambiguity between monopsony and just reducing market power of providers.

Okay, another problem with using price, and even in the hypothetical, price is defined in weird ways in health care markets. So, it's tough to tell if it really declines. There are too many ways of paying providers -- or paying physicians. I'm going to leave out hospital payments because they're even more complex. They have these categories, plus some more. But the two main ways are capitation and discounted fee for service.

geographic markets in the antitrust case -- antitrust sense. So, for example, a plan in LA County might operate in ten or 20 markets. This shows that you could easily have, for example, a big merger in the D.C. area that might create market power in Gaithersburg and nowhere else.

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Thank you.

(A ,).

MR. MCCARTHY: I'm going to boot this up.

Good afternoon. It's nice to join this distinguished panel, and I think you've already heard some interesting insights already on the monopsony issue. In my 15 minutes, what I want to do is touch on several subjects, sort of in a fairly loose structure, recognizing that the panelists you've already heard have put some of this in context already.

Let me start with sort of a quick list. Everybody seems to do our inventories. Is it booting up? Well, a slow load there.

Where do the monopsony issues arise? And as you've already heard, there have been some merger issues, and part of what we're talking about today has to do with whether the guidelines are applicable in a flipped sort of way to monopsony issues as well as monopoly. The two that come to mind recently are the Kartell and the Aetna monopsony merger issue that were in the consensus, as Jeff's already mentioned.

As you may or may not know from earlier sessions, we at NERA worked on Aetna, and I'll make just a few comments on the monopsony issues that came up in that investigation. But also there's litigation, and

this is mentioned as well. I would categorize these in sort of two kinds of categories. There are the various physician provider tract class actions. These really have a pleading which is essentially an alleged conspiracy to monopsonize. In other words, it's not just one payor. This is a group of payors that allegedly, somehow, agree on the mechanism, as I understand it, is basically claims processing, but they agree to do things in a particular way that leads to underpayments of physicians.

The other type of suit Jeff mentioned, which would be lawsuits by a particular hospital against a particular payor. And I think there's probably more than one of those brewing. That I would characterize as an alleged unilateral monopsonization. The words are kind of hard, after we talk monopoly so often. And while it's the same underlying problem, that is, monopsony, buyer cartel, whatever, whether it's a cartel or unilateral, it

that they're not getting their share of that dollar, and that's the real underlying problem. Some have argued it's due to consolidation in the health insurance industry. That's not an argument that I put too much credence in. It may matter in some areas, but the truth is that in my experience health insurance markets are pretty competitive.

I think more it's a long-term trend. In many markets, there have been a significant amount of excess capacity for a sustained period of time. And this is especially true for hospitals and for specialty medical -- for specialty physicians.

Insurers, both as a cause and an effect of that, have used selective contracting, risk sharing, utilization management, other cost containment sorts of tools, to keep premiums low. And the point of that, which has already been mentioned in Ted's example, is to keep the competitive pressure on provider reimbursements. That, of course, leads to physician, in particular, if you measure it by the collective bargaining sorts of statutes that are being sought and then multi-district litigation in Miami and other sorts of measures, that's led to frustration by the provider community.

And, again, I believe that the Aetna and Kartell consents give some legitimacy in the health care

world to this issue.

Okay, is it likely to be a future issue -- an issue in the future? I think it will never go away. I think that as long as the health care dollar is too

actions, I think that will cause some of this issue to fade some. Who knows when that will be.

Now, addressing the question of is it the flip side of monopoly. I guess I agree with most of the panel that generally there are many similarities and symmetries. There's a lot to be said about the mirror image analysis. And certainly as a way to think through, it's very helpful to think in terms of what we're comfortable thinking with monopoly. But I think there are at least two fundamental differences between monopoly and monopsony in the analysis.

The first is that monopsony underpricing is not sustainable over the long run. But super-competitive monopoly pricing is. What do I mean by that? A monopolist relies -- if they have true market power -- relies on a barrier to entry. And as a result, can keep prices at monopoly levels, so long as that barrier to entry exists.

Monopsony, on the other hand, can't afford to drive its suppliers out. A buyer can't afford to drive its suppliers out of business by sustained underpayment, especially if capital investments are involved that have to have a return to capital. Or, as has already been mentioned, the inputs are mobile. And to -- for a simple example in the health care world that maybe a lot of you

end up happening is both an increase presumably in demand and an adjustment in supply that will bring that market back into equilibrium. So, this whole notion of when a market is in equilibrium I think is a very important piece of the analysis.

If the conditions are present, however, you know, the agencies may care about the duration during which it takes for those resources to move in or out of the business and, therefore, you know, want to intervene. How sustained it has to be before intervention occurs, that's a little like asking on the monopoly side, we have a rule, right in the guidelines that pretty much says effective entry that we can't predict to occur within two years, we're going to worry, that there's -- we'll tolerate two years of a market adjusting to bring prices down, but then that's about it. I think everybody understands it's arbitrary, but it's just sort of a public policy statement. What it matters on the monopsony side, I'm not sure. We can pick the same two years, I don't -- that would be a matter of policy.

Now, in health care, not to belabor this, but essentially these caveats apply to health care as well, that is, inputs are somewhat mobile, not all of them, and we'll talk about that. Hospitals can disinvest; hospitals can move to other services that may not be

subject to the same monopsony pressures; physicians can move. But it's limited, and we'll talk about that.

What I think is more important is that the health care rarely fits the textbook case of monopsony. And I'll come to that in some detail. And I think that that conclusion applies to both physicians and hospitals. Okay, what is the textbook case? Well, I'm going to talk about four particular factors. There is of course a dominant buyer; that that dominant buyer as we've heard faces an upward sloping input supply function. The second factor is the affected sellers can't move out of the input markets. Third, if the affected sellers, meaning those that are subject to the monopsony, cannot impact or do not in the textbook model impact quality, I want to come back to that, that's important in the medical world. And there is a single-market clearing price in the input market. That's the textbook case.

At the risk of going overtime, let me give you an example of what I mean by a textbook case of monopsony. A typical example would be hiring of sugar cane cutters on an isolated Caribbean island, in other words, very stylized. The monopsony problem is basically simple. In any labor market, or most labor markets, the supply curve of labor is upward sloping. That means that every time significantly more labor is hired, the

monopsonist not only has to pay the new higher rate for those extra workers, but the monopsonist also bears the brunt of paying the previously hired workers the new higher wage rate.

So, let's make up a simple example. Suppose a thousand sugar cane workers would be willing to work for $10 an hour. If it would take another dollar to get another 25 workers into the sugar cane fields, then the rate of $11 an hour would not only be paid to the new 25 workers but everybody, the original thousand workers. That makes the monopsonist realize that essentially it is bidding against itself, that as it tries to hire more and more workers on an incremental basis, the true price of hiring those workers is higher and higher and higher.

That causes, in a monopsony model, that causes the monopsonist to choose less workers and to pay a less-than-competitive rate. And that's the essential monopsony problem.

Now, suppose instead that that monopsonist could hire the first 500 workers at $5 an hour, the next 250 at $7 an hour and the next 250 at $10 an hour, in other words, not have to pay the new rate to everybody who was previously hired, then we wouldn't have that kind of incremental effect. We wouldn't have this perception that wage rates are really rising fast.

The obvious answer for the workers on this Caribbean island would be to go work for another employer or get off the island. The stylized facts in the textbook monopsony case is that the workers can't leave. They're stuck with low wages, under-employment or unemployment. And with respect to quality, think of it this way. When the sugar cane that is cut by the monopsonized workers gets processed, it is still just as sweet on your dinner table as it is on -- if that sugar

reimbursements, we estimated it to be in Dallas that Aetna, all of its products, indemnity, PPO and HMO, were responsible for about 25 percent of the payments, not -- that doesn't look like a dominant buyer to me. And 28 percent Houston. So, when you analyze this, you've got to look at all payment sources.

Further, the supply -- this is a point I've already made -- but the supply condition may actually be a flat supply curve, if there's excess capacity. We'll come back to that probably tomorrow. Many providers, rather than the sellers not being able to escape, there are two points to be made here. In health care, some providers can escape. Doctors do move. Doctors do shift. Some are more mobile; the hospital-based physicians, like anesthesiologists, being an example.

But I think even more important than the mobility of physicians, which is not always great, is that all of them can serve other insurers. This becomes important. We're not dealing with sugar cane cutters who are hired by one entity, who have to spend all their labor time with one entity. What we have is a contract. The contract says you will be available to treat the members of my insurance company. It doesn't say exclusively. You can sign up with other insurers, and then we get into the switching sorts of issues that have

already been mentioned. And I think that's going to be a subject for tomorrow or for the discussion in a moment.

Finally, and this I think is a critically important difference of health care markets versus the textbook case. Provider underpayment to physicians or hospitals can affect quality. As a matter of fact, it was the basis of the DOJ complaint on monopsony that the patients would suffer lower quality care. Well, that's a little different. That says now the sugar that shows up on your dining room table is not as sweet as the sugar from the non-monopsonized market. So, the consumer would then say I'm not going to buy that sugar; I'm going to buy sugar from the non-monopsonized market. Translated, that means rather than buy from Aetna, in this particular case, they might buy from Cigna or Humana or somebody else.

So, there's sort of, again, a natural correction that goes on, in that the consumer will leave any insurer who is under-pricing so much that it affects the quality of care. And it seems sort of a self-defeating kind of business strategy to have your best docs who are serving the most Aetna, in this case, members be the angriest of all of your docs, which was the theory that comes out of that.

Now, was there a single market clearing price?

So, you have to be aware of that, but it's basically specialty-specific. Secondly, as I pointed out with those Aetna slides, you really have to pay attention to all the sources of revenue for that specialty, not just the payments from commercials. Physicians or hospitals can earn money from and profit from other payors. Charity care is not one.

Geographic market issues, generally the principle would be wherever the affected providers compete. As I mentioned, that could be regional or national, for some specialties, I think particularly anesthesia is sort of an interchangeable part across hospitals and anesthesiologists can move around, as can radiologists, pathologists, but even some top surgeons can be recruited and moved. But I think mostly it's going to be a local analysis. At least there's going to be some portion that's a local analysis, meaning the local delivery system.

And I will leave it at that for now.

(A ,).

MR. FRECH: Good afternoon. I'm just a poor health economist from Pennsylvania. Roger, I bought about four copies of your book. They keep leaving my office.

MR. MCCARTHY: Good.

MR. FRECH: And I think it was terrific. Ted lifted a paper or two of mine in the past, good to see you again.

Where do we begin? I'm here representing the physician members of the American Medical Association. And from sort of an introductory standpoint, what we think that's most important here is to, at least from an overview, protect the competitive process. We think that in the long run this is the bestitive process. be thilitive process

offered on a take-it-or-leave-it basis. We think that

declining supply just at a point in time when the demand in this society peaks between 2010 and 2020, as the Baby Boomers move through the medical care profession.

To start out with, some factual background. What we're facing nationwide, in a very large number of markets, are large, dominant health insurance plans. These plans have more than 30 percent of the markets. A lot of them have more than 40 percent. In Pennsylvania, we have three of them that have about 70 percent of the market. What we've been seeing, at least over the last five years, is substantially rising premiums.

In fact, in Pennsylvania we've seen double-digit premium increases every year for 11 years, not just the last four or five. We had no downward trend in the mid '90s. But at the same time, payments to physicians have stagnated. And, in fact, in our state, in real terms, physician payment levels have dropped.

We think that this kind of industry organization produces what we call unnatural response or economic actors act, we are seeing an expansion in the uninsured roles, we're seeing the development of employer buy-in coalitions. That's something that was alluded to before. We've seen a number of hospital reactions. And, yes, we're seeing physician exit. As a parenthetical, we don't think that it's an appropriate switch to say to a

physician you can always go practice in Italy.

In the midst of all this, the question is what is the enforcement role of people who are looking at these markets. And we leave that as an open question.

Let me take on through the first myth at least, and that is that price-making behavior by large health insurance firms is something that's being done in the public interest. We don't think that this is welfare-enhancing in the long run. We don't think that physician fee reductions necessarily provide long-run benefits to patients, consumers and employers.

Why? Well, first of all, in a lot of markets, not all, we don't see much evidence that the benefits of the reduction in input price are being passed along to the downstream buyer. Health insurers, when they turn around, don't necessarily reduce prices to employers. Second of all, we don't see that there's any evidence of any economies of scale that ought to be driving this.

And then sort of two other points, one of which isn't on the slide, market power may be misused in downstream markets. The reduction in input prices can be used to perfect techniques to keep out entry in those downstream markets. And, also, there are long-run supply reductions that need to be considered in this equation.

What do I mean by that? Well, the long-run

quantity effects, if there's persistent monopoly conduct in the downstream market can be substantial in persistence. And, also, we think that distribution

market share of the dominant insurer and how we define the market becomes crucial.

Here we think that -- and I agree with the discussion a little earlier about the fact that you can look at this from the buyers' or the sellers' perspective in a way, butne

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services. And it doesn't just tie to the payment levels of those -- the government payers or how they fix prices. There are some relevant issues that you can get into in terms of specifics there.

Another question sort of buried in this is what's the meaning of large market shares. Well, first of all, large market shares can give a dominant health insurer what we call the maximum ability to price discriminate. In reality, what a rational monopsony buyer would want to do would be to pay each physician at that level that they would minimally take to provide services. In some areas -- in some ways, that is sort of the flip side of the monopoly situation in terms of price discrimination.

And also it sort of ties to the switching question, and we think that in a lot of ways switching may be impossible for a lot of physicians. What do I mean by that? Well, first of all, physicians supply highly skilled labor. You might say well, that doesn't make them different from a lot of other people, but there is a level of required education and investment there that we all know about.

Second of all, it's an extremely perishable commodity. So, I think from a lot of standpoints, the ability to switch is limited and we don't think that it's

is whether a physician can move to Aetna, to Independence, Blue Cross in Philadelphia, for example, to some other insurer, those switching costs tend to be quite high. Different payers have all kinds of different billing systems, different quality assurance systems, all kinds of various mechanisms, and a lot of physicians actually do a whole bunch in the way of practice overhead costs, dealing with each insurer. So, the switching costs may not be low to begin with.

And as Mario Schwartz has pointed out, those switching costs may be non-linear. In other words, if you're switching a few hundred patients, that may be one issue; but at the point where you're switching 5,000 or 6,000 patients for an individual physician, the costs can really escalate.

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And we think in a lot of markets where there's substantial degrees of dominance that the ability of what we'll call fringe firms to expand their business levels may be quite limited. First of all, the inquiry ought to

who may want to come in. So, it can constitute an entry barrier.

And the last part of it that I think a lot of people don't focus on is that expansion by fringe health insurer buyers does require capital. There are minimum capital requirements in most states, and if you're going

is being exercised in health care. And I just want to put to the panel generally, do you think that that is the case, that that's where we at the Department of Justice and the Federal Trade Commission should be focusing our efforts or do you think it's more likely that power's being exercised on the provider side?

MR. McCARTHY: Steve, I know you might want to answer that.

MR. FOREMAN: You could do my answer for me.

First of all, I think probably what I would say is that it would be my opinion that the Department of Justice and the FTC ought to look at the entire industry and not any one segment of it and look at it in totality and look at how it all flows together and inter-reacts.

Clearly, we think that there are some monopoly/monopsony issues with the way that buying from physicians occurs and then the downstream effects in the health insurance market. We think there are some issues to look at there.

The concept of provider power is an interesting one. From the physician's side of the ledger, I think probably it would be fine to go there and to take a look at it. We think that the countervailing power concept is something that isn't very well developed but might well be something that we could put some more flesh to. What

of was more sort of a geographical across the United States sort of point of view and --

MR. FOREMAN: Okay, yeah.

MR. DANGER: And I know that you've got expertise particular to Pennsylvania, so you may not be the person to go to, but you might have some opinions on it.

MR. FOREMAN: Well, the AMA has also done a study of health insurance markets and cold competition across the U.S., and what we found in the course of doing two of those is that there are quite a number of markets, depending on how you define the markets. But at the MSA level, for example, there are a number of MSAs where you have health insurers with more than a 30 percent share.

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MR. DANGER: Yes, okay.

MR. FOREMAN: So, in other words, at least if there is a propensity to let mergers go in these markets, maybe markets that have a high level of concentration already, you might want to give a second look or greater scrutiny to them.

MR. DANGER: I do want to give the other panelists a chance to respond, but I do want to point out, when you answered that question you said a 50 percent share and I wasn't sure a 50 percent share of what when you say that?

MR. FOREMAN: When I talk about 50 percent share, I'm looking at that actually two different ways and I've short-formed it. It gets to be a lot more complicated, but it's easiest to look at it on the monopoly side in terms of the data that are available. Even that's not the easiest thing to do, but at least you can get there by looking at health insurance enrollment within a given geographic area and it can give you some idea of what's going on in that market in terms of enrollment and relative power.

When you get to the physician side of the ledger, that information in terms of those markets is not very readily available. So, yeah, I short-formed that much more to that.

MR. McCARTHY: Let me take a crack at it, too. I think it's very helpful that the agencies are the cop on the beat and I think that these hearings and certain investigations that have already gone on and certainly the normal Hart-Scott-Rodino process is important. Whether there is a problem that is nationwide I think is highly doubtful. I think that the markets are pretty fact-specific, the instances are pretty fact-specific.

I personally think that monopsony -- I'm among the camp of economists who say monopsony is pretty rare. I think that the situation required for a sustained monopsony just doesn't exist that often. So, I would not say cast your net wide on that. The only reason I would suggest a study on monopsony is probably to put it to bed when it comes to collective bargaining kinds of arguments that organized medicine might make.

Having said that, there are pockets of all sorts of potential problems. I would say that right now, given the managed care backlash, I think the bargaining strength has shifted to providers. Given the changes going on in the managed care industry, I also think that this is a time when an industry has to kind of flex. It's got to -- you're going to get moments of excessive pricing by providers. You might get moments of excessive depressed prices to providers, but it's part of this

competitive process to figure out where we are next in health care markets, given the managed care backlash.

So, I like the fact that the agencies are still looking. I think it's important to keep looking, but I think it's going to be a fact-specific situation that drives what you want to look at.

MR. MILES: I'd make one remark that, again, is probably not responsive to your question, but I'll make it anyway. Just from a counseling standpoint, one of the hardest tasks in counseling physicians and hospitals is explaining to them that regardless of whether a payor has monopsony power, the issue from an antitrust standpoint is how the payor got that power and how the power uses that power. And the fact that if the power was obtained legitimately, if the only gripe is that reimbursement is too low, there ain't a thing, that I'm aware of, that the antitrust laws can do about it, even if it's investigated to death by the two agencies.

MR. BYE: We heard some differing views on the long and short run implications of monopsony power and I was just wondering if anyone else would care to comment as a general matter and then, more specifically, in the context of health insurance markets.

MR. BLAIR: Well, I can just say something about that. I mean, if we think about monopoly,

ordinarily, you believe that demand functions are more

for their life pretty much. So, they're subject to be exploited for a long time.

Hospitals, similarly, have -- their bricks and mortar is probably not as long-lived as a specialist and not a single purpose -- not as much single purpose. It can be converted to something else. But, still, they're kind of stuck for pretty long times. There's a statement by a famous economist about this, and I can't remember who it is, but anyway, the idea was that the two industries that are the most local and the most sort of stuck in their locality were hospitals and universities.

So, I think there is something to this issue that you can exploit them for a while without getting a lot of -- without having a lot of allocative harm, you know, just get a lot of rents. And I think that's a little bit dangerous and it can be a problem occasionally in some areas with private monopsonies, which I think still are basically -- the biggest problem are the Blues. That was true 30 years ago and I think that's still true.

I think the really big monopsony problem, in terms of public policy, is not really an antitrust problem, it's what would happen if the government were to really flex its muscles as a monopsonist even more aggressively than it has so far particularly in Medicare. It already does it a lot in Medicaid to, I would say,

MR. FRECH: Yeah. I think that's right. And I think for those local ones that hospitals are much more the ones that are stuck there than the physicians are. There is still an issue about what's the right horizon for antitrust to be concerned. I mean, if you think position migration maybe fixes large-scale monopsony in Massachusetts in a generation or half a generation, is that quick enough that we don't bother with antitrust?

MR. McCARTHY: I think it has to be determined, yeah.

MR. FRECH: Yeah. I think that's very much a loose end in antitrust in general.

MR. FOREMAN: If I could weigh in on that. Part of what I was trying to say in my remarks is, I don't think telling a physician that you can move is the switching that we ought to be saying, you know, works

of suppliers.

MR. DANGER: One of the issues that seems important to me to talk about is the issue of bargaining power versus monopsony power. The issue here is that when providers depress prices to -- I'm sorry, when insurers depress prices to providers that in the bargaining sense or in the supply and demand sense, if providers had already been exercising market power, you may see an increase in output and consumers may benefit from that. If that goes too far, then you may see a reduction in output.

So, if we look at just price alone, we may be missing something and we may be missing -- that output may actually be going up when prices go down, and if it goes too far, output may be going down. So, looking at output here seems to be critically important.

One of Steve's points is that, at least for the providers in Pennsylvania, it seems unlikely that they have any market power because what happens is they get mailed a price list to their mailbox and it says, here's the prices.

MR. FOREMAN: If they're lucky.

MR. DANGER: If they're lucky.

MR. FOREMAN: Sometimes they're told there's a new price list and they don't get a copy.

MR. DANGER: Yeah. So, from Steve's point of view, in Pennsylvania, at least, physicians don't have any market power, if I'm correct, I guess, in general. Now, there may be some groups that might.

MR. FOREMAN: Once again, like all the other things we've been saying, it's a case-by-case factual analysis. It would, however, be rare for a physician group in Pennsylvania to have market power.

I guess sort of a side comment on that, one that I've been thinking quite a bit about is, also, what's the relationship between clinical efficacy and the way we deliver medical care and market structure. If we're telling physicians to get into groups, multi-specialty groups of a couple thousand in order to have some kind of bargaining power, is that the best way to practice medicine or can that have some clinical downsides to it?

Put another way, I mean, we don't have any research on what the optimal size of a physician practice is from a clinical efficacy standpoint, and I worry a lot that market structure considerations drive changes in the way that medicine is practiced in a way that's not necessarily good for all of us.

MR. McCARTHY: It's not clear you need a group that big, Steve, but -- and there are IPAs and then it

depends on whether we get into the risk sharing and what kind of risk sharing. And I would punt to Jeff who helped form MedSouth and say that there may be other forms of integration that will allow --

MR. MILES: It's looking like it.

MR. McCARTHY: -- physicians to come together. Is MedSouth under siege?

MR. MILES: No, no, MedSouth's not under siege, but I think one thing MedSouth and some of the people I've talked to since MedSouth have convinced me of is that clinical integration is not, let us say, a viable route to circumvent the per se rule against price fixing.

MR. FOREMAN: Also, I might note that the IPA experience in California is kind of worrisome to physicians. That may be another reason you got some reactions.

MR. McCARTHY: In what sense?

MR. FOREMAN: Lots of bankruptcies.

MR. McCARTHY: Oh, a different issue, yeah. Different issue. I do believe that -- look, a lot of what's been done to date is an experiment. I mean, we're talking about organizational structures that are highly complex and we're always trying to build a better mousetrap. And one of those mousetraps that worked for a while was physician groups coming together whether in

IPAs or in California, in many cases, large multi-specialty groups of the kind you're talking -- maybe not

market power and it doesn't necessarily mean the person making the offer has market power. It could be a little HMO sending out these saying, this is our fee list, do you want to sign up, if you sign up, you have to take our people on a non-discriminatory basis. So, it doesn't indicate much of anything.

MR. McCARTHY: I think that's right, but I want to take that to say it could be almost anything, meaning that -- I don't know the facts in Pennsylvania, obviously. It would be very much surprising to me if there were price lists just sent to everybody. I could see where they're sent to the solo practitioners or the dual practitioners, but there are physicians who -- because of transactions cost, just are not worth going out and negotiating a contract with every single provider. So, you have to send out a contract and see how many people take it or don't.

But there have to be large groups. There have to be clinics that negotiate their own contracts.

MR. FOREMAN: I didn't mean to imply there were none. There are some shopping

MR. FOREMAN: I was going to do that, too, if you don't mind.

MR. DANGER: Well, you're the panel, I'm just the moderator.

MR. FOREMAN: Go ahead.

MR. DANGER: Well, what I was going to say is, let's then compare that price level that was mailed out and then say compared to say a Medicaid price or a Medicare price. Is it relevant at all to compare -- in other words, do you think that -- do the panelists think that, say, Medicare is paying below the competitive level or Medicaid is paying below the competitive level?

will keep coming into the markets, making investments to be trained up to a point where they make whatever the flow of income is that pays back that educational investment.

That's obviously a very -- and there are studies. They were much more popular, sort of, in the early '80s, I think, where everybody would try to decide what the rate of return to physician education was. You know, as you might expect, it was a reasonable rate of return. It was not stingy, nor was it excessively generous.

But that sort of begs the question of the prices one gets to determine the flow of income to determine whether you should make the investment in the education. So, there's a certain circularity to the discussion, but that would be the measure: How many docs can pay for their education by coming into the practice?

MR. FRECH: I think, particularly at the theoretical level, we need to distinguish two types of competition or two levels of competition. There's competition to get into the medical profession and that's the one where, in the competitive equilibrium, in that competition, given whatever the current rules are and licensure and so on, that you get the normal rate of return. So, that would be competition there.

But that's sort of competition to get into the arena. Once you're in the arena, then you could have the physicians all be local monopolists. Think of the bad old days, very complete indemnity insurance, no managed care, very poor information, where you'd characterize it as monopolistic competition. Every provider had a fair amount of market power, but was competitive to get in. So, you could easily have the reasonable rate of return to physician education, although it seems like it was above that empirically. But you could have that and then have very imperfect competition in the market.

So, if you're thinking of this in kind of a short run or medium run, up to five or ten years analysis, you probably want to focus mostly on the second competition, the type of competition you have once you're in the market and just kind of forget about the expenditures on education. And then it's just a textbook thing. If both sides are price takers, what's the equilibrium price? No one has any market power.

I'm not saying it's easy to find empirically. But in the context of the actual benchmark, I think the Medicaid -- my problem is, Medicaid, increasingly, doesn't just pay with fee schedules. A lot of places have Medicaid managed care and some physicians are in that and then also a fee-for-service Medicaid and it's

that's actually pretty fair.

There's also an ethical overlay to that that a lot of physicians still have. Again, it ties to how much of their practice is involved with this. A lot of physicians will take Medicaid everywhere, will take Medicaid patients knowing they're not going to get paid much, if at all, just because they think they need to as an ethical obligation.

MR. FRECH: Yeah, that's why I said that there's evidence that Medicaid patients have reasonably good access because there are states like -- I know this used to be true of Delaware. You're closer, you may know if it's still true. They paid very low Medicaid. Really, lots of physicians would take the occasional Medicaid person that they thought there was kind of a strong ethical reason to. But, in general, Medicaid utilization there was extremely low. Well, that tells you there's lots of non-price rationing. And then you'd say, well, this is not -- this is somewhere between charity care and the competitive level. This is not really the competitive level.

That's where, I think, most Medicaid fee-for-service is.

MR. FOREMAN: I actually think that's where studying, too, is, is what's happening in the rest of the

market having an influence there and vice versa. At some point, the physician who sees it as charity care says, I just can't do this anymore.

MR. McCARTHY: And that's the measure that I think is right. Whether ethically 100 percent of the doctors are going to say, no, I'm not taking Medicaid anymore, that's not going to happen. But you could tell by, you know, the movement around whatever the modal amount is that they take. And I think the same applies for Medicare, that is, if Medicare really gets stingy on the RBRVS -- and it varies by specialty. I mean, there are some specialities that are content to take 90 percent of RBRVS. Most of them would like much more.

I would say the typical contracts, in sort of limited sample size, but typical contracts are sort of 115 percent of Medicare.

MR. FRECH: That varies hugely.

MR. McCARTHY: It does vary hugely, which is one of the first things to look at in these monopsony issues, because what I think was true in Dallas at the time of the Aetna deal was that we were doing some hospital mergers at the time and we were told that Dallas physicians generally were about 130 percent of Medicare, which is a pretty good payment. And still are, okay.

So, I guess the point would be, if you find

everybody leaving, you know, as it starts to be -- as Medicare gets cut back and people are putting on their door, not accepting new Medicare patients, then I think you have a measure of what they're willing to do, you know, what the prices are that they're willing to work for.

MR. BYE: I'd be interested in hearing the panel's views on government plans and whether they're part of the market.

MR. McCARTHY: Well, since I teed it up, I guess I better answer that one. It seems to me that if you think about any job, physicians just being one, any job you say, where can I be hired, where can I earn my money, and where can I, in the case of physicians, where can I compete for patients.

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patients, particularly if it's a take it or leave it sort of contract, which I don't think everybody has. So, you're out there trying to drum up business. So, that's why I would include them all in the same market.

MR. DANGER: But that might vary by specialty, right?

MR. McCARTHY: It could.

MR. MILES: I guess I would wonder the extent to which Medicare constrains the ability of commercial payers in decreasing price on the one hand. But on the other hand, I would think to the extent that a governmental program siphons off supply, then by definition, is it going to be a constraint of some kind?

MR. McCARTHY: I don't know that you can argue both that Medicare underpays relative to commercial and then siphons off. If you're a rational physician, you would close to new Medicare patients and treat the higher-paying commercial patients.

MR. MILES: Only if you could fill your practice with the higher-paying commercial patients.

MR. McCARTHY: Right, right. And then you're into -- well, yeah. Then there's no constraint. Then it's not going to -- Medicare isn't -- it might constrain the income of a physician who has a half-full waiting room and is earning less from Medicare than he or she

wishes, but it wouldn't be a constraint in terms of blocking and taking on more commercial patients. That's what I thought you meant by constraint.

MR. FOREMAN: I already weighed in on this one, sort of on the other side of it. We don't think they're the same market -- part of the same market for a number of reasons. In addition, I'd sort of like to make the point again, we think it's a lost volume sale. So, to the extent that you could take on more Medicare or Medicaid patients, you know, by bringing on more physicians in your practice or hiring assistants and things like that, you should be able to do that and to say that, you know, your response to a monopsony reduction in prices to expand your Medicare and Medicaid patient list, I think we'd see that as a non-answer.

MR. BLAIR: I guess I'm a little confused. It seems to me that what we've got is patients that are in need of medical services, and, whether they're represented by a commercial health insurer or a government health insurer, seems to me that should be completely irrelevant. I mean, demand is demand. All of these patients contribute to the demand that's placed on the physician's time, Jeff says, well, you know, suppose that the Medicare is siphoning-off part of the supply. Well, that's like saying, well, we've got male and female

patients and, you know, if the male patients are siphoning off a lot of the supply capability, does that mean something?

That whole notion just doesn't resonate with me. It just seems like demand is demand, you know. Some people have different kinds of insurance coverage, but, you know, I don't see why we should say, well, people with a certain type of insurance coverage don't count in the market because they, of course, do count because they're pressing upon the supply capability.

MR. MILES: I think the point I was making, I think, was the opposite. That is, I was thinking that because these patients are -- I can't think of the right way to phrase it -- are taking up some of the supply of the input provider. That means they are part of the relevant market, not that you would exclude them because of that.

MR. BLAIR: Okay, so you and I agree.

MR. MILES: Yeah, I think so.

MR. BLAIR: I just misunderstood what you were thinking that.

was, given the fact that Medicare rates are typically significantly below commercial rates, and take that as an assumption, it made me wonder whether Medicare serves as much of a constraint on the input -- on what payers pay their inputs. And if they don't, then should they be included in the market?

MR. McCARTHY: To clear that up, does that mean that if Medicare lowers its rates, that your belief is that the commercial payers could then lower their rates and, therefore, Medicare, by not paying a reasonable

trying to flip that around and I know the result in that decision is controversial on that issue. But I was trying to flip it around to see if the same type of analogy might apply in the monopsony situation.

MR. McCARTHY: I guess I would say we're nowhere near that with Medicare. I guess conceptually we could. Medicaid, you would make a different argument state-by-state. But that, again, if you're talking about monopsony, we're talking about less being produced and if a physician takes all-comers. If there's enough supply that a physician takes all-comers, then just because the price is low for even Medicaid, that does not mean that less in total is going to be produced in the market. So, I still would hold to the position that they're going to go out there and compete for whatever source of income they can find.

MR. FOREMAN: One more point on that is, I don't think we have any wholesale evidence that a lot of Medicare and Medicaid patients aren't getting care, although some in California may be. I don't know. I haven't been there for a while. But the reduction of supply, I think, is a concern here on an overall basis and then on a long-term basis.

So, if commercial carriers are reducing price, you could see an overall quantity reduction over time,

even though all Medicare and Medicaid patients are somehow being cared for. So, I mean, that possibility exists out there.

MR. FRECH: I'd like to almost agree with Roger. Really, I think the caveat is where Medicaid is really low, particularly for physicians, and it's a lot of states where it's so low it really is basically relying on the ethical idea of the physicians and it's almost a tax on being a physician having to treat Medicaid patients in some places, there I think you could make an argument for excluding Medicaid. I don't think, at least anywhere near the current situation, you could make a very good argument for excluding any Medicare.

So, I would end up saying it would be state-by-state, or maybe even finer, and it would mostly be all the payers, but there would be places where you might want to exclude particularly low-paying Medicaids.

MR. McCARTHY: And it does beg the whole question of what is a proper income. I haven't done this sort of analysis in a long time, but in the early '90s, during the health reform days, when you looked at the average physician income divided by the average worker income in this country and you compare it to other countries, the United States' physician income was dramatically higher than any other country. The next

highest, I believe, was Germany, and the ratio was -- these are not litigation quality numbers here, but it was something like six-to-one in the U.S. and three and a half-to-one in Germany, and that was the next highest salary.

So, again, subject to this paying for the education and return on education, it's not clear that physicians deserve a particular income more or less.

MR. FOREMAN: That's why I was going to suggest to stick to the return on investment in education. It's all different all over the world. That's a legitimate question is return investment in education. To just sort of do raw comparisons, you might produce a result that you don't want to produce in the long run.

MR. DANGER: A question on supply elasticities, empirical estimates. I know that that's critical in

insurers will tell you -- yeah, they'll tell you they have the biggest headaches. In Alaska, most insurers don't even build networks. They just pay -- they just hope that they get 95 percent of the charges and they've done their work to go get their discount, because the docs are so spread out and they're must-have docs. So, rural areas are usually the opposite where you actually might have sort of the countervailing market power. Docs just won't sign the contract.

MR. FOREMAN: If there are docs there.

MR. McCARTHY: If there are docs there.

MR. FOREMAN: We have a lot of areas nationwide that are medically under-served and their primary care sort of shortage areas and I think some of the issues in those markets actually tie in here. That is, those physicians may have some power locally, but it's not enough for them to stay there.

MR. McCARTHY: We have rural hospitals that have market power, but they can't exercise it, they're empty. They can get a good price, but usually they don't have enough patients to sometimes stay open. I mean, it's a different kind of struggle because of the scale economy you need to at least even have a minimally functioning primary care hospital. So, the market power doesn't do you much good.

MR. DANGER: So, in other words, if we're thinking about a monopsonist in these markets depressing prices, then physicians are going to leave en masse?

MR. FOREMAN: Perhaps are not located there to begin with. And back to the hospitals, that's probably not a matter of numbers of patients, but the overhead situation. I mean, you just can't cover your overhead. So, it might be worth some additional studies of those geographic markets to see if there are issues there. There may not be these kinds of issues in those markets.

MR. DANGER: Following up on the supply aspects, it seems since the agency's typically focus on consumer harm at the end of the day, it seems important to think about how -- whether consumers would follow their physicians if they move to -- switch out of, say, an HMO into a PPO or what have you.

MR. FOREMAN: I thought you were going to say Italy.

MR. MILES: I think it's the other way around.

UNIDENTIFIED MALE: He's still worried about everybody moving to Italy.

UNIDENTIFIED MALE: At least it's not France.

MR. DANGER: And I'm wondering what evidence we've got on consumers following their doctors or sticking with a particular type of insurance product?

HMO product, but you're stuck with low-quality docs. Do we have any evidence or have we seen any evidence of that happening?

MR. FOREMAN: I don't think there's a whole lot of evidence on the quality side from empirical study. But what we do see in a number of areas across the country are substantial increases in waiting times to get appointments for certain procedures and some substantial increases in times for call-backs for things that -- the most recent example I've gotten, again, out of Pennsylvania, out of the southeast, is a three to four-week waiting time for a call-back after a mammography when a mass is detected. That's bothering some people. So, access can become an issue.

MR. MILES: From personal experience, I know even in the D.C. area, there are a number of physicians who have been able to fill their practices with non-insured persons and simply don't take most or, in two cases, I can think of, any type of third party payment.

MR. McCARTHY: And there are more of those instances and I sort of see the question as, if monopsony drove it down, do we have evidence of what I call the country club docs leaving and I don't think there's been that much monopsony to chase them out. I mean, if they cut their rates, they do exactly what Jeff is saying.

They'll go without taking insurance or what will end up happening is the members of that insurance group will say, I'm switching to somebody that my doctor does cover if they're really the high-quality docs. That's exactly what I meant by saying that, you know, the sugar isn't as sweet from the monopsonist as plantation than the other, that the quality is, in fact, affected and that's what causes a switching. That's what ultimately will cause a switching.

MR. FOREMAN: My question is, is that a switch or evidence of a market unwinding?

UNIDENTIFIED MALE: I didn't hear you.

MR. FOREMAN: Is that evidence of a switch or an unwinding of a market?

MR. McCARTHY: What's the endpoint of that? The endpoint of that is that the allegedly dominant insurer has no members. If all the docs go to a point where they won't accept any insurance, it may be a market unwinding, but it's a monopsony unwinding or an attempted monopsony unwinding.

MR. DANGER: I did want to make sure that we get some sort of sense on -- I don't want to say shares -- and if we can, some sort of price point that we think the competitive level is. Again, this is an extremely difficult question to answer, but at what

point, in terms of share, would you think -- what amount of the market would a dominant insurer have to have in order to depress prices below your favorite point, whatever that might be?

It's a very difficult question, though, what the competitive level is and what the threshold is. I think here, if --

say, okay, there's some elasticity to that supply curve in that area and given that there is some -- it is upward sloping. At some point, a dominant insurer could exercise monopsony power.

MR. McCARTHY: I'll let Roger -- I don't want to answer Roger's article, but you can say what the relationships are.

MR. BLAIR: I mean, I think that what you said still applies. I mean, it doesn't matter if you're looking at a specific metropolitan area or in the general context in which Tom described it. I mean, I think that you have to know something about those demand and supply elasticities in addition to knowing something about the market share in order to say anything.

MR. McCARTHY: What you can say is the higher that elasticity, the higher the share has to be to create the kinds of problems that you might worry about. But other than -- and that would be an interesting study maybe to see if and how -- if and why they might move together or something. But I think we'd have a hard time offering any real guidance on that.

MR. DANGER: I figured that would be the outcome to my question.

MR. McCARTHY: I do agree that you have to look at those things and you have to look at the supply

elasticity more than anything else. My belief is that in a lot of areas, there is excess supply. There is excess capacity. And once you have excess capacity, then it really says that the buyer can go out and buy more physician services or more hospital services at the same rate. There's plenty of capacity there to tap into, which is the equivalent of saying, it's a flat input supply curve.

MR. DANGER: I guess when I was thinking about the excess capacity, not all excess capacity is of equal quality necessarily.

MR. McCARTHY: Right.

MR. DANGER: And so, what may happen is that consumers aren't able to get their doctor because their doctor switches out of or won't accept an HMO anymore and so, they're left with falling into the excess capacity of the remaining HMO doctors which may be lower quality.

Now, your enjoiner to me would be that -- well, what is your enjoiner? I'll let you --

MR. McCARTHY: This sort of thing does happen. In other words -- I mean, I don't have any measures of it or any metric to tell you what the numbers are, but you've probably all had the problem that you go to find a new doctor and that doctor says -- that primary care doctor says, closed to new patients. I think that's the

sort of domino effect that happens. I, for the first time, switched to a PPO just because all of the doctors in the areas I lived had all dropped their HMO because they're mad at the HMOs and I couldn't find -- my own doctor was trying to get out of HMOs, and so, I had to switch to get the different kind of coverage.

So, I do think that sort of thing happens in a domino effect, but that is part of the way that the markets adjust, that the enrollees who look for a doctor and can only find somebody who just came out of school and is too far away, then they will switch carriers.

MR. FOREMAN: I'd sort of like to differ a little bit. We don't have any evidence of excess supply. In fact, if you look at waiting times for certain procedures, we have some concerns in some specialties, and also, there are some rural areas that -- not so rural areas anymore, that can't get physicians to tie to that. Half of the general surgery residencies didn't fill, half of the primary care residencies didn't fill last year. There's a Mayo Clinic study on shortages in anesthesiology. So, I mean, depending on the specialty, we have some intermediate term concerns about supply.

So, back to the major premise that I think we can agree on, it probably is a factual analysis, a case-by-case. And, you know, for some areas, there may be an

over-supply. But I don't think we can say that generically by any means.

MR. BYE: Price discrimination was a fairly critical factor in Aetna. Is that unique to that case and does it vary depending on whether we're looking at physician or hospitals?

MR. McCARTHY: We're talking about in the input market, right? Yeah. We didn't -- I mean, frankly, in Aetna, the monopsony issue was not nearly as analyzed as the monopoly issues and I -- the paper that Sen2siss,pVnk95Tohtsy, i

output, my guess is that even if you had monopsony power with this type of offer, you're not going to get a big reduction of competitive.

MR. McCARTHY: And then it becomes a distributional issue Should physicians take the hit, which was one of your points on one of your slides. The economic approach is usually to say, is there an allocative efficiency loss, and if output still stays the same, which is why I argue the short run doesn't matter so much because people are in the market, they still in the market, output doesn't change, so there's been no mis-allocation of resources. There may be, certainly, distributional consequences.

MR. FOREMAN: To agree with the distributional side, absolutely, although I'm not so sure that that all or nothing context actually is welfare neutral. I mean,

of Justice and Matthew here is from the Federal Trade Commission, I didn't mean to imply that we would monopolize the questions. So, I did want to allow for competitive questioning of each other if you had any. I've also been advised never to tell any more jokes.

MR. McCARTHY: None come to mind.

MR. DANGER: Okay, well, let's conclude a bit early. I do want to mention that tomorrow's session will begin at 9:15 and it will end at approximately 1:00, depending upon the length of the roundtable discussion. I couldn't have said it better if I was going to say it myself. We will not have a separate afternoon session as the agenda indicates. Thank you all for coming.

(, , 4:50, , .)

CERTIFICATION OF REPORTER

MATTER NUMBER: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW

DATE: APRIL 24, 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 13, 2003

SONIA GONZALEZ

CERTIFICATION OF PROOFREADER

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

SALLY JO BOWLING