# FEDERAL TRADE COMMISSION

# HEALTH CARE AND COMPETITION LAW AND POLICY

Thursday, May 8, 2003

9:15 a.m.

Federal Trade Commission

601 New Jersey Avenue, N.W.

Washington, D.C.

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

FEDERAL TRADE COMMISSION

I N D E X

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

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MS. OVERTON: -- from MCRA, Microeconomic Research Consulting Associates; we have Meg Guerin-Calvert from Competition Policy Associates; John Marren from Hogan, Marren, Limited; Jeff Miles from Ober, Kaler; and Ernie Weis from Advocate Health Partners. We're going to go ahead and get started with a presentation from Jeff Miles.

MR. MILES: Thank you. It's always interesting to be over here and talk to you. It's interesting, to look around the audience, I see so many people who probably know more about this subject than I do. I should invite some of them up here to talk. I want to do two things. I'm afraid I'll eat this thing if I get too close to

it.

I want to do two things this morning. I want to give you really just an overview based on my experience with regard to PHOs and the antitrust issues that I've run into. And then I want to talk, if I have time, about one case in particular. We have some people here who are familiar with that case. It's a case called U.S. v. Women's Hospital Foundation, case brought against a PHO and a hospital back in 1996.

PHOs are sort of a phenomenon of the '80s, the late '80s and the '90s. Like so many other provider networks, they were set up for mixed reasons, I would say. Like other networks, initially a lot of them were set up to take risk when risk was a lot more prevalent and popular than it is now. A number were set up as alternatives to managed care organizations that were moving into the area at the time, and I think we have to admit some of them were set up to try to deter entry by managed care of block entry.

In my experience, I think the primary reason I've seen them set up is to -- as a physician, quote, bonding technique between the hospital and its physicians, I hate that word bonding, but that seems to the favored expression of the hospitals. To try to induce more loyalty by physicians to the hospital. And in some cases, and I'll get to that in a few minutes, it's been alleged that this loyalty rationale was set up -- they were set up as an entry barrier to new hospitals coming in or expanding in the market.

And I'll talk about that. A lot of PHOs were not successful. They've

gone out of business. There's been some talk that PHOs are dinosaurs today. At least in my experience, that's not the case. I still work with a number of PHOs, some of which have been very successful. And a lot of that work today involves trying to make sure that the PHOs are operated in a way that does not raise antitrust problems because, as I'll mention in a minute, there are a number of PHOs that with regard to physician fees have been using fee schedules for a number of years. And, of course, that can raise a problem, and certainly one that especially today interests both of the agencies.

The antitrust concerns that PHOs have, I think, are one reason that PHOs and other types of networks really are waning in interest today. The message seems to be slowly getting out to physicians and hospitals that it's difficult to use networks as a method of increasing bargaining power without running afoul of the antitrust laws. And certainly over the last year and a half to two years it looks like both agencies have become much more interested in network price fixing issues.

When you look at the antitrust issues PHOs raise, many of them are exactly the same issues that an IPA raises or a provider-controlled PPO raise, and I assume there's really no sense in going back over those issues. I think they've been discussed pretty fully during the hearings. But, of course, the PHO adds the vertical aspect to it in the sense that the hospital and its physicians, in a sense, are a different level in the chain of distribution because the hospitals are, or the physicians are referral sources to the hospital. Although if you look at the concerns that the PHOs have

raised so far, at least in my experience and also in looking at the cases that have been brought, the vertical issues really have not been much of a concern, at least so far.

Statement nine of the FTC/DOJ Health Care statements addresses multi-provider networks, and PHOs are a type of multi-provider network. As I mentioned, the primary focus I've seen on the antitrust ramifications of PHOs have involved the physician component price fixing issue that you see in other types of provider-controlled networks. The antitrust issues and the analysis is, I think, identical for the most part to that in analyzing any type of provider contracting network. The ancillary issue goes to the question of how the physician fees are set: whether there is a price-fixing arrangement; if there is a price-fixing arrangement, whether it's a naked arrangement or an ancillary arrangement.

And one of the things I spend a good amount of time today working on is converting PHOs from networks using a fee schedule of some type to a network using some form of messenger model. And if you've never done this, I can tell you it is a real trip and very challenging. A lot of people think that they can read the enforcement statements and understand completely what a messenger model is and how to implement it.

And my experience is so many little procedural questions that you never expect to arise on the front end do arise and it can be quite a challenging endeavor. Questions regarding how coverage is going to be handled; if some of the providers in the network aren't included; referral problems that can arise, if other

specialists in the area that are members of the network are not included in a particular network. Just a number of little logistical problems that are often overlooked.

I've seen several PHOs that have considered and some are even attempting to implement some type of clinical integration program to circumvent the price-fixing problem. My own experience is that's typically not a particularly viable alternative from a number of standpoints. For example, in working with one state attorney general, that state's antitrust bureau, simply put, we don't buy clinical integration under any circumstances. That might be something the Feds believe in, but don't bring us any type of clinically integrated network.

There are other problems with clinical integration, as well. It's expensive. There's always a question of whether the joint negotiations are ancillary to the program, just a number of issues that, at least from my standpoint, suggest that clinical integration is not the way to go.

Another question that arises sometimes with regard to PHOs is the question of whether with regard to physician prices the hospital can establish the physician prices, ensuring that the physicians play no part in that. There are two business review letters from Justice suggesting that that might be the case. Both the letters are old. There's a 1983 letter to HCA and a 1987, I think, letter to North Mississippi Health Services, both of which involve PPOs set up by the hospital in which the hospitals or a subsidiary of the hospital established the physician fees.

Interestingly, if you talk to the agency people about this question, you

won't always get a consistent answer. And there are reasons for this. It's not because there's any philosophical or theoretical disagreement, but I hate to keep saying this, because everybody says it with regard to antitrust, but the analysis has to be very fact-specific.

Another issue that can arise frequently in a PHO, looking again at the physician component of it, is the over-inclusiveness problem. In other words, the

have arisen in a counseling context. I'll just mention the ones that I've seen. Number one is the time problem between hospital services and physician services. In other words, the hospital says we won't sell you hospital services unless you purchase our PHO physician services, can be a problem, but also it's a rare occurrence. Usually the situation is if you want to contract with the PHO itself you have to purchase both the hospital and the physician services, but the hospital's willing to sell you hospital services outside the context of the PHO, and if it does, there shouldn't be an antitrust problem.

Another issue that's very similar that can come up is the hospital tying problem in the context of a multi-hospital PHO. The PHO that has a number of hospitals tells customers, if you want to contract with any of our hospitals, you've got to contract with all of them. And, again, if that's done only through the PHO, it

foreclosure effects both in the market for networks, other networks have trouble

And generally, according to the government, it did two things. This other hospital also was vertically integrated and had a large MCO subsidiary. And, so according to the government, Women's went to the other hospital and said if you all will not open your OB/GYN service we will increase the discount we give you when your subscribers use Women's Hospital. According to the government, that strategy failed, and so the next thing Women's Hospital did was it formed a PHO. And the rationale for the PHO was the loyalty rationale, that is, an effort to keep Women's t an effor, thaefflhT

an interesting but somewhat misdirected complaint charged the PHO and the hospital with horizontal price-fixing, and then it charged the hospital with attempting to maintain a monopoly. And of course, there's some question whether that even

factual development. Because I think as Jeff indicated, there have been a number of investigations and cases and business review letters that have involved PHOs. In general, those have been the cases, I think as Jeff very accurately described, that have the best possible fact patterns from an enforcement perspective.

They are ones where there are relatively few issues with respect to the extent of other competitive alternatives. They are ones that in general, if you look back over all the cases, have much more in the way of exclusionary practices involved.

what's going on this year or next year or five years from now.

And I think in particular I'm looking forward very much to hearing the other panelists talk about those elements of why they have been involved in PHO, what they see the gains, whether it's quality, whether it's efficiencies, whether or not it's improvements.

I think my perspective as an economist is really to say that a PHO is just simply -- it's a contracting arrangement. As Jeff indicated, of a majority it has some vertical arrangements, at least between a hospital, a single hospital, and a group of physicians. It has other associated possible contracting arrangements. It has, even between those two levels in a number of PHO contexts, we see a top-level, namely managed care, where the organization decides to become much more fully integrated. Perhaps it takes on full-risk contracting, so not just be a provider of hospital services and physician services, but also be essentially a provider of insurance services and so involving all of the risk and intended skills.

And while I know that Kaiser does not regard itself really as a PHO, to an economist, it essentially is. It is a fully integrated health plan, all the way down to enrollees, system. And, you know, I think one of the things that we should all keep in mind is most people regard, in general, Kaiser to have been very successful at what it has accomplished. And, so, in terms of the business justification and the rationale for their particular contractual arrangements, even though those are within the context of employee agreements, they serve as a good benchmark or perspective to be thinking

about what hospitals and providers who are otherwise more independent might be trying to accomplish.

I say it's a subset of possible contracting arrangements, because as we all know, there are a variety of contracting arrangements that have been developed over time, many of which exist simultaneously in a market. For example, you could have a marketplace, particularly in an urban area, where one or more hospitals may be irectd

and the physician level as well as integration among hospitals and among physicians into larger networks.

And then the types can include, as Jeff mentioned, financial integration, and increasing clinical integration. That is an area where I think Jeff correctly points out that state agencies, and also the Federal agencies, to some extent, have been very, very skeptical about the benefits of clinical integration. I think, in part, as I'll get into a little bit later, some of that is: A) because it's new, it does not necessarily show up immediately in the form of a dollar cost savings, it tends to be much more so very, very significant investments in best practices, in protocols, and in development of MIS or IT systems. And, so, the payoffs tend to be further down the road. And I think that affects the types of marketplace outcomes.

I'll also touch very briefly, since I think Jeff has covered it very well, on the antitrust issues. In terms of background trends, how I think about PHOs, and I think the other panelists will be speaking to this in much greater detail, is the background trends that have occurred over the last five to ten years have affected the development, the expansion, in some respects the contraction and the evolution of PHOs as a contracting mechanism.

As we all know, managed care has been through very substantial evolution: the rise of HMOs; some backlash on the part of consumers; and now much more focus on PPOs and broader networks. That, I think, kind of follows, as well, the range of trends on the PHO side, as a number of hospital and physician networks

moved into full-risk capitated contracts. Some did it successfully. Many did not do it successfully, for a whole variety of reasons. And now you see relatively fewer organizations being involved in full-risk contracting.

and somewhat larger groups of hospitals, you may be able to attain the size of data bases to contractual arrangements that you really can't do with much looser affiliations. Other marketplace mechanisms have not developed and have not caused those kinds of investments to occur. So, I think that will be something to focus on. And, as well, there are some integrated systems along the looser version of the Kaiser model.

Let me spend a couple of minutes -- there's a -- let me just skip ahead here -- a very large number of websites that have all sorts of information on PHOs. This particular one I don't assert the quality of. It's one among many I found, and it's advantage was it had a number of nice spreadsheets -- as an economist, I like spreadsheets -- that gave information. The one that was way too big to put up here is a very detailed listing for the year 2002 of the identity of all the PHOs in the country organized by state, very large number of PHOs.

But to give you an idea of the kind of information that is out there, this particular site basically focuses on, in general, what's the distribution of types of members that are in the PHO. And basically what it shows is that the largest proportion -- currently -- this is 2001 data, is in discounted fee-for-service; a relatively comparable number are in full-risk, partial or global cap or in partial risk system, and

entering into. And on the full-risk side, in my experience, that is an area where increasingly PHOs are moving out of and more so into partial risk and also trying to grapple with the discounted fee-for-service model.

Another area, this is again, kind of building a little bit on what Jeff said. It gives you an idea that there is a range of types of PHOs. And as I mentioned at the outset, this reflects a lot of different contracting models that different organizations have chosen. Of a majority, about half are simple PHO models, about 10 percent are what Jeff had referred to, the super-PHO, larger number of hospitals and physicians, and then they show a wide variety of other models as to whether or not it's just an IPA MSO kind of arrangement or different kinds of contracting.

And, again, what this basically implies is that we have different kinds of contractual arrangements that might exist between the managed care level, the insurance product level, the hospital level, and the physician level. And at least at the hospital level and potentially at the physician level, alternative models that might be considered. Let me just go back up.

And, you know, I think as I mentioned, part of what is going on is that you have simultaneously with these different models a variety of trends in terms of the scope of their financial integration, the amount of their full risk contracting, the trends that are pushing them in particular directions. But I do think the most interesting one to watch, because I think it affects the quality outcomes of care, is what PHOs are attempting to do now with clinical integration. I think this is, as Jeff mentions, an area

that is regarded with some skepticism, but I think in terms of business justification is what is driving a lot.

Let me try to supplement a little bit what Jeff had to say about the antitrust issues, because I think he really covered the big picture issues and the areas where the most significant case activity has been. I would regard it really as two related issues that I would like to bring up. One is at the network formation level. I think -- my sense of looking at the health policy statements, looking at the various business review letters and so on -- not surprisingly, how PHO formation and activities have been regarded is really in the context of joint venture analysis.

I think that's the appropriate analysis, the appropriate framework to be thinking about it in, and I think there are, as Jeff mentioned, a couple of the issues that are really important in that formation is is it an inclusive network, and one that is basically open and permits a large number of alternatives, or is it in some way, shape or form an exclusionary network. I think in both of those cases, the inclusion versus the exclusion and the joint venture aspect, it is very critical that the parties to the formation really set out very well what it is that they're hoping to accomplish with the particular model, what systems and mechanisms they have set up, both contractually and in terms of enforcement.

And I think if you look at the PHO contracts that are out there, these are extraordinarily complex documents. And I think that in and of itself gives us all some insight in the task that a PHO is attempting to accomplish. If you look at these

contracts, they have in them entire management systems as to how the relationships at each level and between level are going to be governed, how the financial aspects are going to be dealt with, who specifically is going to bearing what risks, who is going to be covering losses, who is not, and that's where a lot of litigation has gone on between the different levels, when there have been significant losses.

But also, there's a huge amount of the contracting that is focusing on the development of practices, protocols, and development of data. There's a whole lot more in these contracts other than just the establishment of the fee schedules and the negotiations with the managed care plans. And, so, I think in and of themselves they are very rich documents for showing how, within an organization, there is an effort to try to replicate, in essence, the elements of what Kaiser has accomplished, through much more significant contracting.

I think in terms of marketplace competition, putting PHOs and other contracting arrangements between physicians and hospitals and managed care plans, such as IPAs and direct, is again to look at in examining any particular situation whether or not the existence of a PHO still permits and allows the co-existence of other kinds of structures and arrangements and looking to see why these other arrangements continue to exist and why they're evolving.

I think this gives an idea that there are more -- there's more than one alternative mechanism that entities can approach a given set of problems with, and I think what will be particularly important to watch is -- that my sense is from reading

the literature -- is PHOs have focused somewhat more so recently on the quality issues and the quality of care issues; while on the managed care side, there has been more focus on the delivery at a specific price of a set of services to the enrollees.

And, again, those are two different business models, not to say one is better than the other, but as a result, there may be some conflict and some tension between the managed care plans and the PHOs. If the effort to achieve one particular result, for example, on the managed care side, may not either in timing or in substance allow the alternative approach to proceed or the reverse can happen as well. And I think particularly as with new contracting mechanisms, we'll probably be going through some shake-out system.

But as Jeff mentioned, I think something that we do need to keep an eye on is the entry and expansion possibilities. There are going to be certainly some circumstances in which in terms of having the particular structure of the physician network and the particular structure of the hospital network that one will have to look at very carefully and try to demonstrate that it does not preclude the entry or the expansion of alternative systems or alternative choices by managed care plans.

And I think that is why when we see hundreds of PHOs out there, the vast majority of them have not raised significant antitrust issues, because they're existing in marketplaces where the plans have a lot of alternatives, and where the physicians have a lot of alternatives. As a result, the patients have a number of alternatives.

Jeff covered the horizontal issues, so let me just sum up with what I would view as the bottom line. I think that is probably one of the most important areas for us to be looking at. And, again, as I mentioned at the outset, I commend the FTC and the DOJ for focusing on the factual developments in contracting arrangements that are going on among hospitals and physicians in particular, but also between those entities and the health plans, because I think this is the response that we're seeing to consumer demands for more open networks, PPO-type networks, as opposed to HMO and for efforts to try substantially to change the quality of care, improve the quality of outcomes.

It's going to be interesting, and I look forward to hearing more about how compatible these various alternatives are with each other, which ones have come and gone, and which ones are continuing to survive. And, as a result then, what are the comparative advantages of different models for achieving different goals. It may well be that certain models are not best at accomplishing a given goal, but that doesn't mean they aren't achieving good outcomes.

And then in terms of competitive effects. I think just to echo Jeff, I think the key thing is looking at what is the business justification for the particular model, the particular practices, and looking at both. Are there significant concerns at the vertical level, that is, is it exclusionary of other competitors and also of the horizontal effects and then obviously in terms of the competitive effects in the marketplace. Is it resulting in substantially higher prices than would otherwise have

been attained for the same quality of care. I think in particular looking at what is it that is attempting to be accomplished through this contracting mechanism.

**(Applause).**

MS. OVERTON: Thank you, Meg. Next we'll have presentation from Dr. Serdar Dalkir from MRCA.

DR. DALKIR: Good morning. Today I will talk about whether PHOs can accomplish anticompetitive vertical restraints. This presentation was prepared by myself and David Eisenstadt. David couldn't be here today. Without him, this presentation wouldn't have been possible.

MCRA is a consulting and research firm. We are both with MCRA. We are in Washington, DC. We have worked with clients in the health care sector, both providers and insurers. David and I are industrial organization economists. David is a former Department of Justice Antitrust Economist, so therefore, we are not lawyers and as a general matter, we cannot speak to purely legal issues and obviously nothing in this presentation constitutes legal advice.

Previous speakers told us about the trends and different types of PHOs. I will try to bring to your attention some economic models that people might use, the analysts might use to understand and interpret facts and trends. We're starting from hospital-physician complementarity. Hospitals and physicians are usually

two.

The joint pricing of two complements, each with some market power, generally improves consumer welfare. The package price for hospital-physician services will usually be lower after the formation of a PHO. Therefore, this should probably be the presumptive rule to evaluate PHOs, but there are or may be exceptions.

Anticompetitive vertical restraints in economics, industrial organization parlance, usually fall into one of five categories. These are facilitating horizontal collusion; erecting entry barriers or raising rivals' costs; price discrimination; evading regulation; and, finally, reducing substitution away from a quasi-monopolized input.

I will try to explain briefly each of these points. The facilitating horizontal collusion, a hospital might want to foster price fixing or collusion among the doctors in return for rent splitting. Rent splitting could take several forms, which do not have to be explicit. They can cover cases such as a bond market rate payments by physicians for hospital space or services.

To erect entry barriers or raise rival's costs, a hospital could use a PHO to competitively disadvantage other hospitals. If the physician members of the PHO must contract exclusively through the PHO, competitive hospitals who depend on admissions from those physicians may be in a disadvantaged position.

To price discriminate through exclusion, one example would be the best hospital in a geographic area forming a PHO with the best physicians in the area

and bundling their services together to extract more consumer surplus from the payers.

We covered this case in a previous session during these hearings.

substitution away from the hospital reduces the elasticity of the derived payer demand for the hospital.

I didn't expect to see these characters, where I had written the formula, but nevertheless, let me point out that -- this is great.

MS. GUERIN-CALVERT: Economics is a black box.

DR. DALKIR: That's right. There's a positive direct relationship between what we call as economists the elasticity of substitution between hospitals and a given hospital's elasticity of demand by the payers. It's a direct positive relationship. If the elasticity of substitution goes up, the elasticity of input demand for that hospital also goes up.

So, in this graphic or graphic design, the first two characters, the black box and the check, I suppose is the elasticity of derived demand for the hospital, which equals the checkmark, the hospital's share in payers' cost, times the ambulance or the aid truck, which is elasticity of demand for all hospitals, plus one minus hospital share in payers' cost times the question mark, which is elasticity of substitution between the hospital and other hospitals.

And what I'd like you to remember from all this is there's a positive relationship between the question mark and the black box.

**(Laughter).**

DR. DALKIR: Here's a graphical demonstration of the relationship between the question mark and the black box. On the vertical axis is the price of

hospital services. On the horizontal axis is the quantity of hospital services. The blue line that you see is the initial demand for hospital services before a PHO is formed. After the PHO is formed and in this example reduces substitution to other hospitals, the effect of this reduced substitution is that the elasticity of substitution question mark between the hospitals is reduced, but since there's a positive relationship between the question mark and the black box, the black box is also reduced. In other words, demand for the hospitals becomes less elastic.

We show this by the red line, which tilts the blue line at its original equilibrium point. As a result, the hospital is able to price higher than before. Its price rises from P-not to P-one. And the quantity serviced is reduced from Q-not to Q-one.

What may be some general rules for the screening of PHOs employed

encouraged the doctors to obtain pricing from, or shift admissions to, competing hospitals?

Another question that may be asked for these market structures that are neither monopoly nor competition: does the hospital engage in other activities which reveal concern about substitution away from it? And, finally, have the doctors threatened to compete against the hospital, in actuality or potentiality?

This concludes my presentation. Thank you for your attention.

**(Applause).**

MS. OVERTON: Thank you, Serdar. Next we have John Marren.

MR. MARREN: People make jokes about lawyers. That was very good. You have to understand, my orientation in coming to this is somewhat different perhaps. I have -- how do I do this? I started out in health care, not as a lawyer, but as a tech in an emergency room and eventually became an assistant vice president in a hospital. Of course the president made all the decisions, so it was kind of like I had more control as a tech than I did at anything else. But then I spent the next 20 years as a health care lawyer and put together about over 100 IPAs, PHOs, et cetera, write -- and then found out I had to write joint venture or Copperweld type opinion letters, so I started having to learn something in antitrust. I have been involved in a number of kinds of things and teach a lot, but my orientation is really -- although with very few exceptions -- I have to start by saying if you've seen one PHO you've seen one PHO. I really appreciate the opportunity to talk today and I really appreciate the fact the FTC

and DOJ are taking a factual analysis and looking at this, because there really is no way to over-generalize.

In listening to Jeff's presentation and the other presentations, it's important to me to realize that most of the PHOs I deal with, or almost all of them, have no market power and they have no exclusivity and really are focused on medical management. So, I suspect that there are -- we wouldn't be having these discussions if there weren't other types of organizations out there who were doing something differently.

But we have to put this in context. When I started first putting together health plans in the mid '80s, the HMOs and PPOs, we would go around and literally medical staffs would throw things at you because you were talking about some kind of, depending on their orientation, communist or socialist type program. But that generation of physician isn't around anymore. The doctors that are mainstream doctors now that are practicing in America have grown up with managed care. So, when I talk to doctors now, physicians especially, and hospitals, they're really much more oriented towards a managed care and a quality orientation. So my bias is that I truly believe that networks ultimately can prevail and do some good things.

But in terms of understanding this, you know, you have to think about the context of the market, and the market was the Federal HMO Act and creating IPAs and the ability to spread risk amongst different networks of physicians particularly. And we got -- we came up with the creation of the IPA. The PHO

evolved because hospitals wanted to have an IPA and needed to have some kind of input. Doctors don't self-organize very well. So, hospitals became a focal point for

managed care. I personally think there's probably an overall design flaw, but what we've seen is legislators doing what I call anti-managed care legislation. And so when we think about evaluating PHOs or physician networks or hospital networks, you have to think about in terms of -- I think about it in terms of the fact that these people are really trying to protect patients in a lot of ways. We can't just think about them from a pure antitrust perspective in a sense of trying to fix fees or do things that are anticompetitive. Ultimately, especially with respect to physicians, these are people who are caring for patients day in and day out.

We've seen lots of wrongs in managed care. PHOs, networks, medical societies, et cetera, have lobbied to eliminate all products, clauses, prohibition of de-participation determinations based on patient advocacy. Lots of things have taken place in the evolution of what we see in managed care. We've had attorneys general and DOI (Department of Insurance) investigations, focus industry-wide regulations and changes to make things a little bit fairer with respect to how managed care is going to -- plays out.

Lots of court findings about various issues in managed care. Lots of, you know, things that have happened to the managed care industry based on perhaps bad management or bad design. And recently we've had what's going on in Florida and the application of Rico to some of the things that have happened in managed care.

I'm not here to bash health plans or managed care organizations. Again, I've put together a number of them. But I really do believe that there is a role

for a PHO or for a network. Again, this isn't to say that people -- competitors couldn't get together and do something in restrain of trade, but the real focus that we should be

mentioned before. Who is going to incent physicians to really change the way they practice? What's another challenge? Will payers deal with clinically integrated networks? If we have -- can we set up systems between payers and providers where there's a sufficient exchange of data so the providers can actually manage the patients that they have, take a look at different disease states and reduce costs.

I'm going to touch very briefly -- well, I was invited to speak because I represent an advocate, you know, in a lawsuit with Blue Cross. Brad Buxton has the last word today, so that's unfortunate, but Brad and I go way back. It's a very small town, Chicago. Advocate's PHO, AHP, attempted to take its financially and clinically integrated network of physicians and negotiate with Blue Cross of Illinois on behalf of about 1,700 of those physicians.

Blue Cross -- no real negotiation ever took place. Blue Cross filed a

So, we don't think they really prosecuted the antitrust case. I don't know that it was -- Brad can disagree with me and probably will -- but I don't think it was really about an antitrust issue, but again, if you're really interested in that case, I would pull the file and you can take a look at it and see what it has to say.

Essentially, what happened was both sides arrived at an HMO contract. AHP never really negotiated on behalf of the physicians, it was never really -- got very far in the process and was not allowed to negotiate for clinically integrated arrangement for fee-for-service patients. From my perspective, if -- I won't talk about Blue Cross anymore. Let's just talk about any plan. If a plan is willing to sit down and talk with an integrated network and discuss the capacity for exchanging information and then pay money to incentivize the physicians to participate in real disease state management, real quality control and real time, I think we're going to have a much better model.

I think that's really the way to go. It isn't about just price; it's about information; it's about managing patients; it's about a lot of different things. And it's unfortunate that it didn't happen in this case, but trusting Blue Cross' commitment to quality, I'm certain that at some point in the future we'll be able to work out some sort of arrangement.

That's really about all I have to say. And, again, the concept is I look at PHOs as the ones that are still around, the ones that haven't, you know, gone bankrupt or fallen by the wayside of lost their reason for being are struggling to do

medical management, struggling to do quality and control and really trying to do something, you know, on behalf of the patients, on behalf of the providers.

So, again, I don't see a lot of exclusive PHOs, it just might be my experience. And I think that's -- that we should be encouraging networking physicians, we should be encouraging payers and providers to work together to exchange data, and we should be looking at overuse, under-use and misuse. Thank you.

**(Applause).**

MS. OVERTON: Thank you, John. Next we'll have Dr. Ernie Weis from Advocate Health Partners.

DR. WEIS: Good morning. I'd like to review a couple of items from my bio, primarily to indicate the justification for my being here this morning and having the privilege of addressing you. Since 2001, I have been the Vice President of Managed Care for Advocate Health Care and the Chief Executive of Advocate Health Partners, a care management and managed care contracting joint venture between Advocate and the doctors on the medical staffs of its hospitals.

From '98 to 2001, I was Chief Executive of Advocate Health Centers, a community-based medical practice that provides a full range of primary care services, specialty care and support services, treating more than 200,000 patients -- that number always sticks in my throat -- each year in 19 locations throughout Metropolitan Chicago.

Previously, I've held executive positions with numerous managed care organizations in Chicago. And prior to that I practiced pediatrics for 20 years in the same community in the Chicago Land area. I have an M.D. degree from the University of Illinois College of Medicine. I completed my internship and residency at Michael Reese Hospital and Medical Center in Chicago. And in 1983 I was awarded a Master of Management Degree from Northwestern University, Kellogg Graduate School of Management. And I'm a fellow of the American Academy of Pediatrics. Well, enough about me.

Over the years, the need to streamline operations and create efficiencies in the Chicago Metropolitan health provider market became apparent. Several health systems formed, including Advocate Health Care Netwo (7m.f -0.ions ann) g9of Man

integrated health care systems for the last five years. It contains nearly 3,000 inpatient beds and includes small community-based facilities and large tertiary care medical centers, serving diverse populations in the city and the suburbs.

It includes four level-one, highest level in Chicago, trauma centers, out of the total of eight in the Chicago Metropolitan area. Three teaching hospitals training over 600 residents and fellows, more than any other non-university hospital in the state. Also, it includes two of the four major children's hospitals in Chicago and four level three, which is the highest level, neonatal intensive care centers and high-risk pregnancy centers.

In addition to the independently practicing physicians, Advocate Health Partners represents three multi-specialty group practices, which total approximately 600 physicians, including Advocate Medical Group at Lutheran General, the Advocate Health Centers I referred to previously and the Dryer Medical Clinic in Aurora,

slide represents are sort of three areas of relationships within Advocate Health Partners. At the top it describes the governance of Advocate Health Partners. Advocate Health Partners is composed, as Ernie mentioned, of a number of PHOs, as the PHO member, and the system member, which is the Advocate Health Care Network.

In terms of board seats and voting, votes are -- there are -- you can see the numbers next to each of those balloons. Each PHO gets one seat on the board. The Advocate Health Care Network has those seats on the -- two for the Dryer Clinic, two for Advocate Health Centers, five for the hospital and two for Advocate Medical Group. Votes are actually then given to the PHOs based on tens of thousands of covered lives. So, that's the governance relationship. So, you have an evenly balanced relationship between the network and the PHOs.

And then you have within that organization of Advocate Health Partners that board, plus you have a consolidated finance committee, consolidated utilization management committee and a consolidated quality improvement committee. The operations of the -- or what's called the back office of Advocate Health Partners, in terms of managing financial risk is performed through a vendor arrangement with an organization called Health Partners Operations, which provides claim payment services.

At the bottom, you can see the provider relationships. It represents the same groups that are up above in the governance role, but here it reflects that the

relationship by contract, as members participating in Advocate Health Partners managed care contracts.

This next slide represents how Advocate Health Partners is able to financially integrate this very large network of providers. Advocate Health Partners contracts with managed care companies for full risk contracts. It obtains the capitated revenue into its general ledger and establishes member revenue funds for each PHO. Those PHOs, then need to determine how to pay their provider, you know, the physician and hospital expenses through those contracts by developing, in collaboration with Advocate Health Partners, what's called the member financial model. The member financial model then is the blueprint by which the funds from those capitated contracts are paid out to the hospitals, physicians and other ancillary providers.

If, as one would hope, you're managing your expenses well, you would have excess revenue over expense from your capitated contracts, which is then, by determination by the Advocate Health Partners Board of Directors, distributed out to each PHO, who are then able to distribute any surplus that's remaining, as they're non-profits, to the members of their organizations.

MR. WEIS: By the way, the Advocate Health Partners patient population, capitated lives now represents about 400,000 members, patients. In addition to financial integrating, it was also necessary to clinically integrate the AHP providers to create greater efficiencies and to assure against the potential for a

reduction in quality caused by or related to the management of utilization to lower the cost of care.

These systems include AHP's utilization management program, whose

benefits of AHP physicians without compensating AHP in the exchange.

Health care in both the Chicago Metropolitan area and in the U.S. in general is in a state of financial crisis. There has been shrinking reimbursement from Medicare and Medicaid, ever increasing costs for new technology and treatments, and, in the absence of tort reform, skyrocketing jury verdicts, which in turn have caused a drastic shrinkage in the professional liability insurance market and exponential increases in premiums.

Several weeks ago, Illinois State Medical Insurance System, the largest among the handful of remaining physician malpractice insurers in Illinois, announced that it would raise its base premiums by 35 percent. This is on top of the huge

evidence from AHP's experience in messenger model fee-for-service contracts, that managed care organizations value this integration, AHP decided to seek a clinically integrated physician PPO contract from Blue Cross/Blue Shield of Illinois, during its recent negotiations.

In AHP's view, a group physician PPO contract would have maximized for Blue Cross' fee-for-service patients the quality and efficiency benefits of AHP's clinically integrated network.

Given that Blue Cross has historically demonstrated commitment to clinical metrics and Blue Cross has repeatedly indicated their interest in linking increased reimbursement to improved outcomes as demonstrating value to their customers. However, Blue Cross historically contracted only with individual physician practices and not integrated groups.

Through this contracting strategy, Blue Cross had over time developed the ability to contract on a take-it-or-leave-it basis with its large network of individual physicians. In AHP's physician PPO proposal to Blue Cross, it sought to collaborate with Blue Cross to create a demonstration project to incorporate clinical integration within the design of the business arrangement.

This proposal, as you've heard, was ultimately refused by Blue Cross and AHP was unable to negotiate a group Blue Cross PPO physician contract. Nevertheless, one result of the negotiations was Blue Cross' decision to recognize and support AHP's clinical integration through the funding of AHP incentives for specific

clinical integration programs, including physician participation in Advocate's new EICU program, improvement of electronic claim submission capability in physician offices.

We feel that the establishment of these incentives illustrates the crucial role clinical integration can play in creating administrative efficiencies and improving patient safety. EDI speaks for itself as a streamlining efficiency for both managed care organizations and physicians' offices. Advocate's new EICU program has been likened to an air traffic control for intensive care patients. It provides round-the-clock monitoring of ICU patients from a centralized location by Board-certified, critical care physicians and combines state-of-the-art imaging, telecommunications and video technology with cutting-edge clinical decision support software.

It is absolutely phenomenal to watch this in operation. It has reported to dramatically reduce patient mortality in the ICU by 25 percent, reduces the length of stay by 17 percent and decreases cost. However, Visicu, the vendor of the EICU system has counseled Advocate that the greatest obstacle to implementation of this innovative technology is hesitance on the part of the attending physicians to adapt their accustomed practice patterns to maximize the benefits of the program. As a result of the negotiated incentive from Blue Cross, Advocate Health Partners is now able to provide a catalyst for physicians to become early adopters and advocates of this innovative clinical technology.

Thank you.

**(Applause).**

MS. OVERTON: Finally, we will have Brad Buxton from Blue Cross Blue Shield of Illinois.

MR. BUXTON: Hi. Good morning, and I guess I'll have to adjust my comments a little bit now, huh, Ernie?

Anyway, my name is Brad Buxton, and I'm here today representing Blue Cross and Blue Shield of Illinois, and we appreciate the invitation from the Federal Trade Commission and the Department of Justice to participate in these hearings on health care and competition. We look forward to sharing our perspectives on PHOs and their impact on the cost and quality of health care today. And I also look forward to a discussion on this issue with my esteemed colleagues.

I want to talk a little bit about my bio as John did, only I think I started sooner than he did, and my first job was in the delivery room at a women's hospital when I was 15 years old. So, no matter what John says, he may be smarter than I am, but I'm much more sensitive.

**(Laughter).**

MR. BUXTON: I also wanted to let you know that my career includes some time on the provider side also, having worked as a hospital administrator and an association administrator of both the American Hospital Association and the Illinois Hospital Association. So, I'd also like to tell you that I'm a son of a physician who happened to be an obstetrician/gynecologist, and as such, I have some appreciation to

how physicians feel, especially on the matter of quality.

Before I get into my substantive comments, I'd like to provide a brief history of my employer, Blue Cross and Blue Shield of Illinois. Blue Cross and Blue Shield of Illinois is a division of the Health Care Service Corporation and we are regulated as a not-for-profit mutual legal reserve company under the Illinois insurance code. We have been part of the fabric of Illinois health care since 1935.

Today, we contract with approximately 22,590 physicians, 223 hospitals, 45 PHOs, 46 IPAs and medical groups. Currently, my role at Blue Cross and Blue Shield is Senior Vice President of Health Care Management, and in that role,

In our rebuttal to some comments that were made by Lee Sachs of Advocate at a prior hearing, just so we can set the record straight. And, finally, I'll do some concluding brief comments on support of competitive contracting between providers and health plans, highlighting our belief that competitive contracting will help stem the tide of inflationary health care costs.

On the purposes of PHOs, over the years, different constituencies have offered various reasons, as we've heard today, for the formations of PHOs. These include PHOs' improved quality and that PHOs give providers leverage in contracting with payers. Some cynics even suggest that PHOs are there for the purpose of increasing hospital admissions.

As to improved quality, we can report that in our experience there appears to be no difference in the quality of care offered by a PHO than that offered by physicians and hospitals that contract separately. In our experience, no PHO with whom we contract has seen real clinical integration as it relates to PPO and other non-risk arrangements. And I stress that because we have many arrangements with PHOs, IPAs and medical groups where we do have risk arrangements and we do -- there is some clinical integration, but we have never seen it happen on the PPO side. I wanted to stress that.

Blue Cross and Blue Shield of Illinois rates its HMO providers based upon performance in providing patient care in accordance with nationally based clinical practice and preventative care guidelines. And that's based around asthma, diabetes, et

cetera. Of the groups that receive the highest score in promoting outcome-based

sometimes just with physician groups who are related or close to hospitals. In

The hospital at issue expired on December 31, 2002. And that was for all hospital contracts. That was both HMO, PPO and point-of-service. It was not just for HMO or PPO.

Blue Cross and Blue Shield and Advocate, we felt, had virtually -- had completed the negotiations of the terms of this new hospital contract of which Advocate would have obtained, we believe, a significant rate increase and other beneficial contract terms. In addition, Blue Cross and Blue Shield had PPO

physicians provide that Blue Cross will pay a physician for covered services provided to a PPO patient. Payments are made directly to the physicians pursuant to a predetermined discounted fee schedule. This type of fee-for-service contract where physicians are paid certain fee-for-services actually provided does not shift any risk to the physician.

Advocate and its PHO attempted to obtain an agreement from the independent physicians affiliated with Advocate PHO to allow the PHO to collectively renegotiate on the independent physician's behalf, their PPO contracts with Blue Cross. In connection with that negotiation, the PPO sought a significant rate increase. This means devised by Advocate and its PHO to engage in collective negotiation was through a so-called agency agreement with the PHO. This agency agreement purported to give the PHO the authority to terminate an independent physician's individual PPO contract with Blue Cross and to renegotiate a new contract.

In August -- 30, 2002, a letter for approximately 2,800 member physicians in the PHO, Dr. Sachs, President of the PHO, informed the physicians of his proposal to negotiate on their behalf and enclosed the agency agreement for signature. Advocate and Blue Cross, as I mentioned, were near the completion of negotiations concerning the Advocate hospital contracts and HMO medical service agreement for the period beginning in January of 2003.

Advocate and its PHO told Blue Cross they would not sign the hospital contracts and the HMO medical service agreements unless Blue Cross and Blue Shield

contract did not sign the agency agreement or did not understand it.

On October 2nd, 2002, Advocate's PHO, though Dr. Sachs, sent a letter to health insurance plan brokers and insurance agents concerning the status of negotiations between Advocate and Blue Cross, interfering with Blue Cross' relationships with its members during an open enrollment period, the time which over half of the Blue Cross members decide if they wish to continue their Blue Cross coverage. By insisting upon collective negotiation on behalf of independent physicians and refusing to enter into the hospital contracts unless Blue Cross succumbed to the collective negotiation, the PHO attempted to coerce Blue Cross to enter into illegal negotiations or face the prospect of having Blue Cross members move to other health care plans.

The physicians who belonged to the PHO were not financially or clinically integrated with respect to the PPO agreements. Blue Cross repeatedly requested that the PHO provide evidence to support the claims of clinical and financial integration with respect to the PPO agreements. Advocate in its PHO never did provide such evidence, but said that they would work towards it.

Advocate took its fight to the press, taking out full-page newspaper ads, casting Blue Cross as the bad guy. Left with no alternative but to capitulate to strong-arm tactics, Blue Cross filed suit. This suit was later settled and the hospital and HMO contracts were signed. But the physician and PPO agreements were not part of the deal. And I would say that at the end of it, the deal did go through and we

did get some good things, as did Advocate.

Rebuttal to the Lee Sachs testimony, I think this is important because

these graphs in our published comments that we turn in after this.

At Blue Cross and Blue Shield, we pride ourselves on being a fair but prudent purchaser of health care services. In order to make sure that we remain competitive in our reimbursement structure, we conduct our own studies, plus we participate in independent third-party studies. One such study published to participants in February of this year in this Medicare Payment Advisory Commission regarding characteristics of physician payment methodologies and fee levels used by private health plans.

This study of health plans with combined commercial enrollment of more than 45 million members shows that Blue Cross and Blue Shield of Illinois pays physicians solidly within the middle range of payers. We have other studies that show our hospital payments are also within reasonable market range. Thus, we take issue with providers, such as Advocate, that claim we underpay. We pay fairly but

We understand that nursing shortage, malpractice crisis, the cost of technology, government funding and drugs all contribute to the problems today. Although some may disagree, we firmly believe that with margins averaging a little over 3 percent, we do not contribute to the rise in health care costs, but rather as a prudent purchaser, we are doing our best to keep health care affordable.

In closing, we again thank you for this opportunity to provide these remarks and to participate in this educational hearing. And we look forward to the discussion.

**(Applause).**

MS. OVERTON: We'll take about a ten-minute break and then reconvene for our roundtable discussion.

**(Whereupon, a brief recess was taken.)**

MS. OVERTON: We're going to go ahead and get started again, and we're going to begin with a very short rebuttal to the Blue Cross testimony from Thomas Babbo, who is in-house counsel for Advocate.

MR. BABBO: I don't want to take up these hearings trying to rehash our once very public dispute with Blue Cross, which obviously was amicably settled by both parties. The lawsuits were dropped; both parties have an arrangement. Obviously, though, since those were the -- Brad's statements were taken directly from their complaint at the time, they were assertions that should be taken in that context and obviously we categorically deny the characterization, certainly with regard to

Advocate Health Partners exercising any sort of misuse of market power.

We also want to express our surprise certainly in the assertion that PHOs do not have a capability to impact quality, especially through a clinically integrated model for fee-for-service contracting, since this is certainly an area that is on the frontiers of health care and has not been impacted very extensively by disease state management.

With that, I'd like to no longer distract the hearings with Advocate and Blue Cross' former disputes. We certainly would welcome discussions on any future offers from Blue Cross to consider our clinically integrated model and proposals and will take into consideration any offers from Blue Cross with regard to hospital contracts in the future.

MR. BYE: Thanks very much. I wanted to ask a question about the relevance of PHOs. PHOs developed in response to managed care largely, and that is on the decline to some extent. How are PHOs relevant today?

DR. WEIS: Maybe I can take a shot at that. Based on my experience over the last 20 years in various kinds of managed care and on both sides of the issue, both in terms of payers and providers, I don't see any long-term possibility of improving the quality of health care or lowering cost if physicians continue to practice in a fragmented manner with small practices, with no clinical or financial integration. The vast majority of physicians in Chicago were similar to the practice that I was in for 20 years. There were four pediatricians in a group and that practice is still there.

hospital systems. And certainly it hasn't been done successfully everywhere, but there are successful models, including Advocate. Physicians require the management skills, the capital accumulation, systems integration of some organizing entity, and my feeling is that the hospitals are the most likely entity in our society around which that can occur and should be encouraged.

MS. OVERTON: Meg has indicated she wants to respond.

MS. GUERIN-CALVERT: I just would like to add one thing. Matthew, in the introduction to your question, you indicated that there's a decline in HMO, and while it is the case that there's been an increase in the proportion of enrollees that are in PPO kinds of products, nonetheless an HMO product remains a very, very substantial part of the delivery of health care.

And I think as some of our panelists, particularly Ernie, had mentioned, in terms of walking through the diagram, fairly fully integrated systems, including PHOs, have been able, some of them still, to successfully deliver full-risk capitated arrangements. So, not everyone has been able to do that, a number of hospital systems have exited from that, but a number of the very large systems have been able successfully to manage costs, to deliver a fully integrated health care plan.

And, so, I would expect that in that particular context PHOs would continue to remain very relevant. Again, it's an alternative mechanism, other than having the managed care plan provide the HMO product and take on that level of risk, in which a different contracting mechanism can develop. Again, that may be declining

some, there may be some challenges, but I think as long as that remains a viable product PHOs would be relevant for that reason as well.

MS. OVERTON: I want to follow up on this point regarding clinical integration and Dr. Weis suggesting that PHOs are particularly well equipped to achieve clinical and financial integration. Dr. Weis, how are PHOs able to overcome some of the challenges inherent in relationships between physicians and hospitals such as loyalty and trust challenges?

DR. WEIS: Wow. Not an easy question to answer. Certainly we haven't solved all the problems. If you'd attend any of our individual PHO board meetings or the super-board, they're contentious, and there's still a great deal of suspicion on the side of the physicians that we don't always have their best interest at heart. Sometimes physicians tend to, you know, set themselves against each other and against the hospital.

We have to be able to deliver a product, a system, that benefits as many of the constituencies as possible, and it's quite true that sometimes we take decisions that one particular specialty or small group of physicians in one geographic area may see as not in their own best interest. But overall, I think we're able to bring more value to our participating physicians and the hospitals than they would be able to achieve individually.

Don't forget, in addition to the 600 physicians that belong to our employed groups, which do form the core of our PHOs, there are 2,600 other

physicians, independent physicians, that participate voluntarily, so they see value in participating in our full range of products. And if they're a member of our PHOs, they must participate in the capitated products. They don't all like it because their reimbursement rates are lower than they experience in the fee-for-service world, but it gives them access to our PPO contracts, as well, and their participation in our clinical integration activities is a key to that participation.

It's only because we continue to bring value to our participating physicians that we're able to continue and to thrive. And I think we can extend the value of that even more if we could convince the payers to more actively participate in our clinical integration through fee-for-service products, as well.

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hospitalization, eliminate perhaps medical or pharmaceutical contradictions and things like that.

So, the issue is really, is a PHO viable, the issue is do they have the data, can they participate, do they have the manpower, do they have the organizational structure. I'd be skeptical of a PHO that had no organizational structure, no medical management, and no data who said that they were doing clinical integration. On the other hand, I think Ernie's right. I think the real issue here is trying to get the payers to responsibly participate in clinically integrated programs so that the data is there on a fee-for-service patient basis.

The patients -- the PPO patients that the Advocate doctors see right now do not have the advantage of access to that kind of quality management that the HMO patients do, and that's ridiculous, because most of the patients that we have in our market are PPO-type patients. The managed care plans have not engaged in true medical management or quality management, and that's not their business, it really should be a grass roots effort by physicians, using data from plans.

That way -- therefore, what we should be focusing on is the kind oft the Advocate doct

of data on quality in this country, we should stop everything right now and focus on these systems and make quality a lot better on the PPO side. So I'd be skeptical of someone who didn't have the organization, the will or the experience who said they were going to do it. But I wouldn't be skeptical of somebody who had the ability and the commitment and the willingness to follow through.

MR. BYE: I just want to focus at a more practical level, when looking at PHOs and you have various parties making claims, how do or how should the agencies distinguish between them? What evidence should we look at to support claims?

MS. GUERIN-CALVERT: I think one thing would be building on what John said, would be looking at the mechanisms that are being employed by the particular PHO, so focusing first on the business justification, separate and distinct from market power considerations. And whatever is, I think, what it takes is looking particularly at the mechanism that's going to be set up, the contractual arrangements, in relation to the expected outcomes, be it cost savings, be it other forms of efficiency, or being it systems or outcomes to improve quality, in the same way that we've all, I think, gotten fairly comfortable with the use of financial mechanisms and as a result the incentive structure that are set up.

I think we need to explore more the issue as to what are the mechanisms other than financial arrangements that lead to improvement in outcomes. I was really intrigued listening to Ernie's presentation. I had not heard it presented

before. The idea that different kinds of marketplace arrangements that we have seen in the form of large physician management organizations, in terms of developments by payers, all of which are extraordinarily well intentioned, may not have achieved certain kinds of outcomes, and that PHOs may be better able to accomplish certain kinds of things. I think that would be something to be looking at.

I think in terms of market power concerns, again, I think it's very important to be very practical. My experience has been it is extraordinarily rare where you have a significant intermediate market situation, as Serdar had mentioned, where you have a set of hospitals and a set of physicians that have very, very large market share. It's usually the case where there are a lot of alternatives and the ability to shift on the margin. And then lastly I think it's important to think about whether there is a kind of countervailing bargaining on the part of the managed care plan -- is it so important to the hospital systems that there is a balance? So, I think it's -- the market structure is an important part to distinguish among cases, but I think we should all spend a lot more time looking at the business justifications.

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to describe the principles than to identify whether or not there is likely to be a market power concern, because I think -- my overall reaction is that looking at market share alone in terms of the proportion of the physicians, even by a particular specialty, that belong to the PHO and the relevant size of the hospital, both generally and also in terms of its share of commercially insured patients in and of itself tends to give you relatively little information that's useful for identifying whether you have market power.

So, I think, you know, my sense is that it's particularly important in terms of looking at the extent to which there are physicians outside of the PHO, whether or not additional physicians can be attracted into the particular community and also looking beyond the idea of whether or not the only mechanism available to the plan is to either include or exclude the hospital. I guess in my experience most of the way in which negotiations actually work is much more sophisticated than in or out

To the extent those conditions don't exist, where the ultimate arrangement has a very, very large share of both, again, then I think you end up having to look at whether or not it's just essentially almost a bilateral monopoly situation.

MR. MARREN: Market power is an interesting concept. If I'm a plan and there's a very attractive set of hospitals and doctors that I want because my enrollees want them in the plan, does that mean they have market power from an enforcement perspective? I think as the enforcement agencies look at this issue, you have to be very careful to not say just because I'm very attractive from a market perspective means I have market power. In Chicago Land, no one has market power. There may be some isolated pockets where somebody does, but in general, there are so many hospitals and doctors that it's incredible.

So, I think as the law evolves in this area and we define what market power means, I would encourage an approach that doesn't just look at attractability or attractiveness in the marketplace and make that a metaphor for market power.

MR. MILES: Is that sort of a distinction between market power and economic rents?

MS. GUERIN-CALVERT: It could certainly be. In other words, if you get a premium because you're higher quality, exactly right.

MS. OVERTON: Does anyone else have a different take or an additional take on the point that John was raising about an attractive hospital or an attractive group of physicians or, as some might call it, a must-have hospital?

on the margin who can and will move, even if 60 percent or maybe 70 percent or a larger percent are unlikely to move. And that I think is the determining factor in a lot of cases.

MS. OVERTON: We've heard during this session and some past sessions that a number of PHOs have failed, that a number of surviving PHOs are small or non-exclusive or don't have market power. What structures are arriving or have arisen that are attempting to achieve some of the anticompetitive effects that PHOs -- certain PHOs -- were allegedly created to achieve, such as raising rivals' costs or improperly achieving leverage in negotiations?

MR. MILES: Nothing that I know of.

**(Laughter).**

MR. MARREN: My comment would be that the very -- I think it was the second -- it was 1983 or something like that, but it was the second PHO I ever worked on, got done with the formation, we had all the documents in place, we started talking about contracts and contracting, those doctors looked at me and said are you nuts, we're not contracting with these managed care plans, but they never went very far.

But that was a long time ago. The people that are still around are either functioning quasi-effectively from a financial perspective or badly from a

you a lot of money if you're funding IPAs or PHOs that go belly up, because you have to keep paying and paying and paying.

And it's very difficult for them to extricate from the Blues or other plans to extricate themselves from a financial nightmare that occurs at an IPA or a PHO. But the ones that I've seen, again, more recently, and there is a different medical culture out there with respect to managed care. I know there are people that -- doctors -- if you go up to any doctor and ask him if he liked managed care, the answer's probably going to be no. But in reality, there are a lot of people really working hard at, quote, managing care and trying to live within the budget, and I think those are the legitimate ones. I think if people are doing something different, it makes almost no sense. There's really no financial advantage to trying to, you know, sort of manipulate the game plan, I guess, at least from my perspective.

MR. BUXTON: Just related, I feel funny doing that. Nobody's bursting in. Clearly there are IPAs and medical groups out there of different and varying integration levels. And we have gone through the trials and tribulations of financial bankruptcies and those types of things where we end up having to pay twice and I think that what we finally learned, and whether this is an indication of what has to happen with PHOs or not, is that a lot of payers in the past when it came to IPAs and medical groups, not necessarily PHOs, but maybe PHOs who operated, is when they delegated the risk, they basically delegated caring. And, so, they would say, well, here, take it and have a nice day, I've given you the risk and I hope you can make it.

DR. WEIS: You know, I think that Blue Cross is a good example of a payer that has taken responsibility, certainly recently, in being more involved in the operations of the IPAs that they contract with. But what it speaks to is the sophistication and the financial viability of the organizations around which the IPAs

participate obviously continue to want access to managed care HMO patients, as well

panelists on what are PHOs doing to make themselves attractive to payers, particularly given the decline of managed care. And, so, what is it that PHOs are offering with respect to PPOs or point-of-service plans, because it didn't sound like Blue Cross was finding it as helpful to work with Advocate in the PPO space?

MR. MILES: Can I try?

MR. BUXTON: Uncle.

MR. MILES: No, you go right ahead.

MR. BUXTON: No, no, I was saying uncle. I was kidding.

MR. MILES: Well, I guess I would start by saying my experience is there is a phobia on behalf of all managed care plans of dealing with any type of network, because there is almost an implicit assumption that they are getting together for one reason, and that is to jack up reimbursement, and there is nothing of a beneficial nature that can possibly come out of them. And my own experience is it's another fact-specific question. In some cases, indeed that is true; but in other cases, it's not.

I can give you an example of a clinically integrated network that I worked with that put together, I think, a very good clinical integration program. And the honest truth is they did it for the right reason. But unfortunately, they didn't have much of a business plan before they made this investment, and when the program was up and running, they had a great deal of trouble getting payers to even talk to them about it. The impression they got was that really the payers had no interest in quality

services, it's what they produce, and we're not paying them on what they produce today. We're just paying them based on history and unit prices that came from the past, and that really has to change.

MS. OVERTON: A couple of our panelists need to leave, and so we're going to start wrapping up, and I just wanted to give them the chance to make any final remarks, if they choose to do so.

DR. WEIS: Well, one final remark. I agree with just about everything Brad had to say. I would only add that what we're trying to do, through our PHOs, is extend those same programs to the fee-for-service patient population.

MR. BUXTON: You're negotiating, Ernie.

MS. OVERTON: Thank you. And let me extend that same courtesy to the remainder of the panelists, beginning with Jeff. Any final remarks?

MR. MILES: I'd have to think about it and we don't have that much time.

MS. OVERTON: Meg?

MS. GUERIN-CALVERT: I just want to -- I thoroughly enjoyed this. I think, you know, having this dialogue on what the developments are in terms of quality investments has been very, very productive.

MS. OVERTON: Serdar?

MR. DALKIR: No, I'm just honored to be a part of this panel. Thanks.

MR. BUXTON: Thank you very much. I think I've said more than I could possibly say already.

MS. OVERTON: Well, I'd like to thank our panelists for being here and make a couple of housekeeping announcements. I'd like to remind everyone that you are still able to submit materials for the record, and also that our next hearings will recommence on May 27th in the afternoon, when we'll begin our consumer information sessions. Thank you all again, and thank you, panelists.

**(Applause).**

MATTER NUMBER: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW

DATE: MAY 22, 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 20, 2003

SONIA GONZALEZ

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

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

DIANE QUADE