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FEDERAL TRADE COMMISSION  
AND  
DEPARTMENT OF JUSTICE ANTITRUST DIVISION

HEARINGS ON HEALTH CARE AND  
COMPETITION AND LAW POLICY

MATTER NO. P022106

Wednesday, September 24, 2003  
9:15 a.m.

FEDERAL TRADE COMMISSION  
New Jersey Avenue, N.W.  
Washington, D.C.

Reported by: Susanne Bergling, RMR

For TO

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

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3 MR. BYE: If we might start now, I'd like to  
4 welcome you back to this morning's hearings on health  
5 care and competition and law policy. My name is  
6 Matthew Bye from the Federal Trade Commission, and I'm  
7 joined this morning with my co-moderator, June Lee,  
8 from the Department of Justice Antitrust Division.

9 Today's topic is physician market definition.  
10 We'll be looking at a range of empirical and  
11 theoretical questions and also examining some of the  
12 issues associated with barriers to entry in physician  
13 markets.

14 Today's hearing is noteworthy for two reasons.  
15 First is it's the home straight for this year's health  
16 care hearings. We started in February, and we will  
17 conclude next week. It's also significant that we have  
18 six expert panelists, many of whom have traveled great  
19 distances to join us today.

20 I would like to briefly introduce them in the  
21 order that they will present. Complete bios are  
22 available in the handouts which are outside. Once I've  
23 introduced the panelists, we'll start with the  
24 presentations and then toward the end of the session  
25 move to a moderated panel discussion.

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1           Our first speaker this morning is John Wiegand,  
2           who's an antitrust lawyer and litigator working  
3           primarily on health care-related cases in the FTC's San  
4           Francisco office.

5           Next we have Margaret Guerin-Calvert, who's a  
6           co-founding principal of Competition Policy Associates  
7           and spent many years at the Antitrust Division of the  
8           Department of Justice.

9           David Argue works with Economists, Inc., and is  
10          experienced in a number of hospital and physician  
11          mergers.

12          Monica Noether is a vice president of the  
13          Charles River Associates in Boston, where she heads the  
14          competition practice and deals with a range of health  
15          care cases.

16          Howard Feller leads the antitrust practice  
17          group for McGuire, Woods and chaired the health care  
18          committee of the ABA's Antitrust Section as well as  
19          edited the group's Antitrust Health Care Chronicle.

20          Our last speaker will be Astrid Meghrihan, who  
21          is counsel for the California Medical Association and  
22          has extensive background in a range of physician  
23          matters.

24          John, would you like to start?

25          MR. WIEGAND: Sure. Thank you, Matthew.

1           Good morning. First, for the record, the views  
2 I am expressing today are my own, and may not comport  
3 with those of the Commission or any commissioner. For  
4 the past several years, we have seen a great resurgence  
5 in antitrust enforcement in the health care industry.  
6 A lot of what we've seen are challenges of physician  
7 organizations that are based on either a per se or  
8 quick look approach, meaning that the challenged  
9 conduct -- the allegations are to be condemned by  
10 looking at the restraints themselves rather than  
11 looking at their effects.

12           But in this forum and previous sets of these  
13 hearings and in other forums, the health plans have  
14 spoken at great length about the consolidation that  
15 we're seeing in physician markets. Health plans are  
16 arguing that in the face of this consolidation, they  
17 are compelled to contract with large physician  
18 organizations at prices that they would normally say  
19 are above market rates, and the reason that they feel  
20 compelled to do this is because employers, whose  
21 business they seek, demand a broad range of physician  
22 panels that cover all the areas where their employees  
23 live.

24           To date, neither the Department of Justice nor  
25 the FTC has challenged a physician consolidation in a

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1 context where Section 7 of the Clayton Act would apply  
2 and we'd need to define product market, geographic  
3 market and calculate market concentration, but with a  
4 lot of these allegations out there and a number of  
5 issues before the agencies, it's likely that in the  
6 near future we will be faced with confronting some of  
7 these issues.

8           So, what I'd like to do this morning is point  
9 out some of the tools that are applicable to market  
10 definition and identify some of the difficulties that  
11 we may face in defining markets, some of the  
12 challenges, some of the issues that are unique to the  
13 physician marketplace.

14           So, beginning with the product market  
15 definition, the place that we would normally start is  
16 the horizontal merger guidelines, and the basic  
17 premise, of course, under these guidelines is that the  
18 appropriate product market is the smallest group of  
19 products or services for which a hypothetical  
20 monopolist could profitably sustain a small but  
21 significant nontransitory price increase. That's  
22 pretty basic, but it's still the right starting point.

23           Now, in applying this general standard to the  
24 context of physician services, we can first look at  
25 some advisory opinions and some suggestions in those

1 advisory opinions that both the Department of Justice  
2 and Federal Trade Commission have issued as to how this  
3 might be accomplished.

4 In virtually all of these situations, the  
5 assumption has been that each medical specialty  
6 constitutes a distinct and separate product market, but  
7 there's been one exception to this general rule, and  
8 that is in the case of what is commonly referred to as  
9 primary care physicians, because within this group of  
10 physicians that appear to compete with one another, we  
11 have doctors who define themselves as family  
12 practitioners, general practitioners and internists,  
13 but the precise contours of even this market are  
14 subject to some disagreement.

15 For example, in the FTC advisory opinion in Med  
16 South, the primary care physician market was said to  
17 include pediatricians. In some of the Department of  
18 Justice advisory opinions, pediatricians were excluded  
19 from the primary care physician market. It seems that  
20 the primary issue here in looking at and considering  
21 whether pediatricians ought to be included in the  
22 market is whether parents, as they select their  
23 preferences for doctors, view family practice doctors/  
24 general practitioners or internists as substitutes for  
25 pediatricians, and also, from an economic and legal

1 point of view, the extent to which family  
2 practitioners, general practitioners and internists can  
3 target price increases to adults. Questions like that  
4 are going to depend on the facts of individual cases,  
5 so we may not end up with the same market definition in  
6 every instance.

7 Another interesting question involving the  
8 market for primary care physicians is the extent to  
9 which gynecologists may be included in that market. In  
10 some states, by a matter of state regulation, there is  
11 a right of access in a health plan for a woman to see a  
12 gynecologist. In some geographic areas, it's common  
13 for gynecologists to deal not just with health issues  
14 specific to women, but to really act as a primary care  
15 physician for women. So, depending on the facts in the  
16 individual marketplace, it may be appropriate to  
17 include gynecologists within the definition of primary  
18 care physicians.

19 A second kind of interesting issue which arises  
20 in product market definition is the extent to which  
21 integrated groups ought to be addressed, and the  
22 interest here is whether the individual physician is  
23 the actor in the marketplace or whether the market  
24 ought to be defined as a group of physicians seeking to  
25 serve a particular group of patients.

1           This arose in the Department of Justice  
2           advisory opinion involving Los Angeles Medical Group.  
3           That was a group of anesthesiologists, and in that  
4           context, the Antitrust Division concluded that because  
5           the groups contracted to provide a broad range of  
6           anesthesia services, including subspecialties, and that  
7           they competed against each other as groups, that the  
8           proper definition of the market was likely to be a  
9           group of anesthesiologists who are able to provide that  
10          full range of services.

11           We may have this question arise in even a more  
12          interesting context when we're talking about  
13          multispecialty groups, because in that context, there  
14          may be a question about whether the multispecialty  
15          group is really providing a different service than the  
16          doctors can provide individually. Do consumers have a  
17          demand for a service of physician services integrated  
18          across various specialties so that the patient could  
19          conceivably have a greater level of continuity of care  
20          from their primary care physician into various  
21          specialties? And I would suggest that a key question  
22          in evaluating this is whether the group is really  
23          providing a different service, or on the other hand,  
24          whether it's just providing the same service at a  
25          greater volume.

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1           Now, turning to geographic market definition,  
2 we would again start with the general approach of the  
3 horizontal merger guidelines by asking what is the  
4 smallest area in which a hypothetical monopolist  
5 provider of physician services could profitably sustain  
6 a small, nontransitory price increase? We know from  
7 our experience in hospital mergers and just common  
8 sense that the market for physician services is going  
9 to be a local market. The statements of enforcement  
10 policy for the DOJ and FTC emphasize the local nature  
11 of physician markets, and the advisory opinions that  
12 both agencies have issued also state repeatedly that  
13 the markets are local.

14           But again here we have some interesting issues  
15 that are going to arise in applying the general  
16 principle to specific facts. There is a tendency in  
17 health care for us to rely strongly and heavily on  
18 patient origin data. That's proven to be in some cases  
19 a blessing and in other cases a curse, because in fact,  
20 patient origin data give us some objective standard by  
21 which to go and proceed, but on the other hand, there's  
22 a lot of difficulties in relying upon patient origin  
23 data, the foremost of which is the fact that it's  
24 merely a static analysis, where our analysis needs to  
25 be dynamic and needs to ask what would patients do in

1 the face of a hypothetical price increase.

2 The matter is further complicated by the  
3 difficulty of obtaining patient origin data for  
4 physician offices. We may be in a situation where we  
5 would substitute hospital patient origin data, and that  
6 would further remove us from the market we're trying to  
7 analyze.

8 Finally, patient origin data is problematic  
9 when it's used in large metro areas, because it tends  
10 to suggest that every large metro area constitutes a  
11 single geographic market. That tends to contradict  
12 evidence that employers, when they're selecting a  
13 health plan, seek to satisfy their employees by having  
14 physicians in the network which are close to where the  
15 employees live, and if you're looking at our larger  
16 metro areas and thinking about how that's going to play  
17 out, take the New York area, for example, you're not  
18 going to say that an employer in North Jersey is going  
19 to be satisfied with providing their employees with a  
20 physician provider panel that has lots of doctors in  
21 Southern Connecticut and Long Island. That's not going  
22 to bring satisfaction to the workplace, and one of the  
23 key things employers say over and over again is they  
24 don't want their health care plan to be a cause of  
25 employee discontent. So, we are going to face, very

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1 much like in hospital matters, the difficulties in  
2 defining a geographic market based on patient origin  
3 data.

4           Finally, I want to just spend a moment  
5 considering the calculation of market concentration.  
6 The traditional approach found in a number of the  
7 advisory opinions and also found in a couple of  
8 privately litigated cases is that we just count numbers  
9 of doctors in a particular organization and calculate  
10 market share based on the percentage of doctors in a  
11 particular organization. That approach is sensible and  
12 seems to work well in the context of a situation where  
13 we have doctors that are exclusive to single  
14 organizations.

15           However, if we have doctors that participate in  
16 multiple IPAs and we calculate each IPA's market share  
17 based on its number of doctors, we're going to end up  
18 with some of our market shares being well over 100  
19 percent. In that kind of market, it seems to me that  
20 market share is going to best be calculated by looking  
21 at the revenue of each physician organization and  
22 basing that particular organization's market share upon  
23 the revenue that is generated from the contracts that  
24 those organizations hold with individual health plans.

25           Thank you.

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1           MR. BYE: Thanks, John.

2           I might ask the panelists and co-moderator to  
3 shift to the audience, because the next few panelists  
4 will be using Power Points.

5           MS. LEE: You mean sit over there?

6           MR. BYE: Yes.

7           MS. GUERIN-CALVERT: This is a short person's  
8 wonder to have a podium that moves down.

9           While we're waiting for it to come up, it's a  
10 great honor to be here, and what I would like to do is  
11 kind of follow up on what John had talked about and to  
12 really focus on some of the specific contexts in which  
13 product and geographic market definition comes up, the  
14 sets of issues that are being evaluated there, and then  
15 to talk about some practical ways in which, in addition  
16 to using patient origin data, that we could also look  
17 at ways in which to try to get a better handle on who  
18 are the actual participants in a relevant product and  
19 geographic market.

20           The context, first of all, obviously as John  
21 set out, is that what we are most concerned about is an  
22 effort to evaluate market power. We're doing that in  
23 many cases directly in the context of the physician

1 physician market may be relevant to analysis of other  
2 issues, such as HMO mergers, hospital mergers. So, I  
3 want to make in that context some specific comments on  
4 product and geographic market definition, but also to  
5 spend some time talking about empirical support,  
6 because I think as John mentioned, one of the tasks  
7 obviously is to understand the competitive effects  
8 analysis well, to not just be in a static world but in  
9 a dynamic world, and then as a result to really capture  
10 well and identify market participants trying to come up  
11 with good measures of share, but also then thinking  
12 obviously about entry and expansion, because I think in  
13 many physician market issues, whether or not there are  
14 prospects for expansion or entry of new physicians or  
15 new physician groups into the relevant area tends to be  
16 very important to everyone's conclusions with respect  
17 to the competitive effects analysis.

18           What I've tried to do here is to set out just  
19 some of the contexts in which physician market power  
20 and market definition issues have come up, both in  
21 terms of advisory letters, in terms of private action  
22 issues, as well as in terms of enforcement actions.  
23 One obvious one is in terms of physician network  
24 formation.

25           At the beginning of the health policy

1 statements, there were a number of issues where there  
2 were the first nationwide development of, say, cardiac  
3 groups that were going to be located in each of several  
4 metropolitan areas, able to do nationwide contracting  
5 with health plans, and there were some very important  
6 issues about market definition there, both locally,  
7 regionally and nationally.

8           And there have been a number of issues with  
9 respect to acquisitions and mergers of physician  
10 practices, both with respect to acquisitions by public  
11 entities, acquisitions by hospitals and then  
12 acquisitions or consolidations among physician groups  
13 in a particular marketplace.

14           With respect to hospital mergers, a very  
15 important mechanism that has been identified and  
16 discussed at great length in these hearings by which  
17 hospital pricing can be disciplined post-merger, is the  
18 ability of a health plan to have sufficient physician  
19 access or ability to be able to divert patients to  
20 other, arguably lower cost, hospitals. So, the  
21 availability in a given marketplace of sufficient  
22 independent hospitals who may or may not already have  
23 admitting privileges at other hospitals is an important  
24 part of how we evaluate hospital mergers.

25           Similarly, many of the HMO -- less so often

1 PPO -- but many of the HMO merger cases and vertical  
2 issues with respect to the effect of most favored  
3 nation clauses or other kinds of clauses have turned,  
4 in part, on the ability of a new entrant HMO to get  
5 access to a sufficient number of other physicians so as  
6 to be able to discipline the incumbent HMO. So, there  
7 -- and John alluded to that in terms of the exclusivity  
8 issues in terms of whether there are enough physicians  
9 left outside of a given panel to form a competitor  
10 panel.

11 In the private sector, there have been a number  
12 of cases which go to mergers and acquisitions but many  
13 of which have turned on exclusive contracting and  
14 physician admitting privileges or credentialing  
15 matters. These are very complex cases. Some of the  
16 exclusive contracting ones have tended to involve  
17 anesthesiologists, other kinds of practices which may  
18 tend to be more hospital-based practices, and again,  
19 one of the issues there is evaluation of market power  
20 and particularly the issue as to whether or not the  
21 hospital that may be engaging in the contracting has  
22 plausible alternatives either within the local market  
23 or, practically speaking, is able to attract another  
24 group outside the market. Some of the same issues are  
25 with respect to admitting privileges and credentialing.

1           I think -- and this is something that John  
2 alluded to -- is obviously market power definition is  
3 a demand-side analysis, and I think the most important  
4 thing, since we have so many different contexts in  
5 which it arises, is that we really need to be very  
6 specific about what's the nature of the claim. What is  
7 the concern that is raised about market power? Is it a  
8 concern that a group of physicians somehow have been  
9 able to raise and maintain prices for their services?  
10 Is it an evaluation of something that says that they  
11 are so large and have such an important skill set that  
12 there is not a sufficient set of alternatives that are  
13 available?

14           And I think we then get into having to define  
15 right away for the specific market definition exercise  
16 who are the customers that are purchasing the services  
17 that are affected. In some cases, it's much more  
18 specifically hospitals. As in the exclusive  
19 contracting case, it's a circumstance where a hospital  
20 may be making a choice to hire a group of  
21 anesthesiologists, neonatologists, emergency room  
22 physicians, a set of things, and they may be the  
23 immediate customers, obviously doing it on behalf of  
24 their patients.

25           There may be other contexts in which hospitals



1 may be having a concern that a particular group is so  
2 large in the area that they do not have the ability to  
3 have sufficient alternative physicians available to  
4 them to contract with. An example of this is that if  
5 you have a hospital system that may have its own HMO,  
6 where the issues come up is whether or not there are  
7 sufficient physicians other than those contracted to  
8 that particular hospital, particularly if it's a large  
9 one, that are available to the other hospitals in the  
10 area so as to discipline perhaps not just the HMO  
11 pricing and the physician pricing but also the hospital  
12 pricing. Obviously managed care plans in many  
13 dimensions, trying to set up panels, it's an issue.

14           And then lastly, in many cases we're looking at  
15 it at the outpatient level, looking to see what  
16 alternatives would patients have after a particular  
17 merger or a consolidation.

18           And just to touch on briefly something that  
19 John spent some time on, we have to look in each of  
20 those contexts as to what the relevant product  
21 attributes are, and again, to define preliminarily, and  
22 as John alluded to, the first area tends to be looking  
23 at it by specialty, and I think that this is something  
24 that one wants to be open-minded about in terms of  
25 testing to see, once you've identified your candidate

1 specialty, as to whether or not there are other  
2 physicians who can play particular roles that you may  
3 not have identified.

4 A specific area in which primary care versus  
5 specialists is very important is that particularly with  
6 respect to managed care plans, for many -- and this is  
7 increasingly less so -- but for many HMOs, obviously  
8 the primary care physicians are the gatekeepers, and so  
9 in terms of having access to a sufficient number of  
10 primary care physicians in order to be able then to go  
11 ahead and make referrals could be important in the  
12 evaluation of some market power issues.

13 Again, it may be at the individual physician  
14 level versus the group level, and something that I'd  
15 like to spend a little bit of time on as well, is that  
16 it's important in looking at group levels or the IPA  
17 level to identify what the concern is. For example, to  
18 give one concept, is that in evaluation of certain  
19 kinds of hospital cases and in certain kinds of managed  
20 care cases, issues have arisen as to whether or not  
21 there are sufficient independent IPAs that are  
22 available for contracting with a new plan or a plan  
23 that is concerned that it wants to switch patients away  
24 from a given IPA/hospital combination, and so obviously  
25 doing a head count and examining the relevant size and

1 the attributes of given IPAs is useful, but I think  
2 something that's important to keep in mind is that in  
3 many contexts, it may be possible for the managed care  
4 plan to do the assembly of the network itself.

5 So, if you focus too narrowly on the product  
6 market definition as the IPA, you may forget that an  
7 HMO may be able to assemble its own IPA which doesn't  
8 exist yet in the marketplace, but then you're needing  
9 to look at whether there are sufficient physician  
10 components that could be assembled to create an IPA.  
11 And obviously we blur -- as we do in many industries  
12 -- right away into a geographic component as well.  
13 There may be some needs not only to have particular  
14 specialties but a particular range of services for the  
15 particular customer.

16 I think with respect to geographic market  
17 definition, once you have the product market specified,  
18 you've identified the types of physicians that you are  
19 interested in looking at without any regard to  
20 geography, the types of groups that you're looking at,  
21 you're really saying for the group that you are or the  
22 set of physicians that you are concerned in a given  
23 area, that in that product market they have market  
24 power, you're immediately going to who are the  
25 effective alternatives. Who are the other physicians

1 or physician groups or entities to whom the affected  
2 customers could turn, again, not exclusively or  
3 completely but in sufficient numbers to discipline the  
4 pricing of the group or the set of entities that you're  
5 concerned having market power? Not everybody has to  
6 switch, just enough to discipline. So, obviously we  
7 come down to trying to identify those market  
8 participants.

9 In my experience, I think there are some  
10 practical tools that are readily available and  
11 increasingly available even at the screening stage  
12 fortunately on the internet to be able to at least do  
13 plausible head counts and plausible sets of  
14 information, starting with you have certain kinds of  
15 physician databases, you have medical society lists,  
16 you often times have IPA membership lists, and you have  
17 HMO websites.

18 Let me kind of talk about the managed care  
19 databases, because this is one that I have found to be  
20 most productive to use. If, for example, you're  
21 evaluating -- let me just pick a state randomly -- if  
22 you're looking at Missouri and you have a particular  
23 concern that has been raised that a specific group of  
24 physicians in a given county have market power, let's  
25 say they're primary care physicians, and there's the

1 concern that they have the ability to raise and  
2 maintain their prices directly to patients, to managed  
3 care plans, and that that is an issue. How do you test  
4 whether or not there are effective alternatives for  
5 those physicians?

6 One of the places you can go is if you identify  
7 first of all what are the panels that those physicians  
8 are on? You can identify in many cases relatively  
9 quickly the three or four top HMO or PPO panels that  
10 they're on. Typically what you can do now is you can  
11 go onto that HMO's website, whether it's, for example,  
12 Blue Cross or Aetna or United or some other entity, and  
13 you have the ability very quickly to click on their HMO  
14 product and to pull up for a given county usually --  
15 sometimes it asks you for zip codes. The ones that are  
16 the best are the ones that let you do it by county and  
17 even by state, but it will immediately give you a list  
18 of all of the physicians.

19 It often times gives you their specialty, may  
20 give you their secondary or tertiary specialty. So,  
21 they may be an internist who's also board certified in  
22 infectious disease. They often times will give you  
23 each of the physician's office locations, including zip  
24 code, city and county. It may give you some additional  
25 information. Some of them will give you the hospitals

1 at which that physician has admitting privileges, and  
2 sometimes it will also give you, if relevant, the IPA  
3 that they belong to.

4 You can also get onto an IPA's website and find  
5 all their member physicians. They're usually  
6 classified by primary care and specialist.

7 So, what you can build from this -- and of  
8 course, it's the case that the names are never quite  
9 the same in each of the databases, and some of them do  
10 require you to input every single zip code separately,  
11 but you can without enormous difficulty get a sense of  
12 for the given county and say the surrounding four or  
13 five counties what does the population of physicians by  
14 type of specialty look like, and you can then begin to  
15 put this particular group in context.

16 In addition, what you can do is -- again,  
17 depending on the nature of the case, to the extent  
18 you're examining something that has a particular  
19 concern about whether or not the group of physicians  
20 constitutes a very, very large share of a particular  
21 hospital or group of hospitals' admissions and as a  
22 result there is a concern that there are not sufficient  
23 other hospital -- not sufficient other physicians to  
24 whom that hospital or other hospitals could turn, you  
25 could look at a hospital privilege list, and as John

1 alluded to, this is one of those elements that's pretty  
2 static. It gives you name, address, specialty, gives  
3 you some idea of who's relevant but no sense of the  
4 order of magnitude.

5           So, what you may want to go to -- and again,  
6 this is usually available from the hospitals -- is you  
7 can get by physician the number of discharges that they  
8 have, by DRG, zip code, what plans that those  
9 discharges were under, which IPA those physicians may  
10 belong to, and again, you may be able, depending on the  
11 case, to evaluate overlap in discharge patterns. So,  
12 you can readily test then the hypothesis of is it the  
13 case already that this group of hypothetical physicians  
14 in a given Missouri county, are they really accounting  
15 for a substantial share of a given hospital's  
16 discharges, or indeed, might there be substantial  
17 alternatives already in place, and then one can look at  
18 expansion.

19           To go back up to the managed care databases for  
20 a moment and to talk about a point John addressed, one  
21 of the things I have found very possible to do working  
22 with physician groups and also with hospitals is it is  
23 possible to get a sense and identify from where are the  
24 physician groups at a given location attracting their  
25 patients, and what I have found is that in metropolitan

1 areas such as Manhattan, Washington, D.C., San  
2 Francisco, it is the case that a very substantial  
3 number of residents of the suburbs do, indeed, have  
4 their primary care physician in the immediate downtown  
5 area, because they tend to use physicians and go to  
6 physicians' appointments when they are working there,  
7 and -- but that is something that ought to be tested.

8 It's an empirically verifiable set of  
9 information that one can look at to identify at least  
10 as a baseline, is it the case or is it not that there  
11 are substantial inflows of patients from the areas for  
12 standard services such as family practice, general  
13 practice, gynecology and other kinds of services.

14 Something also that's important to take into  
15 account is in general, the narrower the specialty, the  
16 fewer the number of physicians there may be, the  
17 greater the concern. Perhaps it is also the case the  
18 less frequent somebody is going to see a cardiologist  
19 or a cardiac surgeon or a neurologist or a neural  
20 ophthalmologist, and so as a result, the more it is  
21 that people may be willing to travel, the more it is  
22 that reputation may matter and affiliation with  
23 hospital may matter. And again, if you look at the  
24 physician's draw pattern, historically the broader the  
25 actual draw pattern of his or her practice may be.



1           I think to try to make it more dynamic, as John  
2 suggests you really want to make it a dynamic analysis,  
3 we should really be looking at what are the practices  
4 that the physicians are doing? Are they increasingly,  
5 in order to attract volumes, doing marketing efforts,  
6 setting up satellite offices in suburban areas to draw  
7 people in more so? And again, to look at the actual  
8 patterns. But I have found that the patient data is  
9 very useful for looking at what actually has gone on.

10           Since my time's up, let me just kind of go very  
11 quickly to in terms of looking at share, I think it's  
12 very important, the most important thing is to look at  
13 whether or not you are looking at nonexclusive groups  
14 versus exclusive groups, because many times the same  
15 physicians are in multiple panels, and so you have to  
16 take that into account in evaluating whether or not you  
17 have a concern.

18           I think by far the most important thing -- and  
19 again, to take it from being static to making sure it's  
20 dynamic -- is to look at what the practical experience  
21 in the marketplace has been with respect to expansion.  
22 Many markets are very dynamic, with expansion of  
23 locations, expansion by entry of new physicians,  
24 tendency toward nonexclusivity and reaching out in  
25 broader areas and bringing in new physicians by

1 hospitals. That makes, in general, for broader  
2 markets, less of an issue.

3           So, in general, where I would conclude is  
4 saying market power could be a substantial concern, but  
5 I think there's a substantial amount of data that are  
6 available to us fortunately to be able to test in a  
7 particular context whether the concern that has been  
8 raised is something that's real or whether there are  
9 substantial facts that one could point to to say we  
10 don't need to be quite so concerned.

11           Thanks.

12           MR. BYE: Thanks, Meg.

13           David, would you like to give the next  
14 presentation?

1 There are some distinctions in geographic market that I  
2 think are important, we ought to mention a little bit.

3 We talked a little bit about the primary care  
4 versus specialty care distinction, but there's also  
5 something underlying that hasn't been addressed head  
6 on, which I think is important and has some very  
7 important antitrust implications of the office-based  
8 versus the hospital-based physicians.

9 And finally, take a few minutes to talk over  
10 some of the challenges and information sources. As Meg  
11 indicated in her talk, there are some good sources, but  
12 there are a number of shortcomings.

13 Just beginning with some thoughts on the merger  
14 guidelines, and I agree wholeheartedly with John that  
15 conceptually the right place to start is with the  
16 merger guidelines, the hypothetical monopolist paradigm  
17 of an attempted price increase, and then consideration  
18 of whether there would be sufficient payer and patient  
19 switching to defeat that price increase, and an  
20 integral part of that is a critical loss analysis or  
21 something equivalent, so that you're measuring whether  
22 you've met that sufficiency threshold.

23 One of the aspects of a standard merger  
24 guidelines analysis that's likely to be especially  
25 relevant for physician market definition is the

1 possibility of price discrimination. Antitrust issues  
2 in physician matters are most likely to arise in  
3 situations where it's a large group to begin with. To  
4 the extent that these groups have different locations,  
5 for example, and are able to price differently in the  
6 different locations, it may result in effective price  
7 discrimination that would require an analysis of  
8 separate markets. And I will talk a little bit more  
9 about that in a few minutes.

10           With regard to product market definition, the  
11 fundamental challenge for physician services is the  
12 same as it is in a lot of other health care services,  
13 and that is that from a patient's perspective, the  
14 individual service that they're receiving isn't  
15 interchangeable, you know, isn't interchangeable from a  
16 medical standpoint, and consequently, the patient often  
17 can't switch services based on price. Even though that  
18 fundamental principle seems to exist in a lot of health  
19 care analyses, very seldom are product markets defined  
20 based on those.

21           Rather, they are defined based on the specialty  
22 of the physician. Some of that's convenience; some of  
23 it's just a practical matter of doing it. There are  
24 occasions where there are exceptions or ad hoc  
25 distinctions that are made, but they're often made as a

1 matter of convenience rather than a rigorous  
2 application of the model.

3 If, for example, specialty physicians are  
4 treated as a group, it's unlikely that each of those  
5 specialties constitutes, you know, an equal ability for  
6 patients to switch among them, but nevertheless, they  
7 may be treated as a group.

8 One product market that often does have  
9 physician specialties grouped together is, as John  
10 indicated, primary care services, and typically primary  
11 care services are thought of to include internal  
12 medicine and family medicine, often pediatrics and  
13 sometimes OB/GYN or at least the GYN component of it,  
14 and the rationale is that many of these physicians or  
15 these physicians provide many of the same services so  
16 that a patient can decide which one of those  
17 specialists they want to go to.

18 Obviously that's not true for all of them. You  
19 wouldn't get a pediatrician providing adult medical  
20 care, but nevertheless, there are some services that  
21 are interchangeable among them which tends to lead to  
22 those being grouped together into a single product  
23 market.

24 In contrast, specialty physicians are typically  
25 considered to be in separate product markets by the

1 specialty. There may be some circumstances where  
2 particular services overlap. A neurosurgeon and an  
3 orthopedist might both be capable of doing spinal surgery,  
4 and whether that's relevant or not to an analysis  
5 depends on the particular issues at hand.

6 An important distinction in product and  
7 geographic market definitions for physician services is  
8 that between office-based physicians and hospital-based  
9 physicians. The office-based are primary care doctors,  
10 general surgeons, a number of medical specialties, as  
11 distinct from the hospital-based physicians, which  
12 might include the anesthesiologists, the  
13 neonatologists, ER doctors, radiologists and an  
14 assortment of others.

15 What are the distinctions of office-based  
16 physicians? Well, typically an office-based physician  
17 will treat patients in their office, certainly see them  
18 in their offices, although they would use hospital  
19 services with some frequency depending on the nature of  
20 the capabilities of doing include the anesthesiologists, ER doctors, radiologists and an assortment of others the hospital

1 that has gone by the wayside. More typically, the  
2 office-based physicians are not employed by hospitals,  
3 and the office-based physicians compete directly for  
4 patients. They get onto managed care contracts and are  
5 getting their patients directly rather than through the  
6 hospitals.

7           The hospital-based physicians, in contrast, are  
8 contracted typically or employed by the hospital,  
9 sometimes on an exclusive basis. So, a single  
10 anesthesia group or a single neonatology group may asic sore





1 and it depends on the particular analysis being  
2 conducted.

3 One of the important distinctions that's missed  
4 in this presumption about patient travel patterns is  
5 that distinction between hospital-based and  
6 office-based physicians. The hospital-based physicians  
7 compete for contracts to be employed by or contracted  
8 by hospitals. Consequently, their markets are not  
9 likely to be local. They serve patients on a local  
10 basis, but they compete for those contracts nationwide  
11 or at least on a regional basis.

12 The hospitals have incentives to attract  
13 physicians or to employ and contract physicians who  
14 will provide the desired service at a competitive  
15 price, and the hospitals frequently exercise their  
16 ability to terminate contracts or fail to renew  
17 contracts and hire a more desirable group.

18 Typically, there are no particular barriers to  
19 entry to these types of hospital-based physicians, and  
20 part of the reason for that, anyway, is that, as I  
21 mentioned, hospital-based physicians serve the patients  
22 who are coming through the hospital. They don't have  
23 the same referral issues that office-based physicians  
24 might have, and they don't rely on the same  
25 patient-physician relationships that many office-based

1 physicians would have.

2 And finally, turning back to price  
3 discrimination issues, as I indicated, there may be  
4 large groups that have multilocation practices  
5 scattered throughout some area of consideration, and to  
6 the extent that they can price differently in those  
7 different locations, issues of separate geographic  
8 markets arise, and potentially issues of unilateral  
9 effects from a merger would arise as well.

10 Now, having said that, since I qualified just  
11 about everything I said with a "may" and saying  
12 everything is a factual analysis, it probably warrants  
13 a little bit of time on what sorts of information can  
14 you use to address some of these questions of market  
15 definition. There's certainly information that can be  
16 applied to product market definition. I'm going to  
17 focus mostly on geographic market.

18 As John had said, one of the sources of  
19 information is just what are the employers saying?  
20 There are interviews and documents that may be relevant  
21 for that. And as Meg had indicated as well, there's  
22 information out there of different quality and  
23 different reasonableness to acquire on physician  
24 locations. But what I wanted to focus a little bit  
25 more on was what about the patients themselves? What

1 can we find out about the patients?

2 Before I get to that, let me just cover this or  
3 tie off this hospital-based physicians aspect. In  
4 assessing the extent to which there are -- the size of  
5 the market for hospital-based physicians, it's typical  
6 that the hospitals will have recruiting information,  
7 there are placement services that you can find  
8 information from as well, and certainly so-called trade  
9 press advertisements.

10 But what about this patient-flow information?  
11 One of the sources -- and office-based physicians  
12 often have it -- are the practices themselves. They  
13 may have their own patient records -- they will have  
14 their own patient records; whether they're usable or  
15 not is another story -- and that information in a  
16 large group can often be good, computerized, easily  
17 accessed, easily worked with, but in many physician  
18 practices, it's spotty, it's of questionable quality,  
19 and there's only a limited amount of work you can do  
20 with it.

21 Another source is referral information.  
22 Sometimes it's useful to find where a specialist is  
23 receiving his referrals from, how many referrals are  
24 coming from this doctor in that town or this doctor in  
25 the other town.

1           Probably the best source of information for  
2 patient-flow is the utilization data from insurance  
3 companies, and it's a proxy for patient origin data  
4 because it includes competing physicians. It's not  
5 just the group you're working with but all the other  
6 groups in the area that are contracted with that  
7 managed care plan. The data tend to be much better  
8 quality and much more comprehensive. Of course,  
9 there's always the proprietary issue of this, that you  
10 can't always get your hands on it.

1 do you do if you don't have complete data? And I know  
2 there are a lot of different approaches to this, and  
3 I'm just going to discuss one of them that I think may  
4 be helpful. Suppose you're representing a group and  
5 all you've got is your own physician data. You can get  
6 from public sources where the locations of the  
7 competing physicians are. Then, one approach you might  
8 take is to find the service area for your doctors, use  
9 that as a proxy for the service area of the other  
10 doctors, and check for the overlap of services.

11 Now, if my slides work, I'll see if we can walk  
12 through one of these. Let's see, this is some  
13 semi-fictitious data for the physicians that we might  
14 be representing or interested in, in this case they are  
15 identified here as these purple stars -- they're kind  
16 of light purple, a little hard to see -- but clinic  
17 one, two, three, four and five, and the symbols are the  
18 their patients, where they get their patients from,  
19 where they're located.

20 So, the first step is to find out the service  
21 area, say a 90 percent service area, whatever seems  
22 appropriate for your clinics. In this case, this is  
23 just one clinic, clinic number three I guess. It's  
24 toward the center of that. Then identify that service  
25 area, approximate it with something. Here I've drawn a

1 circle on there. Maybe you're going to use a different  
2 shape, maybe just use the outline of the zip codes or  
3 what have you.

4 The next step is to identify the competitors,  
5 competitor A, B, these blue crosses, C, D and so forth,  
6 and follow that up with superimposing that service area  
7 over your competitors. You don't know where the  
8 competitors actually get their patients from, but we're  
9 approximating it using our own data. Then you can see  
10 that a lot of your own patients are actually located in  
11 the service area of some other doctor.

12 That's far from perfect, but given the lack of  
13 data, this may be some way to get a sense as to whether  
14 there's competition for or alternatives available for  
15 your patients.

16 Just concluding, let me recap a little bit. I  
17 want to go back and stress that the merger guidelines  
18 is a good place to start. The common problem in health  
19 care, they're often difficult to implement, but at

1       significance in terms of what the geographic markets  
2       are and the extent to which there are competitive  
3       issues.

4               And finally, no matter what you do, you're  
5       going to run into some challenges in the data issues,  
6       and it's just a matter of applying what you can or what  
7       you've got to the issues that are ahead of you.

8               Thanks very much.

9               MR. BYE: Thanks, David.

10              Monica, would you like to make the next  
11       presentation?

12              We'll just have a brief break and start back in  
13       a couple of minutes.

14              We'll cancel that break and start right up.  
15       Thanks for your patience.

16              MS. NOETHER: All right, with that great intro,  
17       now that you've seen all the email from everybody, I  
18       assure you my presentation won't be nearly as  
19       interesting.

20              One of the advantages and disadvantages of

1 physician fees, which is something they haven't talked  
2 about, so maybe I'll try to get to that a little more  
3 quickly, although there the evidence is very mixed as  
4 to what one can do.

5 Obviously physician competition has been a hot  
6 issue in the last several months, as there has been  
7 more and more scrutiny of physician practices, and it  
8 comes at a time when, in fact, there hasn't been a lot  
9 of empirical work that at least has been published on  
10 physician market definition, and some of that is due to  
11 the -- well, a lot of it I think is probably due to  
12 the paucity of data that are available, and so we're  
13 all kind of struggling with how to get a handle on it  
14 better.

15 So, as I say, I will talk about some of the  
16 things one can do with the fee data when one can get  
17 it, imperfect as they are, but first let me add my own  
18 observations on product and geographic market. As has  
19 been suggested already, one of the issues to think  
20 about in product market definition is the extent to  
21 which specialties compete, and as David pointed out, in  
22 fact, from the patient perspective, which is one of the  
23 perspectives one certainly wants to think about in  
24 market definition, they're really thinking about  
25 particular services that they need to consume, and so



1 for certain particular services, different specialties  
2 may compete, whereas they don't for others.

3 Family practice sometimes competes with  
4 obstetricians in the delivering of babies. Similarly,  
5 they sometimes compete with pediatricians in treating  
6 the sick kid or the well kid. And sometimes, I don't  
7 have it on here, they actually compete with internal  
8 medicine physicians in the treatment of adult patients.  
9 Internal medicine, though, often also classified as a  
10 primary care specialty, I think is less likely to try  
11 to compete with obstetricians and pediatricians than  
12 family practice, and that's just sort of the training  
13 and the way physicians think about it.

14 Neurosurgeons and orthopedic surgeons certainly  
15 are recognized as different specialties. They have on  
16 the supply side different kinds of training, different  
17 kinds of board certification, but on the demand side do  
18 provide some of the same services, some of the same  
19 surgeries, such as the spine surgery that David  
20 mentioned. So, therefore, at least in some

1 their primary care physician. So, the views of the  
2 primary care physicians and how they select which  
3 specialty to refer to can have an impact on market  
4 definition.

1 they do in urban areas. So that I think in thinking  
2 about which types of physicians compete with each other  
3 from a product perspective, it is important to think  
4 about the geography that's involved as well. Because  
5 of this, I think the population in rural areas is more  
6 likely to be tolerant of generalist physicians or they  
7 travel more.

8           Also, I think there are often significant  
9 differences across the country in practice patterns.  
10 Certain areas of the country, because of the nature of  
11 medical school training and just custom, historically  
12 may just do things a different way, so there's been a  
13 lot of analysis of local practice variation done by  
14 Jack Wenberg up at Dartmouth that looks at numbers of  
15 different services provided in different areas of the  
16 country and just huge variation that cannot be  
17 explained by differences in health care characteristics  
18 of the population. Some of that also translates into  
19 local physician practice patterns and referral patterns  
20 as well.

21           Kinds of evidence to look at in figuring out  
22 the extent to which different specialties compete with  
23 each other, to the extent that you can get views of  
24 managed care or just even look at the construction of  
25 their physician panels, do they have a full range of

1 specialties, or if they are trying to cover a less  
2 densely populated area, do they lack the  
3 subspecialists, which suggests maybe that there's more  
4 substitution of general physicians.

5           What are the referral patterns of the local  
6 physician community? Are they referring always to a  
7 particular kind of specialty, or do they sometimes  
8 refer their patients to one specialty and sometimes to  
9 another for the same condition? What kinds of  
10 requirements do hospitals have about board  
11 certification in particular specialties? What kinds of  
12 subspecialties are they trying to attract to their  
13 medical staff? That can give you information as well.

14           And finally, obviously, if you can get it,  
15 looking at fee data can be instructive, though I do  
16 want to caution you that just seeing that there are  
17 differences in the levels of fees that physicians in  
18 different specialties charge for the same services is  
19 not necessarily indicative if they don't compete. It  
20 could be that there's some kind of equilibrium  
21 differential, and if you want to be a subspecialty that  
22 would raise its price, you still would see shifting,  
23 but you're starting out with different levels. So, if  
24 you're doing an analysis with fee data, to assess this  
25 question, you really want to look at changes over time

1 and try to get to some measure of cross-elasticity,  
2 which, of course, is usually impossible given the data  
3 available.

4           Just to bring home the notion of some variation  
5 in fees, what I have here are data from a single large  
6 multispecialty group practice that has a number of  
7 offices in an urban area, and what I'm showing here are  
8 the fees for two particular kind of office visits, one  
9 a mid-level visit for a new patient and the other a  
10 mid-level visit for an established patient. So, these  
11 are fairly precisely defined, specific CPT codes that  
12 physicians use to bill, and what I'm showing are the  
13 fees that are -- now, I will say these are charges,  
14 and that's another issue. Just as with hospital data,  
15 charges are often the only data you can get. They  
16 obviously are not the same as transactions prices and  
17 can be more or less meaningful depending on whether the  
18 actual payment rates are calculated as a percentage off  
19 the charges or something different. But at any rate,  
20 we see here that even the charges do vary somewhat  
21 across the different specialties for these office  
22 visits.

23           Now, in some cases these are not specialties  
24 that are going to compete, but on the other hand, it's  
25 possible that, in fact, the pediatrician charging \$145

1 for a new visit, a new patient visit, is, in fact, to  
2 some extent competing with the internal medicine person  
3 charging \$130 but doing perhaps a slightly more  
4 thorough job.

5 Another issue that comes up in product market  
6 definition is: To what extent are physicians and  
7 associate allied health professions complements or  
8 substitutes? I think physicians would often like to  
9 make the associated allied health professions  
10 complements to them. Obviously that way they would  
11 have less competition from these allied health  
12 professions, but also they can extend their own  
13 productivity and run a more efficient practice if they  
14 can find a way to use the allied health professions as  
15 complements.

16 Various examples of allied health professions  
17 who might complement or substitute for an associated  
18 physician specialty, a well known one,  
19 anesthesiologists and certified registered nurse  
20 anesthetists, and there has been some litigation on  
21 issues related to this, relating to whether nurse  
22 anesthetists can get privileges at hospitals to  
23 practice independently. Obstetricians and midwives in  
24 delivering kids; ophthalmologists and optometrists, at  
25 least for certain services, sometimes compete, but also

1 sometimes will work together, where the optometrist  
2 provides the post-surgical care and the  
3 ophthalmologists provide the surgery.

4 Orthopedic surgeons and chiropractors are  
5 probably more generally viewed as substitutes than  
6 complements but in certain situations might work  
7 together. And finally, primary care physicians and  
8 nurse practitioners. In some areas of the country,  
9 nurse practitioners will practice independently, and in  
10 others they essentially assist physicians and, again,  
11 may be more productive.

12 Kinds of things to think about, about whether  
13 one should think about the allied health professionals  
14 as providing any sort of competition to particular  
15 physician specialties, regulatory restrictions on the  
16 scope of allied health professions, scope of practice  
17 vary substantially across states.

18 In some states, for example, optometrists can  
19 prescribe medications, eye medications, and in others  
20 they can't. That obviously limits the extent to which  
21 they can compete with ophthalmologists. The same is  
22 true of other allied health professionals.

23 Supervision requirements, I think there is  
24 variation in the extent to which midwives can operate  
25 without any supervision from obstetricians or when they

1 need to refer to obstetricians. The same with CRAs and  
2 anesthesiologists.

3 As I said before, this kind of analysis has to  
4 be done on a service-specific basis. There may be some  
5 services where the allied health professionals, in  
6 fact, do compete and substitute for the relevant  
7 physician specialty and others where they complement  
8 them.

9 Other kinds of evidence that one might want to  
10 look at, practice patterns. Do you see collaborative  
11 relationships between the physicians and the allied  
12 health professionals that suggest complementarity? I  
13 mentioned the co-management of eye surgery patients.  
14 Again, that's something where there is substantial  
15 variation across the country, areas where  
16 ophthalmologists don't want to have anything to do with  
17 optometrists and other areas where they recognize that  
18 they can, in fact, augment their own practice and they  
19 can, in fact, see more patients more productively by  
20 employing optometrists. The same with CNAs and  
21 anesthesiologists.

22 Nurse practitioners have been certainly thought  
23 of as -- particularly in rural areas -- a substitute  
24 for primary care physicians, yet it seems that the data  
25 suggest otherwise. A recent study by MAMSI's National



1 Ambulatory Medical Care Survey, which is actually a  
2 very large database of physician office patterns, shows  
3 that 96 percent of office visits, the patient sees a  
4 physician at least part of the time. So, this suggests  
5 that nurse practitioners are not completely  
6 substituting for physicians in any kind of major way.

7 On the other hand, attempts by allied health  
8 professionals to obtain hospital privileges certainly  
9 suggests that they view themselves as able to  
10 substitute for specialists in certain areas at least.  
11 Again, the kinds of evidence that one might want to  
12 look at are very similar to the previous question on to  
13 what extent do specialists compete? What do managed  
14 care plans do in setting up their panels? Is there any  
15 evidence that one can get of price competition?

16 Turning quickly to geographic market  
17 definition, I want to sort of differentiate a little  
18 slightly different dimensions than the previous speaker  
19 has, though some of the same issues arise, and that is  
20 to distinguish between the short run and the long run,  
21 where I define the short run essentially as where the  
22 existing supply of physicians in an area is fixed, and  
23 there are obviously varying views of how long this  
24 short run lasts depending on how easy one thinks it is  
25 to recruit physicians to a particular area.

1           In this situation, from the patient  
2 perspective, the extent of the market is largely going  
3 to depend on the patient's willingness to travel, and  
4 as has been mentioned before, patients are often more  
5 willing to travel further for tertiary services, as is  
6 the case with hospital care as well, and I think in  
7 general rural patients either accept a broader product  
8 market by going to generalists rather than specialists  
9 or they accept a broader geographic market, i.e.,  
10 they're more willing to travel.

11           Physician willingness to travel, I think, is  
12 also something that eTet eTekulre, takngndnase2 trege, I thw



1 think it's pretty well known that physician incomes on  
2 either coast, either the Atlantic or the Pacific coast,  
3 are substantially lower than they are in the rest of  
4 the country, so obviously income is not the only thing  
5 that affects physician location decisions, and there  
6 is, in fact, a body of research that tries to tease out  
7 the different factors that do affect physician  
8 location.

9 A recent study in the Joul thiyfr5Hletty well we locatio



1           That prediction came out of a study that had  
2           been commissioned by the American Society of  
3           Anesthesiologists that I actually undertook, which  
4           essentially forecast future demand for anesthesiology  
5           services and what the "need" for anesthesiologists  
6           would be based on how much CRNAs were substituted.

7           So, what happened as a result -- I don't know  
8           whether it happened as a result of this article but  
9           sort of as a result of the fact that new anesthesiology  
10          trainees were having a really hard time getting jobs --  
11          was the word got out, and there was a substantial  
12          decline in the number of anesthesiologists entering  
13          residency programs.

14          So, what has happened now is, if you read the  
15          trade press, anesthesiologists are in very hot demand.  
16          It's very hard to recruit them. So, if anything, there  
17          is excess demand for anesthesiologists. And in fact,  
18          if you look at what's happened to anesthesiologists'  
19          incomes relative to all other specialties, you can see  
20          that, in fact, not surprisingly, that period in the  
21          early nineties, anesthesiology incomes were high  
22          relative to other specialties. This probably reflects  
23          the fact that it had been in short supply.

24          Lots of physicians entered residency.  
25          Presumably if you extended the line back to the late

1 eighties, it would also be high up there, and as they  
2 came out of medical school or out of residency in the  
3 early nineties and flooded the market, surprise,  
4 surprise, anesthesiology incomes went down, and now we  
5 see them going back up. If you looked at the 2002  
6 numbers, they'd be high again, suggesting in the long  
7 run, in terms of thinking about specialties, that the  
8 physician population or the potential physician  
9 population does certainly respond to these things.

10 Similarly, I don't know if you've been  
11 following the trade press that apparently cardiac  
12 surgery, which used to be a really hot specialty, now  
13 can't even fill their residency slots because so much  
14 cardiac surgery is now being done noninvasively and  
15 also because cardiology surgery reimbursement has gone  
16 way down.

17 Turning, as promised, a little bit to some of  
18 the things that one can do with physician fee data,  
19 obviously if one had, you know, really good physician  
20 fee data that showed transactions prices and was really  
21 disaggregate, then you could look directly at the  
22 direct effects of alleged anticompetitive behavior.  
23 You wouldn't even have to worry that much about the  
24 precise market definition, because you could estimate  
25 cross-elasticities of demand and you could look at

1 whether prices had gone up.

2 Obviously we are not in that kind of a world,  
3 which is why we're mainly talking about market  
4 definition, but there are some fee data out there, and  
5 sometimes you can get a hold of things, and so there  
6 are some things to think about in terms of if you are  
7 lucky enough to get some fee data, what kinds of things  
8 you should think about in working with them.

9 One obvious question is standardization.  
10 Physicians bill using at least 7000 different -- they  
11 are called CPT codes that all indicate different  
12 services, so trying to do any kind of analysis on 7000  
13 separate fees -- it would be less than that for a  
14 single specialty, but still could be several  
15 hundred -- tends to make the analysis pretty  
16 cumbersome.

17 You can do and what is often done is  
18 standardizing by something called relative value units,  
19 which are essentially the units that come off of the  
20 Medicare physician fee schedule, which the Medicare  
21 physician fee schedule is known as RBRVS or the  
22 Resource-Based Relative Value Scale, they are at least  
23 intended to reflect variation in the resource available  
24 from physicians. That's the problem associated with  
25 providing different services. It's only a supply-based



1 measure.

2           It doesn't reflect differences in demand, but  
3 at least it is a way of standardizing fees to some  
4 extent, so you can take the fee for a particular  
5 service, divide it by its relative value, and you could  
6 get a more standard measure, namely, the dollars per  
7 relative value unit.

8           Another issue that you need to think about is  
9 that many particular individual codes may have multiple  
10 fees associated with them, for example, radiology  
11 procedures. If it's just the physician providing the  
12 service, that physician bills a professional service  
13 fee. If, on the other hand, the physician owns the  
14 equipment and is providing the service in his or her  
15 office, he or she will bill a global fee that  
16 incorporates the capital costs of the equipment.

17           You can't distinguish between those two.  
18 There's no way to interpret the fee data that you have.  
19 So, you have to make sure that you know whether you're  
20 looking at professional or global fees.

21           Finally, many surgical services have modifiers  
22 attached to the fees, indicating whether it's a surgery  
23 that's done with another procedure or whether it's a  
24 surgery that's extra complicated. So, again, these are  
25 things that if you're going to analyze fee data, you

1 need to keep in mind.

2           Where you get the data tends to be from claims  
3 data, from managed care plans, or maybe from a  
4 particular physician group. Looking at claims data,  
5 you have many of the same issues that you have if  
6 you're trying to look at claims data on the hospital  
7 side. The data are, while voluminous, not necessarily  
8 particularly easy to interpret. Often, despite their  
9 voluminousness, they don't have the information you  
10 need.

11           You may not have information on specialty, for  
12 example. You may not have information on all of these  
13 modifiers that I was talking about. Physicians now do  
14 tend to all have unique identifiers that were  
15 established a number of years ago by the Government, so  
16 it is easier now to figure out a particular physician's  
17 claims than it used to be, but often, if you've got a  
18 bunch of physicians practicing in the same group and  
19 operating under the same fee schedule, you can't link  
20 them together. So, that's another problem.

21           And finally, there are a lot of adjustments --  
22 I shouldn't say finally, but in terms of just my  
23 laundry list of issues, adjustments to initial claims.  
24 If some payment gets reversed or challenged or  
25 whatever, it may be difficult to link with the initial

1 claim. So, you don't know that the fee you're looking  
2 at is actually the fee that was actually finally paid.

3 But given all those --

4 MR. BYE: Could you wrap up, please?

5 MS. NOETHER: Sure, I will wrap up quickly.

6 Given all those caveats, different sources of  
7 physician fee data, the best place tends to be from  
8 managed care plans who actually have good transaction  
9 data, and if you get those kinds of data, you can ask  
10 questions about whether a particular specialty or group  
11 has raised price substantially in a short period of  
12 time. That's the sort of temporal question that you  
13 can get from a time series of managed care data.

14 Or, if you're trying to look at a particular  
15 area and it's a managed care plan that operates in  
16 multiple areas, you can compare physician payments  
17 across different areas.

18 Benchmarks that may exist to make comparisons,  
19 the Medicare RBRVS is out there, but not particularly  
20 very useful given that it tends to be, as I said, just  
21 a resource-based measure and therefore not reflective  
22 of different demand conditions or different competitive  
23 conditions in different markets.

24 There is a database out there called Medicode  
25 that Ingenix puts out that gives you percentiles of

1 charges. The advantage it has, while it is just  
2 charges, is that it is available at a very detailed  
3 level, specifically for any zip code or CPT code  
4 combination.

5 Let me just close with what is going to  
6 undoubtedly be a very confusing picture, but this is  
7 essentially taking that same physician group that I  
8 showed you a slide for before and comparing their fees  
9 by range of CPT code that respond basically to  
10 specialty and comparing it to these Medicode data, and  
11 what we've got here are median charges per relative

1     So, you can see that even within this urban area, there  
2     is a fairly large variation in the fees, making it that  
3     much more difficult to draw any kind of firm  
4     conclusions.

5             So, on that pessimistic note, I will close.

6             MR. BYE:  Thanks, Monica.

7             We might actually have a quick break now, so if  
8     you could return in five minutes, that would be great

1 issues, the legal standards -- and I am going to talk  
2 about it from a lawyer's perspective since I am not an  
3 economist -- but the legal standards that govern the  
4 definition of the relevant product and geographic  
5 market are fairly well established, and for the service  
6 market, which is really what we're talking about here  
7 today, you focus on the services that are reasonably  
8 interchangeable for the same purpose, so you look for  
9 physician practice areas that can substitute for other  
10 practice areas.

11 For the geographic market definition, you try  
12 to define the area of effective competition where the  
13 physicians practice and where patients can turn for  
14 alternative sources of supply. The geographic market  
15 issue has been litigated frequently in hospital staff  
16 privileges cases, and in many of those cases, the  
17 plaintiff physicians have tried to define the relevant  
18 geographic market as the hospital at which they have

1     which the physicians sell and provide their services  
2     and where the patients can practicably -- which is an  
3     important concept -- find alternative physician  
4     suppliers.

5             Now, while these legal standards obviously are  
6     important to set the analytical framework, from a  
7     practical litigation perspective, the facts are what  
8     drive the determination of the relevant product and  
9     geographic market. This issue is very fact-specific  
10    and is really won or lost based upon the facts that are  
11    presented, and the quantity and the quality of the  
12    facts presented are very important to this analysis.  
13    As a result, a detailed factual analysis is critical to  
14    determine what the proper service and geographic  
15    markets are in a case.

16            Now, starting with the service market, I agree  
17    with some of the comments that have been made here  
18    today, that the specialist labels should not be  
19    controlling and a more realistic assessment of  
20    alternatives needs to be evaluated. For example, let's  
21    take radiology, and some of that's been touched on  
22    today. Radiology has historically been viewed as a  
23    separate specialty area for physicians, but today, many  
24    different types of physicians, such as cardiologists,  
25    general surgeons, orthopedic surgeons, rheumatologists,

1 neurologists, oncologists, many others, read and  
2 interpret x-rays on a regular basis. Many of them have  
3 x-ray machines in their own offices.

4           To determine whether radiology constitutes a  
5 separate service market or whether these other kinds of  
6 physicians need to be brought into the definition of  
7 the market, you need to look at the extent to which  
8 these services really are interchangeable. They may be  
9 interchangeable for some uses but may not be for  
10 others. And part of this analysis may require an  
11 evaluation of the quality of the x-ray interpretations  
12 that are being performed by that physician and by  
13 radiologists in comparison. For certain kinds of  
14 procedures, a higher quality and a more specialized  
15 type of interpretation is needed than others.

16           Now, turning to the geographic market, as a  
17 practical matter, the geographic market definition  
18 depends on an evaluation of a number of factors, and  
19 you've heard a lot of these ticked off today. Patient  
20 origin data, which usually focuses on zip codes from  
21 where the patients reside; physician referral  
22 practices, such as where primary care physicians refer  
23 for speciality or specialized services; the location of  
24 physician offices; the hospitals at which physicians  
25 have privileges; the views of managed care plans as to



1 the areas that are included in a geographic market; and  
2 the marketing activities of physicians in an area, such  
3 as where they advertise their services.

4 Now, this analysis of where patients are likely  
5 to turn for alternative physician services often boils  
6 down to a mix of distance, convenience and the type of  
7 service needed. So, a mix of distance, convenience and  
8 the type of service needed. People are likely to  
9 travel farther for higher level specialized services.  
10 For example, some people who need cardiac surgery or a  
11 heart transplant are likely to travel to facilities  
12 that are located several hours away in order to get the  
13 desired level of care.

14 As a result, in analyzing the geographic market  
15 for higher level specialized services, like cardiac  
16 surgery, it's instructive to look not only where the  
17 patients of those specialists in the area come from,  
18 but also look at other comparable specialists who do  
19 other kinds of procedures to see where they get their  
20 patients from. This will shed some light on whether  
21 physicians in different geographic areas actually  
22 compete with each other or not.

23 I'd like to make a comment about the  
24 traditional type of economic analysis that's used in  
25 defining the geographic market. Traditionally, the

1 geographic market definition has relied primarily on a  
2 zip code analysis, and you've seen examples of that  
3 today, of where the subject physician's patients come  
4 from. They look at the zip codes of where that  
5 physician's or where that type of physician's patients  
6 come from.

7           Now, you saw from the presentations made by  
8 Meg, Dave and Monica today that they look at other  
9 factors. Now, these are all very good economists, but  
10 I would submit to you that there are some economists  
11 out there who focus very heavily on just a zip code  
12 analysis. This zip code analysis, however, only  
13 presents a static and limited view and a partial view  
14 of the relevant geographic market.

1           In that case, the plaintiff cardiac surgeon  
2           practiced in Lincoln, Nebraska, and he alleged that the  
3           relevant geographic market for cardiac surgery services  
4           was limited to the city of Lincoln and its surrounding  
5           areas. The plaintiff relied on an economic analysis,  
6           an economic expert report, which showed that the large  
7           majority of residents in the Lincoln area went to  
8           Lincoln cardiac surgeons.

9           However, the Court went beyond that zip code  
10          analysis and found that the geographic market for  
11          cardiac surgery services included not just Lincoln, but  
12          also Omaha, Nebraska, which was located 58 miles away,  
13          and the Court did that because consumers in Lincoln  
14          could practicably turn to cardiac surgeons in Omaha for  
15          services. And in fact, when they talked to primary  
16          care physicians, they found that primary care  
17          physicians viewed cardiac surgeons in Omaha as  
18          reasonable and viable substitutes.

19          Now, that's all I'm going to say about market  
20          definitions, since I think it was pretty well covered  
21          today, and I want to turn to the main thing I want to  
22          talk about, which is the relationship between health  
23          care plans and physicians and particularly the market  
24          conditions and trends that are affecting their rate  
25          negotiations.

1           To do that, we first have to look at how  
2 physician reimbursement normally is set. Health care  
3 plans, as I'm sure you know, compete with each other in  
4 a number of areas, such as price, which in that case is  
5 the premium rate to groups, quality, service, benefit  
6 packages and provider networks. The last area,  
7 provider networks, is very important to health care  
8 plans, because they need to develop adequate networks  
9 of physicians and hospitals to provide access and  
10 covered services to their members.

11           To put these networks together, health care  
12 plans typically enter into provider agreements with  
13 physicians that are of relatively short duration, and  
14 these provider agreements include fee schedules that  
15 the health care plans offer to the physicians who are  
16 willing to participate in the plan's network. The fee  
17 schedules set forth the specific amounts that the  
18 health care plan is willing to pay the physicians for  
19 the services they perform by CPT code.

20           Most health care plans set their fee schedules  
21 by monitoring a number of things. They look at the  
22 participation rates of the physicians in various  
23 practice areas and specialties. They try to obtain as  
24 much information as possible from physicians about the  
25 fee schedules offered by other health care plans. And

1 they estimate their total physician payment cost based  
2 upon projected utilization of services. So, a health  
3 care plan usually has an annual budget or cost budget  
4 that it needs to meet, and it will try to set its fee  
5 schedules for the various physician practice areas and  
6 specialties within the constraints of that budget.

7 As an example, let's say that a health care  
8 plan budgets a 2 percent overall cost increase for  
9 payments to physicians in 2004. Its fee schedule will  
10 literally have a list of dozens of different physician  
11 practice areas and specialties that are in that  
12 network, but not all of those practice areas and  
13 specialties are going to get that 2 percent increase  
14 that's projected for 2004.

15 Instead, the health care plan will prepare a  
16 fee schedule which lists each physician practice area  
17 in its network and will come up with a proposed fee  
18 increase by group, you know, for that area in 2004.  
19 Some practice areas will receive an increase that's  
20 more than 2 percent; some will be kept flat; and  
21 others, in fact, will probably see a decrease in their  
22 payment levels from the health care plans.

23 Now, health care plans typically make these  
24 decisions as to who gets what on that schedule, which  
25 practice areas get an increase, who's kept flat and who

1 gets a decrease, they typically make that based upon a  
2 supply and demand analysis. The health care plan  
3 assesses supply and demand by, again, focusing on the  
4 participation rates of the physicians in their network.  
5 If a health care plan has a high participation rate in  
6 a physician practice area, it most likely will conclude  
7 that its payments for that practice area are adequate,  
8 and it will not increase the fees for that practice  
9 area in 2004.

10 On the other hand, if a health care plan does  
11 not have an adequate number of physicians in a practice  
12 area in its network, it will probably decide to  
13 increase its fee schedule for that practice area in  
14 order to attract and persuade more physicians to join  
15 its network. So, for example, if a health care plan  
16 doesn't have enough urologists in its network, it just  
17 hasn't been able to sign up enough urologists, it's  
18 probably in the next year going to look at raising its  
19 payment rate to urologists to try to get more people in  
20 the network. So, this is essentially how the  
21 fee-setting process works between health plans and  
22 physicians in many markets, and I might add, it's also  
23 a perfectly legitimate way of setting physician  
24 reimbursement under the antitrust laws.

25 Most health care plans then, based on that fee

1 schedule, offer a standard amount set forth in their  
2 fee schedule to physicians in the geographic market or  
3 area covered by that fee schedule unless other factors  
4 come into play, and now I'd like to address some of  
5 those other factors.

6           There are a number of market conditions and  
7 trends that are directly impacting the relationship  
8 between health care plans and physicians, especially  
9 the amounts paid to physicians, and I would suggest  
10 bear watching by the FTC and the Department of Justice.

11 These trends include a high level of concentration in  
12 certain physician practice areas;     Te           l by nhotv nhotd   The  
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1 hit the Government's radar screen and are usually not  
2 scrutinized from an antitrust standpoint.

3           However, what we are now seeing is that there  
4 is a high degree of concentration in some physician  
5 practice areas in many communities throughout the  
6 country. Now, typically this is not going to be the  
7 case in Washington, D.C. or New York or Chicago, but it  
8 is going to be the case in many smaller cities and  
9 rural areas throughout the country.

10           Now, these physician practice groups that tend  
11 to be large in these communities usually hire business  
12 managers, and they have become much more aggressive in  
13 their dealings and negotiations with health care plans.  
14 In fact, some large practice groups, which have a  
15 substantial share of a particular practice area, have  
16 been using their market power to raise the rates that  
17 are paid by health care plans and obtain a higher than  
18 normal rate increase.

19           In situations where a normal rate increase their rate increases



1 often feel a need to agree to the higher fee demands of  
2 the large physician groups.

3 As a result, there is evidence from many places  
4 in the country which indicates that physician  
5 concentration has had a direct impact on the rates paid  
6 by health care plans for physician services. And since  
7 many of these situations occur, as I indicated, in the  
8 smaller secondary cities and in rural areas, they often  
9 do not receive the same amount of attention that market  
10 conditions in the larger cities attract.

11 However, I would submit that this increased  
12 amount of concentration in physician specialties is an  
13 area that bears watching by the federal agencies as  
14 they continue to monitor competition in the health care  
15 market.

16 Secondly, I would submit that there also has  
17 been increased pressure to raise physician  
18 reimbursement because of a recent trend of physician  
19 groups to either partially integrate or affiliate their  
20 practices with others, and this has been happening in a  
21 number of different ways, and I'm talking about  
22 situations that are outside of the cases where  
23 physician groups or organizations try to financially  
24 integrate their network or may not do it successfully,  
25 but they at least are trying to fit the models.

1           As most of you know, there are many consultants  
2           and health care attorneys, but usually not antitrust  
3           attorneys, who are trying to sell physicians and  
4           physician groups on the advantage of partially  
5           integrating or partially coordinating their practices,  
6           but I would submit to you that in many of these  
7           situations, these consultants either do not understand  
8           or do not follow very carefully the FTC/DOJ policy  
9           statements on physician network joint ventures.

10           In a number of markets, consultants have  
11           convinced previously independent physician practices  
12           that they have adequately combined and integrated their  
13           practices if they use the same tax ID number to submit  
14           claims for payments; if they jointly hire employees; if  
15           they utilize the same staff for billing and  
16           collections; if

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1 care plans under the umbrella of the so-called  
2 coordinated activities, and they use their larger size  
3 to try to obtain higher rate payments from health care  
4 plans.

5 Another variation of this is the use of a  
6 common practice management firm by a number of  
7 physician groups in the same specialty and in the same  
8 geographic market, so this is where a number of  
9 physician practice groups that are in the same  
10 specialty kind of area, practice area, all hire the  
11 same practice management firm to do their business work  
12 for them, manage their practice. What happens here in  
13 many cases is that the practice management firm gets  
14 each physician group, when contract renewal time comes  
15 up with a health care plan, to request the same rate  
16 increase from the health care plan, and if the health  
17 care plan refuses to give the same rate increase to the  
18 various practice groups, it faces the prospect of  
19 losing contracts with either all or most of the  
20 physician practice groups in a specialty in that  
21 geographic area, and therefore, will not have an  
22 adequate number of physicians to fill out its network.  
23 This practice has also put pressure on health care  
24 plans to raise physician reimbursement.

25 And lastly, a number of significant hospitals

1 or hospital systems throughout the country have  
 2 attempted to improve and expand their market position  
 3 by acquiring large numbers of primary care and  
 4 specialty physician practices. Now, I hear from Astrid  
 5 this does not occur in California and a few other  
 6 states in the country because of some statutory bars  
 7 that they have, but in many areas of the country, there  
 8 is no such statutory bar, and many hospitals have, in  
 9 fact, acquired sizeable numbers of primary care and  
 10 specialty practice groups.

11 Health care plans often are at a disadvantage  
 12 in dealing with these large hospitals because they need  
 13 the hospitals and they need their own physicians in  
 14 order to have a competitive network. So, these  
 15 hospitals in some of these cases have aggressively used  
 16 their market strength to obtain higher than normal or  
 17 higher than competitive level, I would submit, rate  
 18 increases for their own physicians.

19 This trend towards building large hospital  
 20 systems with a sizeable amount of owned physicians  
 21 should also be watched carefully and monitored because physicians  
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1 ventures, and most recently, we've seen the fruits of  
2 some of that in terms of actions that have been brought  
3 against networks that claim to be messenger models but  
4 really were not. I would suggest that the agencies  
5 expand their focus to monitor these other trends of  
6 increasing physician concentration, the other forms of  
7 integration or affiliation, such as common practice  
8 management firms that are being utilized by physician  
9 practices and hospital acquisition of physician  
10 practices.

11 Thank you.

12 MR. BYE: Thanks, Howard.

13 Our final presentation will be from Astrid

14 Geixlrigan

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1 is not a monolithic group of people by any chance.  
2 It's actually got in more conflicts than some of the  
3 other people and its law firms that are here. In fact,  
4 we represent small physicians and group physicians and  
5 owners of groups and reports from owners of groups  
6 that, in fact, they are getting faced with extra highly  
7 competitive pricing fees from reimbursements and  
8 reports from specialists that they're getting excluded  
9 from groups and generalists and specialists and  
10 self-proclaimed monopolists because they're the best,  
11 urban physicians, rural, suburban physicians and  
12 physicians from LA. So, what we have is a whole  
13 interconnected mess of physicians that oftentimes have  
14 adverse interests against other physicians.

15 So, when I was looking at what I was going to  
16 say today, I was saying, oh, my God, you know, whose  
17 side am I going to be on? And I actually decided to be  
18 on the side of what's best for patient welfare.

19 In California, at least, I don't know what  
20 numbers you're looking at, there is a severe  
21 underfunding of health care in California. There's  
22 been a crisis in the state as many of you may have  
23 heard. Many physicians and physician groups have gone  
24 bankrupt, closed their doors, restricted their  
25 practices, and it's been disastrous for everybody.

1 Physician-patient relationships are destroyed. There  
2 has been disruptions in care, which does result in  
3 negative patient outcomes. And for patients, in  
4 addition to the disruptions, there's just longer  
5 waiting times and access problems in general.

6 In light of all of what's happening, I think  
7 that what makes the most sense at this point is to have  
8 a broad common sense application of the antitrust laws  
9 and that the use of narrow definitions of product and  
10 geographic markets and mechanical and statistic  
11 approaches really makes little sense in today's  
12 environment.

13 First, with product market, I think that we all  
14 learned this morning that the general issue is  
15 substitutability, and substitutability, I think, is an  
16 objective factor that is based on whether there were  
17 others who can do the job, not how well they can do it.  
18 CMA has been very concerned about the use of  
19 reputation, you know, in terms of when they're dividing  
20 markets, when markets are analyzed in terms of whether  
21 or not a specific group has a good reputation or not.

22 First, reputation is not a factor which is to  
23 be used for substitutability. The issue is what  
24 alternatives are available to the consumer and can they  
25 get the care elsewhere? Substitutability does not turn

1 on whether those existing alternatives have the same or  
2 identical reputation. And in fact, you can never do  
3 that when you're talking about human beings. No two  
4 persons have the same or identical reputation. It's an  
5 impossible task.

6 For that reason, reputational factors for the  
7 purposes of product definition really contradicts the  
8 Clayton Act, which recognizes that a labor of the human  
9 being is not a commodity or an article of commerce.  
10 Therefore, medical services should not be treated as  
11 commerce.

12 California case law, by the way, recognizes  
13 this and says because of the dependent nature and the  
14 trusting relationship between the physician and the  
15 patient, you never want to treat physician services as  
16 a commodity in trade, which brings us to the next  
17 point, and that is reputation as a practical matter in  
18 terms of the way businesses are structured and financed  
19 and sold can never be bought and sold. So, let's look  
20 at it in the context of distinguishing it from good  
21 will.

22 Good will is an asset that can be bought and  
23 sold, and in fact, as we learned from the Office of the  
24 Inspector General, if it's bought and sold beyond the  
25 fair market value, there are actually fraud and abuse



1 implications, but in both the commercial and medical  
 2 contexts, good will can be sold and is tradable because  
 3 of consumer ignorance. That is, because of what people  
 4 did in the past, consumers are willing to go to this  
 5 place not knowing if the people who have purchased the  
 6 asset are as good as the people in the past. There's  
 7 consumer ignorance.

8 Reputation, on the other hand, is a product of  
 9 an individual whose reputation rises and falls with the of  
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 e 12 did he pastBluo Shield/Bluo Cro aeversus Marshfield Clin c  
 1 Foree'sutacors aInc.

1 reputation of the clinic was superb, it was really a  
2 monopoly, and therefore, you know, there needed to be  
3 some sort of challenge against the clinic.

4 Well, the Court there rejected that, saying  
5 that the suggestion that the price of being best is to  
6 be brought under the authority of the aegis of the  
7 antitrust laws and stripped of power to decide whom to  
8 do business with does not identify an interest that the  
9 antitrust laws protect. The successful competitor,  
10 having been urged to compete, must not be turned upon  
11 when he wins.

12 Next, we are concerned that reputational  
13 analysis actually assists competitors and not  
14 competition and in and of itself creates some sort of  
15 barrier to entry. The big reputational case in  
16 California was the ORLA case, which was the one that

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1 Number one, we have gone to the OIG on this, there is a  
2 number of instances of coercive contracting in  
3 California, where hospitals are coercing physicians to  
4 enter into certain managed care plans at certain fee  
5 levels as a condition of contracting, and at the same  
6 time there's instances of terminations and exclusions  
7 of physicians who advocate for quality of care.

8 In California, the courts have created an  
9 affirmative obligation of physicians to protest on  
10 behalf of their patients, and as a result of this  
11 protesting, they're considered by some to be rabble  
12 rousers, and they have been either terminated or  
13 excluded from the positions of medical staffs, health  
14 plans, medical groups, et cetera. CMA actually  
15 sponsored legislation to prohibit that retaliation, but  
16 unfortunately California courts are a little confused  
17 sometimes, and the application of that statute has been  
18 heavily litigated.

19 But I guess my point in this context, that  
20 hospitals and physicians have a say in arbitrarily  
21 deciding who has or has not a good reputation, there  
22 may be even more coercion to satisfy managed care's  
23 contracting needs of a hospital. Physician advocates  
24 may be wrongfully excluded from the equation, and there  
25 could be further barriers to entry to the extent

1 remaining groups are labeled as having an inferior  
2 reputation.

3           Next, reputation, as we all know, is subjective  
4 criteria, and it's subjective criteria that we believe  
5 is inappropriate when defining inherently complicated  
6 matters such as medicine. I mean, when you're dealing  
7 with a patient, you're dealing with severity of  
8 illness, comorbidity, heredity, outcomes and pain  
9 thresholds. Now, when you're looking at all of this,  
10 how can you tell who is good and who is not?  
11 Professionals still can't do that.

12           I mean, despite an enormous amount of resources  
13 and money and experts that have studied the issue,  
14 there's still no reliable mechanism that exists which  
15 fully risk-adjusts physician outcomes data. And you  
16 know, many consumers are very knowledgeable and able to  
17 tell who are and who are not good physicians, but  
18 still, many consumers still don't have an idea in terms  
19 of who is a good clinical physician, because a lot of  
20 that depends upon, again, outcomes, pain thresholds,  
21 diagnosis, and a lot of it depends upon bedside manner.

22           As a result, and because the issue of product  
23 market really depends upon substitutability, courts  
24 don't like this type of testimony and tend to reject it  
25 to the extent it does not address what alternatives



1 MS. LEE: Thank you.

2 I want to thank all the panelists for their  
3 informative presentations, and we're now going to begin  
4 our question and answer session. I'd first like to  
5 begin by inviting the panelists to ask questions of  
6 each other or to respond to other panelists'  
7 presentations.

8 I'm going to start with Meg, who I know has  
9 some questions that she would like to ask.

10 MS. GUERIN-CALVERT: I wanted to pose one  
11 overall question to any of the panelists, because I  
12 think that there are some potentially different views  
13 on the usefulness of patient-flow data here than I've  
14 heard before in the context of hospital patient-flow,  
15 and just to maybe set up the question, it strikes me  
16 that what Howard had set out was the concept that  
17 patient-flow data on the physician side may be too  
18 static and may be best as a starting point or a  
19 baseline and that you really needed to look beyond it,  
20 but that it is a useful starting point.

21 I have heard elsewhere -- and I don't know  
22 whether John was referring to it in this way -- of a  
23 concept of where patient-flow data may be static and  
24 may be less useful because it's historic and that the  
25 fact that you are looking at the fact that perhaps a

1 very large number of patients may, indeed, for example,  
2 move from the suburbs into the center city may not be  
3 predictive of whether or not others would also move and  
4 others would have alternatives.

5           So, I would just raise for the group, where do  
6 they think patient-flow data works? Is it something  
7 that really encompasses useful information with respect  
8 to what has actually happened with referral patterns,  
9 admitting patterns, use patterns, managed care use  
10 patterns, or is it something that one should not use at  
11 least as a baseline?

12           MR. ARGUE: I'll start, just give a thought or  
13 two on that, Meg.

14           I think that the patient-flow data -- first of  
15 all, it is difficult to get, and that alone may limit  
16 its usefulness, but to the extent that you can get real  
17 patient-flow information so that you can see people  
18 from a certain area using various alternatives, it's  
19 analogous to what we would do in a hospital case, and  
20 yes, it's got limitations because of the points that  
21 were raised before. It's static, it's not a perfect  
22 reflection of where people can go, and the application,  
23 as I think that you've done in the past and I know that  
24 I have, is to apply some sensitivity tests to that,  
25 some assumptions as to the likelihood of people being

1 able to move, just to get a sense as to what other  
2 alternatives might be available should there be a price  
3 increase.

4 I don't know that that's fundamentally  
5 different than the way that patient origin analysis is  
6 currently used, but again, it's only one part, and I  
7 don't think anyone would disagree that there are other  
8 elements of an analysis of markets that's going to be  
9 relevant in addressing that.



1 limitation is in part dependent on what question you're  
2 asking. If you're looking at the effects of something  
3 that's going to happen in the future, like a merger,  
4 then clearly relying on historic data is limited. If  
5 you're trying to assess whether something bad has  
6 already happened, if you've got enough historic  
7 information to see whether there have been any changes  
8 in patient-flow, that can help you assess the activity  
9 and also the extent of the market. So, I think it is  
10 in some circumstances, but in no situation is just  
11 looking at patient data, patient-flow data, sufficient.

12 MS. LEE: But haven't the courts relied on  
13 patient-flow data a lot in terms of defining geographic  
14 market? I mean, there seems to be a consensus, at  
15 least amongst the economists, that it gives you a  
16 snapshot in time and certainly will not tell you what  
17 would happen in the face of an anticompetitive price  
18 increase.

19 MS. GUERIN-CALVERT: I would differ with that a  
20 little bit in the sense that I think -- I would agree  
21 certainly with the part that particularly in the  
22 hospital context, but also in the physician context,  
23 courts have systematically looked at and used  
24 patient-flow data as an objective source of information  
25 that can be tested.

1           Where I would disagree is that I think what a  
2 lot of courts have done is to go the next step and  
3 really push either the plaintiff or the defendant to  
4 address the issue as to how might that data, those  
5 data, inform whether or not in the event of a price  
6 increase there actually would be a substantial supply  
7 response, a substantial switching to alternatives.

8           An example of a case I'm familiar with in  
9 California, there was an inquiry as to whether or not  
10 it would be the case that in the event of a  
11 hypothetical price increase, you could demonstrate that  
12 there would be sufficient use of other hospitals so as  
13 to discipline pricing, and looking at both where  
14 patients are currently going and in what numbers, what  
15 order of magnitude, and then as David alluded to,  
16 looking at and examining the critical loss, how many  
17 more would have to move to make a difference?

18           That's something, interestingly enough, that  
19 courts seem very comfortable with in trying to get a  
20 handle on how much more and is there enough evidence.  
21 They do look at other factors to try to show that  
22 that's going to happen, but I think they do use it as  
23 the basis for doing a dynamic analysis.

24           MR. FELLER: Yeah, I would agree with Meg that  
25 courts do look at the patient origin, patient-flow

1 data, pretty heavily in either a hospital-type case or  
2 a physician case, but they really do, at least many  
3 courts, want to go beyond that and look at the other  
4 kinds of qualitative evidence. Often what you're  
5 presented with in a piece of litigation are sort of  
6 dueling patient origin data studies, and you have, you  
7 know, differences as to what is the number, you know,  
8 that you should look at and how you define that, and  
9 the courts get faced with those kinds of things, and  
10 they do look for evidence of referral patterns by  
11 physicians, where do managed care plans view -- what  
12 do they view the market to be, and if there was a need  
13 for a change, what would they do in response, and so a  
14 lot of that comes into play, because you often are  
15 faced with two different reports that are somewhat  
16 different in terms of the statistical analysis.

17 MR. WIEGAND: In looking at the question that  
18 Meg poses, how many more patients would go in a certain  
19 direction, if there's already, say, some going from  
20 suburb to central city for medical care, physician  
21 care, the question may be answered perhaps by looking  
22 at what the employers say, because in a way, they're  
23 the purchasers of the services.

24 If we look at employers that are in the suburbs  
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1 historical data that are going to the city, those are  
2 folks who are working in the city, and the health plans  
3 that are being purchased for them have adequate  
4 provider panels in the city, and they're willing to  
5 take advantage of that, but for those of us who are  
6 maintaining our offices out in the outer suburbs, our  
7 employees aren't willing to do that. So, we may need  
8 to look kind of behind the data to employers to see how  
9 many more patients are willing to travel in a certain  
10 direction.

11 MS. LEE: Let me switch gears a little bit.

12 There's been a lot of discussion about the  
13 definition of physician markets on the selling side,  
14 but what has not come up is the definition of physician  
15 services on the buying side. So, one question that I  
16 thought of a little bit, and I'd like to get the  
17 panelists' input on, is can we think of physician

1 MS. LEE: Actually, I mean something a little  
2 bit different from that, which is that a -- you know,  
3 the flip side of looking at a selling side issue is,  
4 well, could a hypothetical monopsonist impose a, you  
5 know, small but significant nontransitory decrease in  
6 price, for example, so is it that -- you know, what  
7 I've heard from different physicians is that, you know,  
8 some prefer dealing with just PPOs, for example, that  
9 HMOs impose a lot more administrative burden, and  
10 they're not equipped to deal with that. So, it seems  
11 that rather than switching to an HMO, which may, in  
12 fact, you know, reimburse at comparable rates or  
13 perhaps slightly higher rates, they prefer to just sell  
14 their services to PPOs or are more willing to contract  
15 with PPOs.

16 On the flip side is that, you know, some  
17 physicians prefer selling -- you know, prefer dealing  
18 with HMOs. They're set up to deal with that and they  
19 like that sort of situation.

20 MS. NOETHER: When you think about a monopsony  
21 question generally, you need to think about from the  
22 physician's perspective all of the sources of revenue  
23 that physician can get. So, limiting it to narrow  
24 insurance products like HMO or PPO doesn't seem  
25 particularly realistic.

1           That being said, if it were the case that it  
2 was truly such a hassle to get payment from an HMO,  
3 then one could perhaps argue that that source of  
4 revenue needs to be excluded from an equation, but that  
5 doesn't seem like that's consistent with most of the  
6 facts that one generally encounters.

7           MR. FELLER: Yeah, I think you're actually  
8 asking a different question. I don't think this is a  
9 definition of a physician market. I think you're  
10 asking a question of how you would define the purchaser  
11 market in that case, and is it HMO versus PPO or  
12 traditional indemnity or something else?

13           In my view, health care plans offer a variety  
14 of products, insurance products, whether it's  
15 traditional indemnity, PPO, HMO, POS, there is all  
16 kinds of varieties today, and typically the providers  
17 are signing up with a multitude of different products.  
18 So, you know, it's difficult to say that you have  
19 distinct product markets within that insurance segment,  
20 and employers are offering usually a menu of different  
21 products for their employees, and they get a choice of  
22 whether they want to go with the HMO option or they  
23 want to go with the PPO option or some hybrid.

24           So, I think that's the question that you're  
25 asking, really how you define the purchaser market as

1     opposed to the physician market, and I guess my view is  
2     it's difficult to define in many cases a separate --  
3     carve out a separate HMO market, for example, and  
4     exclude the PPOs and the traditional indemnity and all  
5     that, because they do compete with each other.

6             MS. GUERIN-CALVERT: I would agree with Howard.  
7     I think in part what you would be looking at is  
8     attempting a factual circumstance, to say, first of  
9     all, you have in a given area, a given market, so few  
10    managed care plans who are providing all of the HMO and  
11    PPO products, and I would agree completely with Howard,  
12    you have to look at and see if there's any basis  
13    whatsoever for concluding that an HMO is in a separate  
14    market from a PPO.

15            I think there have been some claims and some  
16    issues raised as to whether or not certain managed care  
17    plans may be requiring that if you want to be in the  
18    PPO, you also have to be in the HMO, or certain kinds  
19    of things that can raise some more complications there,  
20    but I would agree, you fundamentally have to look at is  
21    there a sufficient alternative, and then in general it  
22    is the case that reimbursement levels for HMOs have  
23    tended to be substantially lower than for PPOs.

24            In part, there is supposed to be a sense that  
25    HMOs are more restrictive panels, so as a result,

1 someone is likely to get more volume of business.  
2 There have been some issues as to I think whether that,  
3 indeed, has been the case as well.

4 MS. LEE: Let me -- I think I did ask the  
5 question the way I meant to. You know, I started  
6 thinking about this in the context you mentioned, Meg,  
7 which is, you know, there have been some issues about  
8 insurance companies requiring physicians, you know, to  
9 sign up with, you know, their different plans, and  
10 physicians, you know, in some areas have quite a strong  
11 reaction to this, and one thing that, you know, some of  
12 these physicians would say is that, you know, I'm just  
13 not equipped to deal with that HMO. So, the fact that  
14 different types of -- it seemed like, you know, that  
15 these could be thought of as different products, that a  
16 hypothetical PPO monopolist could impose that price  
17 decrease -- a price decrease and, in fact, that  
18 physician would not switch away to selling to HMO  
19 service -- to selling, you know, medical services or  
20 physician services to HMOs.

21 I understand that this is a factual inquiry,  
22 and you know, as Monica noted, it's pretty rare now to  
23 meet a physician that doesn't contract with HMOs.  
24 There are some that exist, but you know, that is part  
25 of the factual inquiry.



1           John?

2           MR. WIEGAND:  There is one structural  -- I  
3 notice  -- I don't know how prevalent it is, but that  
4 is the increased frequency with which HMOs are willing  
5 to negotiate fee-for-service contracts with individual  
6 physicians rather than with IPAs, so the situation  
7 where the physician says, you know, I'm not willing to  
8 handle this, the health plan says, okay, we will not  
9 delegate to you utilization management, quality  
10 assurance and, you know, other kinds of things that we  
11 would normally delegate administratively, we would  
12 normally delegate to an IPA in an HMO contract, but  
13 instead, we will just put you on our HMO provider  
14 panel, we will retain those administrative functions  
15 ourselves, and we will pay you on a fee-for-service  
16 basis.

17           We are seeing that more at least in California.  
18 I just don't know how prevalent that's become, but that  
19 kind of structural response is what we're seeing to  
20 physicians who say I don't want to take that HMO  
21 product line.

22           MR. ARGUE:  I think if I could just add  
23 something in response to the question, and it seems to  
24 me that there may be an aspect of it that's really not  
25 an antitrust issue, that if an HMO is imposing

1 additional costs on physicians in terms of their  
2 participation, and then you would expect a PPO would be  
3 able to reimburse physicians at a lower rate and not  
4 lose physicians going over to the HMO panels,  
5 regardless of whether there's any competition issue in  
6 that. So, it's just a matter of a physician trying to  
7 decide where are they better off, incurring some of  
8 these administrative costs or taking a lower  
9 reimbursement.

10 MS. LEE: I want to give Matthew an opportunity  
11 to ask some of his questions as well.

12 MR. BYE: I would be interested to hear other  
13 panelists' views on the distinction that David talked  
14 about, which is the office and hospital-based  
15 physicians and how that would affect the product market  
16 definition.

17 MS. NOETHER: Well, I think it's certainly true  
18 that the hospital-based physicians are not so much  
19 competing for patient business but more are competing  
20 for a contract with a hospital. That's most starkly  
21 the case when you've got a hospital that has exclusive  
22 contracts with particular groups of physicians, so you  
23 have groups of physicians -- the only sort of  
24 dimension then is competition to become the exclusive  
25 provider at the particular hospital, but I think there

1 are a lot of other situations where it's more mixed,  
2 where you might have multiple groups of  
3 anesthesiologists practicing at a hospital, and in that  
4 case, then, there may still not be direct competition  
5 for the patients, so in that sense, it's different from  
6 PCPs.

7 On the other hand, they're still going to be  
8 competing for referrals from physicians or at least  
9 working with physicians, and that is analogous to at  
10 least the role of office-based specialist physicians.  
11 So, I think it's a continuum.

12 I wouldn't, I guess, draw the same totally  
13 stark contrast, but I think there certainly are  
14 different issues and different types of competition of  
15 more or less importance, depending on whether it's a  
16 PCP, an office-based specialist or a hospital-based  
17 physician.

18 MR. WIEGAND: The structure of the market, too,  
19 for hospital-based physicians I think, as David  
20 suggested, makes entry barriers much less of an issue,  
21 because you can enter into a market for a  
22 hospital-based physician with basically a full load of  
23 patients if you win the contract to serve the hospital.  
24 So, entry barriers may not be as significant for these,  
25 and I think it's an important point in the analysis.

1           MS. GUERIN-CALVERT: I think also the point  
2           that David had referred to in terms of the scope of the  
3           geographic market is very important here in the sense  
4           that while the services are delivered locally, the  
5           ability of the hospital to reach out and replace what  
6           typically may be a smaller number of people from

1 use hospitalist programs, and in some cases, not in  
2 all, that has set up a circumstance whereby physicians  
3 in office-based practice are more willing to have  
4 admitting privileges at a broader set of hospitals,  
5 because they know that there's a core group of  
6 physicians at the hospital who can do some of the basic  
7 management, and so that's been a change that, again,  
8 depending on the specific marketplace can make a given  
9 set of physicians locally sustain more competition than  
10 what might otherwise be the case.

11 MR. BYE: Those comments lead on to two other  
12 questions I'd be interested in hearing views on. One  
13 is entry barriers. At a geographic level, we have had  
14 some different views expressed, and also over a  
15 physician's career, do they change?

16 MR. ARGUE: I think just a quick comment on  
17 entry barriers, setting aside the hospital-based  
18 physicians, and I think I expressed before that as the  
19 hospital is trying to attract physicians to that  
20 position to fill their ER or to fill their radiology

1 entry isn't you go to medical school, you do your  
2 residency, and you know, this multiyear process of  
3 getting into the business, but from a competitive  
4 standpoint, it's are you able to switch from location A  
5 to location B in response to a price increase or not,  
6 you know, that would allow you to get in, and I think  
7 that for individual physicians, that's often  
8 straightforward to do.

9           There are issues that need to be confronted  
10 with regard to establishing referrals, whether you need  
11 a large group in order to enter or multiple providers  
12 to enter. There are occasions where an individual  
13 physician can enter and then recruit others to go  
14 along, you know, it doesn't have to -- the scale  
15 issue, you know, how significant a scale does this  
16 entry have to occur at. I think these are all  
17 important. The answer to that is going to depend on  
18 the type of specialty, the location that they're in and  
19 so forth. So, fundamentally, it comes back to a  
20 factual question again.

1 contracts for the type of service that's at issue. You  
2 know, you may have some entry problems in those kinds  
3 of communities where there's a limited number of  
4 hospitals and they have exclusive contracts, let's say,  
5 for anesthesiology services. That can also be a  
6 barrier to entry as well.

7 MS. GUERIN-CALVERT: I think also in terms of  
8 looking at local communities, one of the things that I  
9 have seen working on a number of different matters is  
10 that there is more entry than one 's at issue. YouWoblelpect

1 of established referral practices and eventually take  
2 over. So, the concept of having to go into a solo  
3 practice into a small community is less the mechanism  
4 by which things are occurring and that there is  
5 actually in many communities a fairly surprising rate  
6 of entry by new physicians, particularly if they are  
7 viewing that they will ultimately take over a somewhat  
8 small practice. It's an empirical issue, but I think  
9 there are mechanisms in place in many communities for  
10 it to occur and evidence that it has occurred.

11 MS. NOETHER: Yes, I think the major issue for  
12 the prospective physician thinking about entering a  
13 market is how easy is it going to be to be able to  
14 build up the patient base, which usually depends on  
15 referrals of some sort, so entry by joining an existing  
16 practice, as Meg mentions, I think is often a fairly  
17 low-cost mechanism.

18 However, if you've got a competitive problem in



1 nonfinancial aspects that physicians take into account  
2 when deciding where to move?

3 MS. NOETHER: It certainly seems to be the case  
4 that entry into urban areas where there tend to be  
5 medical schools, a lot of physicians tend to practice  
6 within, you know, not too huge a distance from where  
7 they've gone to residency, or just areas that have the  
8 nonpecuniary benefits that physicians tend to like I  
9 think probably have an easier time of attracting  
10 physicians than the typical areas that are for good  
11 reason called underserved.

12 MS. GUERIN-CALVERT: I think it's also a  
13 trade-off, as Monica had noted in her information, the

1 that's where you did your residency, it may be that a  
2 moderate-sized town in Missouri or a, you know, a  
3 larger city in Kansas may give you much greater  
4 long-run opportunities, you know, in terms of your  
5 affiliation with a hospital and so on than you could  
6 ever hope to get in a given metropolitan area, and I  
7 think that's where the dynamics are showing substantial  
8 shifts of physicians into areas, but I would agree with  
9 Monica, smaller, rural areas continue to have the  
10 problems they have always had with attracting  
11 sufficient physicians.

12 MS. LEE: So, it's always true that economists  
13 find it easier to disprove a proposition than prove  
14 one.

15 MR. ARGUE: Absolutely.

16 MS. LEE: And you know, the economists on the  
17 panel have certainly suggested different sources that  
18 we might look to in terms of -- they seem most useful  
19 in terms of eliminating potential market power or  
20 eliminating the possibility of, you know, physician  
21 groups, for example, or physicians having market power.  
22 Do they have any suggestions -- I want to ask, you  
23 know, not just the economists but everyone. What about  
24 trying to affirmatively prove that physicians in a  
25 given specialty might have market power? Do you have

1 any suggestions in terms of types of data, what sorts  
2 of projects one should do in that situation?

3 MS. GUERIN-CALVERT: I would say you do exactly  
4 the same thing. I think, speaking for the economists,  
5 we have probably been in a variety of cases on the  
6 plaintiff side as well as on the defense side, and I  
7 think there is nothing better in terms of trying to  
8 prove market power to go to the same sources of  
9 information and have the best objective as well as  
10 qualitative evidence to demonstrate that customers in  
11 the effective market lack sufficient alternatives to  
12 move enough patients to, and you know, I think that  
13 it's something that the same data sources can be used  
14 to prove.

15 MS. NOETHER: Well, and obviously if you can  
16 get information on direct effects, namely, the price  
17 information, if you've got a managed care company that  
18 really thinks it's got a problem with a physician group  
19 and they can give you really good data, say that  
20 compares a particular market with another market, and  
21 you could somehow control for quality of the physicians  
22 and all the other things, and you can demonstrate that,  
23 in fact, prices are higher in an area when everything  
24 else really is constant, then --

25 MS. LEE: How about in something like a merger

1 where you do not you are trying to establish that yes,  
2 indeed, these two physician groups merging would create  
3 market power?

4 MR. ARGUE: I think it gets back to the same  
5 thing, and Meg is absolutely right. It's the same  
6 questions. It's the same data. As an economist, what  
7 you should be doing is you ask the question, you take  
8 the data, try to answer it, and the answer is what it  
9 is, and then you go forward and draw your conclusions  
10 from that.

11 It may be that there are relatively few  
12 circumstances in which physicians really do possess  
13 market power, and that may make it appear that we're  
14 always trying to find, you know, ways to defeat that,  
15 but I think that really, the objective view of the  
16 economist is to identify the theory, the principles  
17 that you need to be following, address it with the data  
18 that you've got, and then just take whatever comes out  
19 of it.

20 MR. FELLER: I think from a legal standpoint,  
21 if you just look at what the law tells you to prove as  
22 opposed to the economic theory behind it, they are very  
23 similar, and if you are going to try to prove that  
24 somebody has market power, whether in a merger context  
25 or otherwise, you've got to look at market share, you

1 have got to look at the ease of entry versus barriers  
2 to entry, you look at whether it's a competitive market  
3 or not, and ultimately you have to prove they have the  
4 ability to raise price above competitive levels without  
5 losing business.

6 I mean, that's really what you're looking at,  
7 and that's what the courts say you've got to prove, and  
8 I think that as Dave said, that this analysis is pretty  
9 much the same for a number of different issues.

10 MS. LEE: I also want to ask the economists to  
11 react a little bit to some of Astrid's comments. What  
12 she was saying is that physician services are different  
13 from commodities and that it's difficult to apply that  
14 same sort of commodity analysis to physician services,  
15 and I wanted to ask, you know, are physician services  
16 really different? Can we apply the horizontal merger  
17 guidelines in the same way we would to a commodity?  
18 And in this context, how do you account for differences  
19 in reputation and its subjectiveness?

20 MR. ARGUE: I think obviously there are a lot  
21 of components of that question, but from a conceptual  
22 standpoint, you should be able to analyze physician  
23 services the same way as everything else. You've got  
24 the merger guidelines that are constructed to be able  
25 to handle a lot of different circumstances. They're

1 broad enough but yet they focus on the right issues.

2           It riles certain people, you know, to think of  
3 health care as a business and to treat physicians or  
4 hospital services as just anything else that's bought  
5 and sold. In fact, it is a business, and there are  
6 profit-making decisions that are made and, you know,  
7 non-profit or for-profit institutions alike.

8           What's difficult about physician services and  
9 hospital services has got a lot to do with the  
10 institutions, the third-party payers the principal  
11 agent problems, some of these issues that are hard to  
12 grapple with, but there's nothing fundamentally  
13 different about the antitrust approach that you should  
14 take, I think, for physician services as for anything  
15 else.

16           MS. NOETHER: Yeah, I would agree. I think at  
17 least from a theoretical standpoint, there are some  
18 complexities to health care markets that one needs to  
19 take into account, but in some sense, it's just another  
20 example of a differentiated product where you have to  
21 analyze it in the context of recognizing that no two  
22 physicians are going to be perfect substitutes for each  
23 other, but that doesn't mean they don't compete and  
24 that you can't assess the degree to which they

1 I think the more taxing issue is in the  
2 empirical analysis. I think that unfortunately, we  
3 don't have very good data to be able directly to  
4 account for the kinds of quality and other attribute  
5 differences across physicians, and you know, that's  
6 where it becomes difficult, but that doesn't mean we  
7 shouldn't be trying.

8 MR. WIEGAND: From the legal standpoint, the  
9 Supreme Court applied a traditional analysis going way  
10 back to Arizona versus Maricopa County.

11 MR. BYE: I'm sorry, I just lost my place.

12 Monica, you mentioned a trend, that we're  
13 seeing the increased use of allied medical  
14 professionals as both substitutes and complements.  
15 What I'm interested in is their use as complements and  
16 whether we're going to -- and raise this with the  
17 other panelists -- but how will that affect  
18 physician-patient volume and whether there's going to  
19 be a trend over time that will affect a market  
20 definition analysis.

21 MS. NOETHER: Well, I think to the extent they  
22 are used as complements, what it does is it extends the  
23 number of patients and sort of the supply that a given  
24 physician or physician group can provide, and I think  
25 physicians recognize this. So, you know, a group of

1     pediatricians will have a whole bunch of nurse  
2     practitioners who handle all the kids who come in with  
3     runny noses but nothing serious, and then, you know,  
4     sort of save themselves for the more challenging cases  
5     that really require the medical expertise.

6             So, I think essentially it enables what was  
7     once a relatively fixed supply of hours in the day that  
8     a physician could handle patients to be extended in  
9     ways, and so it makes each physician more productive,  
10    which says something about maybe expansion that used to  
11    not be the case, adding a dimension to potential  
12    competition of physicians in any given area.

13            In other words, it used to be that if you  
14    wanted to increase competition in an area, you had to  
15    encourage entry one way or another, and it may be now  
16    that you can do it by having individual physician  
17    groups just expand more.

18            MS. GUERIN-CALVERT: And I think the logical  
19    follow-up reply is this idea that a given HMO, if  
20    they're looking to drop certain, say, pediatricians  
21    from their panel because they're concerned about their  
22    pricing, may be able to replace them with fewer  
23    pediatricians than they used to in the past and so  
24    thereby discipline.

25            MR. BYE: Do any of the panelists have any



1 remarks they'd like to make or closing comments on what  
2 we've seen and discussed today?

3 (No response.)

4 MR. BYE: In that case, I'd like to thank  
5 everyone very much for coming. It's been a great  
6 session, really appreciate you devoting your time, and  
7 the hearings will continue I believe tomorrow. Thank  
8 you.

9 UNIDENTIFIED SPEAKER: Matthew, are you going  
10 to take no questions from the audience?

11 MR. BYE: Unfortunately, we don't take  
12 questions from the floor.

13 Actually, we do resume at 2:00 this afternoon.

14 (Whereupon, at 12:15 p.m., a lunch recess was  
15 taken.)

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## 1 AFTERNOON SESSION

2 (2:00 p.m.)

3 MR. BERLIN: Okay, I guess we will try to get  
4 started here this afternoon. Welcome to the afternoon  
5 session of these joint hearings on health care policy.  
6 This session will focus on physician information  
7 sharing. My name is Bill Berlin, and Randi Boorstein  
8 is my co-moderator here today.

9 Today's topic will probably focus primarily on  
10 the recent business review issued by the Division in  
11 the Washington State Medical Association matter, the  
12 FTC's Dayton advisory opinion, but we hope to explore  
13 other aspects of this topic as well that goes beyond  
14 those two pieces of prospective guidance.

15 We will be ending at 5:00 today, if not perhaps  
16 a little bit sooner given the somewhat smaller size of  
17 our panel.

18 As far as the usual logistics, interested  
19 parties may submit written comments. Those will be  
20 ultimately published on the FTC's website. And of  
21 course, the transcript, any Power Point presentations  
22 and written presentations by the panelists themselves  
23 will also be up on the website.

24 Each panelist, as is our usual procedure, will  
25 have approximately ten minutes to speak, but again,

1 given the smaller size, we won't be too strict with  
2 that this afternoon.

3 After that, we'll take a short break and then  
4 engage in a round table discussion that Randi and I  
5 will have some questions for our panelists, and we also  
6 invite the panelists to ask questions of each other  
7 that are presented by the presentations.

8 I guess I'll turn over the mike now to Randi to  
9 introduce our panelists, and I'll extend my thank you  
10 now to you all for being here.

11 MS. BOORSTEIN: Thank you. Welcome, everybody.  
12 We're very fortunate today to have four very  
13 distinguished panelists who know quite a bit about our  
14 subject, some with firsthand knowledge, having been  
15 involved in a case. I'll introduce them in the order

1 PriMed, the group in Dayton, Ohio.

2 Then we will have Robert Matthews, who's the  
3 president of MediSync Midwest, a management services  
4 organization for large physician-owned medical groups,  
5 and in that capacity, he's also an executive at PriMed,  
6 which is in Dayton, Ohio.

7 And then finally, we have Robert Leibenluft,  
8 who's a partner at Hogan & Hartson specializing in  
9 health and antitrust, and he is here on behalf of the  
10 Antitrust Coalition for Consumer Choice in Healthcare.  
11 That's a group of employers, health plans and others  
12 who purchase, manage and deliver health care services.  
13 He is going to concentrate primarily on the DOJ  
14 advisory opinion to the Washington State Medical  
15 Association.

16 So, with no further adieux, Roxane, we will  
17 turn it over to you.

18 MS. BUSEY: Thank you.

19 First of all, I would like to thank you for  
20 inviting me, and I would like to actually commend both  
21 of the agencies for the depth and breadth of these  
22 hearings. Following it through the website, I think  
23 they've covered just about everything under the sun,  
24 and I think that's terrific.

25 As was stated, the topic today is information

1 sharing among physicians, and I promised to Bill and  
2 Randi that I would at least kick off the discussion,  
3 and I thought the best way to do this was to provide  
4 just a little bit of background. To me, this is  
5 actually a confusing area of the law and one that  
6 appropriately deserves some attention.

7 I think that everyone is aware of the general  
8 case law pertaining to the sharing of information.  
9 It's not per se illegal to share information. It's  
10 subject to a rule of reason analysis. Added to that, I  
11 think we have to have the economic perspective, that  
12 the more information that is available in a  
13 marketplace, the more competitive the marketplace is  
14 likely to be, unless there is collusive activity  
15 relating to that information sharing.

16 And of course, in the health care industry, I  
17 think it's fairly well known that there is a lack of  
18 information or an uneven amount of information among  
19 players in the health care industry, and I can  
20 illustrate that by asking any of you, do you know how  
21 much your doctor charges for an office visit, and do  
22 you know how much you pay, and does it vary from the  
23 time of the year, depending on whether you have a  
24 deductible or not? Again, that information is not as  
25 readily available in this market as it might be in

1 other markets.

2           The case law, of course, going back to cases  
3 that are not particularly in the health care industry,  
4 also supports looking at a number of factors when there  
5 is no explicit agreement to fix prices, and typically  
6 looking at the Supreme Court decisions, including  
7 United States versus Container Corp, it's very  
8 important to look at the type of information that is  
9 being exchanged, the frequency, and then also the  
10 market structure, and I want to emphasize that, because  
11 that's not something that is particularly emphasized in  
12 health care analysis. Sometimes it is; sometimes it  
13 isn't.

14           It's also true, based on the case law, that the  
15 more concentrated an industry is, the more likely that  
16 the exchange of information may lead to illegal  
17 conduct, whether that be a price fix or a boycott.

18           Having said that, I think it's also important  
19 to keep in mind that giving information to the public  
20 and particularly to buyers of services is an important  
21 function, and to the extent that there are mechanisms  
22 and agreements that provide information to the public,  
23 to the buying public, this generally should be  
24 considered procompetitive, and in this context, instead  
25 of focusing on a health care case, I would focus on a

1 case that the Justice Department brought some time ago  
2 relating to the airline industry.

3 They looked at the airline industry's computer  
4 reservation system and said, well, it was okay for the  
5 airlines to post their prices on a public system, but  
6 once they started to use that system privately between  
7 the airlines, then there was an antitrust problem, but  
8 the original posting of that information for the  
9 benefit of the public was not illegal.

10 I'd also like to add to that a concept that  
11 we're finding in an important case that has been  
12 brought involving the medical residency matching  
13 program. Here we have a situation where there are two  
14 sources of information with respect to medical resident  
15 stipends. One of them has to do with the collection of  
16 stipends according to the policy statements and their  
17 safety zone, and the other has to do with the AMA  
18 listing the stipends for all medical residents for  
19 those programs that choose to have their stipends  
20 listed.

21 And the question in the case, of course, is  
22 that an illegal exchange of information, one that is  
23 likely to result in depressed wages or stipends for the  
24 medical residents, or is it a procompetitive function  
25 where there are many players in the market, in this

1 case many medical residents and many programs, is it  
2 more efficient to have those programs that want to list  
3 their salaries do so in a public way?

4 I think all of this is sort of part of our  
5 topic, even though I know we're going to be focusing on  
6 the more traditional questions of what do physicians  
7 exchange with each other and what do they exchange with  
8 payers.

9 I'd also like to say that having presented this  
10 background, which is clearly beyond just the health  
11 care industry, it's clear that the agencies in the  
12 nineties attempted to synthesize this law and provide  
13 us with a number of policy statements relating to the  
14 exchange of information, and I'm sure all of you are  
15 familiar with them. They relate to statements  
16 concerning the collected exchange of nonfee information  
17 to purchasers; statement 5 pertaining to the exchange  
18 of collective fee information to purchasers; and number  
19 6 pertaining to the collective fee information among  
20 providers. And in each of them, there is a safety  
21 zone.

22 One of the questions that I would just sort of  
23 like to throw out there is -- and I think it's going  
24 to be demonstrated by these letters that have recently  
25 been issued -- is whether these policy statements are



1 sufficient in terms of covering the types of exchanges  
2 that are common in the industry, and another question  
3 is whether they have had a limiting effect in terms of  
4 the-ferrtferms of

1 was representing, and I say that because if you look  
2 carefully at I believe it is statement 5, which is the  
3 collective provision of fee information to purchasers,  
4 there seems to be an exception carved out there for  
5 when you're involved in a situation with negotiating,  
6 and I'm positing a situation where the messenger was  
7 acting as a pure messenger and not negotiating, would  
8 the messenger be able to perform the role that perhaps  
9 has traditionally been delegated to a third party or to  
10 an association in terms of the surveying of fees?

11 The other thing that I would like to point out  
12 with respect to the guidelines has to do with clinical  
13 integration. When I went back to look at the  
14 guidelines in terms of where clinical integration would  
15 fall, it seemed to me that it was clearly covered by  
16 statement number 8, which has to do with when you can  
17 jointly negotiate and when you cannot, but the  
18 information-sharing aspect of clinical integration I  
19 don't think is specifically covered by the guidelines.  
20 It is only implicitly covered by statement 8, and that  
21 might be another area where the agencies might wish to  
22 comment.

23 Having provided just this little bit of  
24 background, I guess I would like to begin the  
25 discussion by commenting on the two agency letters that

1 have come out pertaining to providing specific  
2 information with respect to insurer reimbursement, and  
3 before I do so, I guess I would say I'm not sure this  
4 is true, and other panelists can correct me, to my  
5 knowledge this is the first time that the agencies,  
6 since the policy statements have come out, have issued  
7 a business review letter which attempts to deal with  
8 the exchange of information that is not covered by a  
9 safety zone that is under the rule of reason. I could  
10 be wrong about that, but it seems to me that it is very  
11 unusual for them to do that.

12 It may be because they're not asked to do it,  
13 but we don't have much advice coming out of the  
14 agencies or even too much case law in which there is an  
15 attempt to apply a rule of reason analysis to this type  
16 of information. To my knowledge, it's also the first  
17 time that we've had the agencies bless a situation  
18 which involved the reporting of information with  
19 respect to specific players as opposed to an aggregate  
20 form, and I think this is noteworthy. And just so  
21 there's no misunderstanding here, I applaud the  
22 agencies for attempting to do this analysis and putting  
23 forth this analysis, because first of all, it's not  
24 easy to do, and secondly, as I read the two opinions,  
25 it wasn't necessarily a very easy decision to state

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1 that it would be okay under each of these circumstances  
2 to provide reimbursement information with respect to  
3 insurers by specific name, okay?

4 Having said all of that, there are really two  
5 things that I think concerned me about each of the  
6 opinions, but for slightly different reasons, and I  
7 think I should state what those are. In both cases I  
8 was concerned about something that may be beyond the  
9 scope of the letter, which had to do with the accuracy  
10 of the information that would be provided, and I say  
11 that only because it's a complicated area to talk about  
12 reimbursement, and in this particular case or in both  
13 cases, the reimbursement that would be provided would  
14 be provided by the provider, and to my understanding,  
15 not by the insurer, and therefore, there could be room  
16 for some misstatement of what the reimbursement  
17 actually was or some inappropriate comparison in  
18 determining, you know, what a service was and what CPT  
19 codes apply to it. So, one of the concerns that I had  
20 just generally was whether the information that would  
21 ultimately be collected and disseminated would be  
22 accurate and would not be misleading.

23 A second issue that I was concerned about was  
24 an argultimately ejust g3 boupspect to  
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1 also more clearly articulated in the competitor  
2 collaboration guidelines and not so much in the health  
3 care policy statements, and that is the concept of is  
4 what is being proposed here the least restrictive  
5 alternative for what the purpose is, and in both cases,  
6 I wondered whether the way in which the data would be  
7 reported would, in fact, be the least restrictive  
8 means, and I think there will be a lot more discussion  
9 about this, but it wasn't clear to me why in each case  
10 the insurers had to be identified, and if they had to  
11 be identified, why in the Dayton case we were just  
12 talking about two insurers and not all of the insurers,  
13 and when we were talking about the insurers in the  
14 Washington case, why there again we could not use some  
15 form of aggregation to provide the information that  
16 would be necessary to serve the purpose that was  
17 required.

18 I would also point out that in the two cases I  
19 was astounded to read that in Dayton, everybody seems  
20 to know everything. The physicians seemed to know what  
21 they were being reimbursed at, and the insurers seemed  
22 to know what each other was reimbursing the physicians  
23 at, and that all seemed to be very well known, whereas  
24 in Washington, exactly the opposite was suggested, that  
25 really physicians have no idea what kind of

1 reimbursement they're getting or who they're getting it  
2 from and that this would be a mechanism for providing  
3 that additional information.

4 Okay, that's about all that I would like to say  
5 as sort of a kick-off to maybe provoke some discussion  
6 in terms of the exchanging of information among  
7 physicians.

8 MR. BERLIN: Thank you.

9 Greg?

10 MR. BINFORD: First I'd like to thank the  
11 Federal Trade Commission and the Department of Justice  
12 for inviting me to attend these hearings today on what  
13 I personally feel is a very important topic of the  
14 sharing of physician information.

15 As indicated, one of the reasons for my  
16 inclusion in the panel was my participation as the  
17 counsel to PriMed in obtaining the FTC advisory which  
18 involved Dayton, Ohio and was an advisory permitting  
19 the setting up by my client of what we've termed a  
20 physicians health care advisory group. When I look  
21 back at the acronym, Physicians HAG, I think we could  
22 rethink the name, but we will work on that later.

23 In any event, the FTC issued the advisory  
24 opinion on February 6th of this year, the essence of  
25 which permitted the sharing of information between

1 competing providers of information involving policies  
2 and procedures, including fee reimbursement information  
3 by third-party payers in the Dayton health care market.

4 At the outset, I would like to compliment Judy  
5 Moreland at the FTC, who was my primary contact in the  
6 process, along with her colleagues and the FTC itself,  
7 for what I perceive as a very collaborative process in

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1 future. I see that as one of the purposes of these  
2 hearings.

3 I'd like to share with you my perspective on  
4 the needs of information sharing by physicians who  
5 provide health care services in separate competing  
6 practices and the benefits to the community that  
7 derives from that process. My perspective comes from  
8 my experience as an attorney in the health care  
9 industry exclusively really for the last 25 years,  
10 actually longer than that, but I can't bear to admit to  
11 that in writing.

12 When I began focusing my practice in health  
13 care, my early assignments and projects were the  
14 formation of some of the original health maintenance  
15 organizations in the Midwest, and I can tell you that  
16 at that time, going back about 25 years, at that time,  
17 physicians were king of the hill in the medical care  
18 marketplace. It was a lovely world for physicians. It  
19 was a fee-for-service world where physicians basically  
20 set their fees, and those fees were for the most part  
21 paid by very passive insurance companies.

22 Over the course of the ensuing years, however,  
23 many factors have intervened, all of which have  
24 cumulatively changed dramatically the health care  
25 landscape to where we are today and over time has



1 brought more and more pressure to bear upon both  
2 physician fees and physician authority in general and  
3 their ability, I might add, to provide quality care.  
4 Those factors that intervened over the years include,  
5 of course, the advent of Medicare, the advent of  
6 managed care, whatever that means. It's come to mean  
7 many things to different people today. It certainly  
8 means possibly capitated fees, although less so in the  
9 market, and I was asking Bob earlier if capitated fees  
10 were a dead thing, and he indicated that he thought  
11 they were, but certainly deeply discounted  
12 fee-for-service fees, burdensome and costly red tape  
13 and wholesale diversion of patients. By that I mean  
14 the ability of a third-party payer to essentially  
15 corral patients into their networks and threaten  
16 physicians to move their patients elsewhere, which can  
17 constitute a major portion of their existing practice.

18 Managed care includes, as I indicated,  
19 discounted fee-for-service, PPOs, HMOs, Medicare Part  
20 C, managed Medicaid, and many other types, but that has  
21 been a major, major impact.

22 To give you an idea of how far we've come, it  
23 was very interesting, I just came from a two-day  
24 session, a forum held by the American Health Lawyers on  
25 fraud and abuse in the health care industry, and one of

1 the phenomena which has been detected is something  
2 which came as a total surprise to me and I think will  
3 be of interest going into the future. For as long as I  
4 can remember, the focus of regulators, particularly the  
5 Department of Justice and the OIG, the Department of  
6 Health and Human Services, has been on the physicians  
7 for unbundling of charges, which enables them to  
8 realize a higher gain, and upcoding of CPT codes, which  
9 enables them to get a higher fee for a particular  
10 procedure.

11 Now, there's a growing interest being focused  
12 upon the payers -- for the payers doing just the  
13 opposite. Instead of unbundling, bundling by computer,  
14 downcoding of fees, establishing and changing global  
15 periods, and that is, certain medical procedures are  
16 authorized by a payer, and if it's necessary to repeat  
17 a procedure within a certain period of time, the  
18 physician doesn't get compensated for the second  
19 procedure or third or whatever. By having a global  
20 period, there necessarily involves a deadline, and  
21 insurance companies will just extend that deadline  
22 unfairly. They're focusing on delays or denials in  
23 claim processing, as well as improper determination of  
24 medical necessity.

25 I've been told, at least one of the attorneys I

1 talked to at this hearing, that there is a movement  
2 afoot in the south of putting together a possible class  
3 action of physicians, and it's interesting to see this  
4 focus change in this regard.

5 Another of the factors which has brought us to  
6 where we are today has been the advent of hospital  
7 networks and the acquisition of many hithertofore  
8 independent and competing physician practices, which  
9 has enabled hospitals to really control the negotiating  
10 process of not only their own contracts, but physician  
11 contracts, and to control how fees are divided up.

12 Another factor has been the advent of the  
13 national malpractice insurance crisis, as we have seen  
14 and we're all aware of, and this has caused a large  
15 number of physicians to retire early or to be acquired  
16 by a hospital or to move to another jurisdiction,  
17 another state, where the malpractice laws are more  
18 favorable and the premiums for their malpractice  
19 insurance are lower.

20 Finally, the last factor I'll mention has been  
21 the aggregation of third-party payers. Ten or 15 years  
22 ago, there were hundreds, if not thousands, of  
23 third-party payers across the country. It was not  
24 uncommon for any average metropolitan area to have  
25 three or four health maintenance organizations, other

1 private-party payers, et cetera, et cetera. Today,  
2 there has been a large aggregation and roll-up of those  
3 plans to where most major markets, we have the Uniteds,  
4 the Humanas, the Anthems and so on of this world,  
5 Dayton being a primary example where, in effect, there  
6 are two dominant players in the marketplace and a few  
7 minor players who have driven physician fees so low as  
8 to actually drive out some subspecialty groups, cause  
9 early retirements and inhibit the recruitment of new  
10 physicians to the area, all of which inexorably reduces  
11 the accessibility to the physicians as well as, Bob  
12 will elaborate in a moment, in lowering the overall  
13 quality of health care in the area. These are really  
14 the harsh realities faced by independent physician  
15 groups in many areas across the country.

16           Along with an understanding of the physician's  
17 plight in today's climate, I think it's also important  
18 for the regulators to recognize the uniqueness of the  
19 health care marketplace. This morning we heard a lot  
20 of testimony on the health care marketplace, and it  
21 involved a lot of statistics and factors, primarily  
22 from economists, as to how to measure the marketplace  
23 and so forth and so on, but I didn't hear any  
24 description of how the marketplace really works, and it  
25 really is a unique market.

1           Unlike any other, the end users are not the  
2 payers, the customers. When was the last time you  
3 heard someone say, you know, hey, which cardiothoracic  
4 surgeon gives the best operation for the lowest price?  
5 In the first place, nobody knows that except perhaps  
6 some payers, and the patient cannot possibly make that  
7 explanation. It really turns the market upside down.  
8 From the time that health care benefits became a job  
9 benefit, in effect, in the middle part of the last  
10 century and subsequently through government-sponsored  
11 programs, such as Medicare and Medicaid, the purchaser  
12 in the marketplace is not the user but is instead the  
13 third-party payer or what I call the payer/employer/  
14 governmental complex.

15           Historically and for the most part and today,  
16 physicians practice in very small groups, what I would  
17 almost term mom and pop businesses. Many of my clients  
18 consist of a small number of physicians practicing  
19 either singly or with a few others, and their spouse  
20 may be the business manager. These are not competitors  
21 that are equipped to undertake any kind of due  
22 diligence, let alone negotiations with the large,  
23 powerful and well-financed payer complex to which I  
24 have referred.

25           Groups of independent and competing physicians

1 must collaborate in order to coordinate and fund their  
2 ability to perform the due diligence that I've  
3 mentioned on third-party payers in order to make  
4 employers who are choosing the payers and paying the  
5 bills educated consumers. Independent physician groups  
6 need to collaborate primarily in three efforts.

7           One is in the information-gathering area,  
8 including but not limited to fee information. It would  
9 also include information involving claims review and  
10 medical necessity criteria, as we talked about earlier,  
11 in terms of the determination of medical necessity. It  
12 would include the gathering of information regarding  
13 the representations made by payers to employers versus  
14 mandates made to providers, and Bob will I think give  
15 us some examples of that.

16           As to the accuracy of the information that is  
17 provided, as Roxane brought up, the process that has  
18 been proposed and approved is not just information  
19 gathering but information processing, and part of the  
20 effort will be to process and attempt to discern the  
21 accuracy of the information, and that is in part what  
22 feeds the need for collaboration in order to fund that  
23 kind of analysis, which is going to hav23 .....tlhat has  
14 et0 e

1 information, as I just indicated, there will be  
2 information analysis, and the third step of the process  
3 will be information dissemination and publication, and  
4 that is the educational process, the disseminating of  
5 the analysis of the information, which can involve fee  
6 information, but also communications as to what is  
7 covered to patients versus what is mandated to the  
8 physicians, et cetera. It will involve public ad  
9 campaigns, I think meetings with large employer groups,  
10 all in an effort to come to have a more informed buyer  
11 in at least this marketplace.

12 We believe strongly that adequate safeguards  
13 can be built into the process through the use of  
14 independent third parties, aggregation of information,  
15 and prohibitions, strict prohibitions, against any kind  
16 of joint bargaining by physicians or boycotts.

17 As far as Roxane's question about the concerns,  
18 whether or not this is the least restrictive means of  
19 data, from my perspective, part of the purpose of this  
20 is the education of the buyers, the employers, and part  
21 of that involves sitting down and saying, here's United  
22 Health Plan, here's what we have found. Here's Anthem,  
23 here's what we have found. And then let them make the  
24 decisions based upon that. It's really the only way to  
25 get to that, and frankly, it's necessary to name names,

1 we believe, again viewing this as an educational  
2 process.

3 And you asked why two and not all, and the  
4 intention has never been to limit it to two payers. I  
5 think the intention is -- that would probably be a  
6 jumping off point, but I think it would be useful to  
7 take a close look under the microscope of all  
8 meaningful payers in the marketplace and should.

9 In the end, we believe that enabling competing  
10 physician groups to collaborate for the purposes that  
11 I've discussed should result in the enhancement as well  
12 as the balancing of both the competitiveness and the  
13 quality of health care delivered in each unique  
14 marketplace, in the instance of ours, in Dayton, Ohio.  
15 In the long run, I believe this collaboration should  
16 result in an increase certainly in the availability and  
17 perhaps the number of physicians and assurance that an  
18 adequate number of physicians as well as specialists  
19 are represented in any health care marketplace as well  
20 as an increase in the efficiency of the operation and  
21 the delivers the balancing oldt aomEacemas well





1 comment, but I think we have to be realistic here.

1 negative effects.

2 We also see a number of companies saying at  
3 this kind of price, we just have to pull as a company  
4 out of the system. So, I'm very well aware that this  
5 is a crisis and that we really have to come up with  
6 some solutions. In fact, we as a company, PriMed,  
7 employs a couple hundred -- 250 people, and we sit  
8 around every year and wait with unbelievable anxiety  
9 for our rates to come out, and every year they're  
10 pretty devastating, and every year we turn more and  
11 more to the employees, and we dig deeper into our own  
12 pockets. So, there is a real challenge out there, and  
13 competition is very much necessary.

14 Just as a comment, and this is the medical  
15 group perspective, who is the customer? If we're  
16 talking about value and competition and providing a  
17 value to the market, as we see it, the patient is for  
18 us the customer. Very often, if we have a recognition  
19 it's the employer paying a very substantial or at least  
20 half the cost, that's our customer. We do not see the  
21 health insurance company as our customer. We see those  
22 as transaction warehouses. They serve a role and a  
23 function. They are not our customer. And they  
24 moderate payments and contracts and things like that,  
25 but that's just from our perspective.

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1           And just, again, I don't want us to look like  
2 the troglodyte end of the medical community, they're  
3 saying, you know, as long as we're doing fine, it  
4 doesn't matter how everyone else is. Just at PriMed,  
5 we have 15 of our managers, including one physician,  
6 who are black belt trained in Six Sigma. We are  
7 consistently relooking at every single thing we do with  
8 respect to the quality of care. We're stepping up to  
9 the plate now to try and make about a \$2 moelIe 6T(

1 good or bad, with respect to defining or improving the  
2 quality of care or the cost-effectiveness of care.

3           There was a lot of that going on in the  
4 nineties, and some of us actually here today worked  
5 together in the context and saw rates go down. In our  
6 market, we see the major payers no longer managing  
7 care. They fired all their staffs, and they are out of  
8 the business of trying to drive quality up or costs  
9 down other than through the aggressive contracting.  
10 Just in our group, every doctor is required to  
11 participate in some sort of quality effort as a  
12 requirement.

13           I want to talk a little bit about the health  
14 care environment, because I think unlike some other  
15 economic sectors, there are some differences. In a lot  
16 of sectors, if I go to Wal-Mart versus Target, I can  
17 buy the same thing and I can look at the price and it's  
18 the same thing, and there are in health care some  
19 instances where the customer can go out and see the  
20 value in what I purchased. What am I getting and what  
21 am I paying for it?

22           And I don't know, Roxane, why, but at least in  
23 every one of our groups of doctors, you get a statement  
24 with how much we charge on every -- on your sheet, and  
25 it's actually printed on the form. So, if it's a

1 mystery in your part of the world, that's different.  
2 And there are people who don't have, for example, an  
3 insurance benefit, so they pay out of pocket, and they  
4 can call my group or someone else's group and say, what  
5 does this cost? And they can elect plastic surgery or  
6 Botox or those relentless people on night TV selling  
7 the eye laser surgeries for your eyes and all that.  
8 There's a price. That's a single-service sort of  
9 purchase.

10 A lot, though, the majority of health care  
11 purchasing is in a great big roll-up I'm calling it,  
12 where the employer pays a PMPM, a per employee or per  
13 family price. That includes the entire array of  
14 medical care, hospital, pharmacy, doctor, ancillary,  
15 lab, da-da-da -da, plus the insurance and the  
16 transactional and whatever margin in one price, and I'm  
17 going to argue that if you want to promote competition  
18 and the value shopping, we have to break that roll-up  
19 purchase in which are embedding a whole string of value  
20 equations, and people need to be able to see what's  
21 inside that box. Otherwise, you have no meaningful  
22 power to exercise a purchaser's right.

23 And I'm going to take as the most simple,  
24 standard, economic, you know, what is value? It's  
25 quality as a function of cost. If you're making

1 quality better at the same cost or bringing cost down  
2 for the same quality or whatever, that's quality.

3 In health care, the first thing I want to say  
4 is that what we see is a huge decreasing focus of  
5 attention, i.e., the leapfrog group and others, on the  
6 quality part. People have been beating costs down and  
7 around for a long time, but quality is a much bigger  
8 part of cost than it needs to be. Successful companies  
9 in today's economy know well that in their own  
10 business, errors are money lost. They impose a cost.

11 The New England Journal of Medicine on June  
12 26th of this year published a very strong article, I  
13 heartily encourage everyone to read it, in which a RAND  
14 study is cited, and basically they're saying that the  
15 error rate in our Six Sigma terms, 450,000 errors per  
16 million opportunities or 45 percent error rate, and  
17 these include both errors of commission, giving someone  
18 the wrong drug, the wrong dose, cutting off the wrong  
19 foot, as well -- and these are -- one -- recently  
20 one University of Michigan epidemiologist told me --  
21 what about the errors of omission, the failure to meet  
22 the standard? He said incalculable. The RAND study  
23 tried to round it out at 45 percent. So, the employers  
24 we speak with know they're paying too much for error,  
25 and they know that the cost of care is also of great

1 concern. So, quality and cost are both important.

2 But in the matter of cost of care, the things  
3 that we so focus on almost exclusively, like the unit  
4 cost, how much does a doctor visit cost, how much does  
5 the surgical procedure cost, is only one dimension, and  
6 we want to point out here today that the real value  
7 equation is a whole lot more complex than that.

8 So, we in Dayton came up with some hypotheses.  
9 First we said -- and this isn't so much a hypothesis,  
10 I'd say this is moving towards the fact -- our market  
11 is controlled by two huge health plans. Both of us --  
12 appear to us to display a sense of impunity. We're  
13 right because we have over a quarter of a million  
14 members. And we also have a region in which there are  
15 two hospital systems. One dominates the north part of  
16 the region; one dominates the south part. Everyone  
17 pretty much acknowledges you've got to have both  
18 networks in. And the health plans have flat out told  
19 us, we'll pay doctors after we've paid the hospitals.  
20 The money that's left over after we do the hospital  
21 deals is how we'll pay you.

22 What we've also learned and we believe, and  
23 this is part of what we're going to study, is that a  
24 city competes with other cities for capital and talent.  
25 In other words, if you're a doctor coming up and in



1 Dayton, Ohio, they pay 40 percent less than in  
2 Indianapolis, Indiana, and they're two hours apart,  
3 guess where the doctors who in the main graduated  
4 towards the top of their high school and college class  
5 are going to go? They're going to go to the  
6 higher-paying market. So, you wind up in a place where  
7 you have a competition that goes market to market and  
8 that is something sometimes people don't see until  
9 things have gotten pretty far out of hand.

10 Now, here's where -- up until this point, it's  
11 pretty much a prelude and some context for where I  
12 think we brought the reasoned analysis to the FTC. We  
13 were saying that we think the health plans are cutting  
14 spending in areas where there's very great damage but  
15 it's less visible, and we think that the employer and  
16 the patient has the right and need to know that when  
17 they make their competitive choice, and we were asking,  
18 in essence, the FTC to make a balanced judgment about  
19 releasing a small amount of information under very  
20 controlled circumstances with respect to physician  
21 fees, which is a unit cost, and we were going to follow  
22 all the guidelines in order to explode or explore these  
23 other realities and see whether we could show them.

24 Just to look -- and this is -- I hesitated to  
25 put this slide in, but if you look at a premium of \$235

1 per month at the bottom of the first -- the middle  
 2 column there, total premium, that's comprised of about  
 3 \$79 and change in hospital costs, \$30 in pharmacy, \$65  
 4 in physicians, and you can see, totaling up to \$195.  
 5 Now, in Dayton, Ohio, that is probably about an average  
 6 premium. There are companies that are paying \$400 a  
 7 month, and there probably are some companies that are  
 8 paying \$199 or something under \$200, but in the main,  
 9 smaller companies are paying the high side of -- more  
 10 than that, and the large companies are paying that or  
 11 slightly less, because they have more clout, and you  
 12 can see there the percentages.

13 So, the question came then that if we could  
 14 draw the data, what do we think we could show? We  
 15 thought we could show that insurance companies make  
 16 deliberate decisions in creating their products and  
 17 their contracts which have very negative results on  
 18 cost as well as on quality, and so, for example, that  
 19 they treat our market significantly different than they

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1 drawn, gathered data and made to the public without the  
2 FTC ruling; that some insurance companies make  
3 decisions that save pennies today but that will  
4 significantly increase -- and let me give you a simple  
5 example of that, and as the session goes on, we may get  
6 into others.

7 In Dayton, Ohio, cardiology and orthopedics in  
8 rough terms get paid 115 percent of RBRVS, 15 percent  
9 over Medicare, and those are procedural specialties.  
10 They're highly visible. If the ambulance rolls into  
11 the emergency room and there's no cardiologist, that  
12 would make the night TV. Whereas endocrinology,  
13 rheumatology, primary care are paid we think -- these  
14 are rounded numbers -- 5 percent below Medicare.  
15 They're not procedural, they're not highly visible.

16 Now, in our work with General Motors and  
17 others, they can go on for hours about the cost of  
18 poorly managed diabetes, who treats diabetes,  
19 especially the brittle cases, and their chronology, and  
20 if you don't keep your diabetes managed, there is a ton  
21 of medical literature that says that you're going to  
22 wind up having a stroke, a heart attack, blow your  
23 renal artery and get on -- I mean, you know, just the  
24 untoward consequences of poorly controlled diabetes.  
25 In fact, they've quantified that for -- there's a

1 long-term measure of glucose control called the  
2 glycohemoglobin. Every half point of that you reduce  
3 saves some thousands of dollars in downstream care.

4 So, to be paying -- and what we found in our  
5 market is that our -- we didn't have endocrinology in  
6 our group, and the one we used left and moved to  
7 another town. Now, these cases are going to wind up in  
8 the ER in a heart attack or a stroke, and in our  
9 market, you're not going to be able to see an  
10 endocrinologist in the next couple of months, and the  
11 same is true with rheumatology.

12 I was just on the phone last night with  
13 rheumatology. We are way underserved. We have very  
14 strong financial people on our team. We can't make a  
15 competitive offer. We need them. We're desperate.  
16 And you can't send them to Cincinnati, it's in more or  
17 less the same shape. Now you're telling people go to  
18 Columbus, go to Indianapolis, go to someplace where  
19 they're better paid. And I think that the health plans  
20 need to be held accountable for that, because if you  
21 don't treat rheumatoid problems, you are going to wind  
22 up popping new hips and knees and everything into  
23 everybody three years down the line, and that's a --  
24 now, I -- we needed to gather this data. We have it  
25 -- we have data, but if we're going to go out to the

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1 public, you want to have that. So, when we said let us  
2 go out and gather data, it was to show these kinds of  
3 stories, and this is only one sample, but untreated  
4 chronic disease is bad, and it is plain stupid in our  
5 view to knock down -- and let me put that in context.

6 If you take the \$65 per year that are spent in  
7 this mock average PMPM that I gave you and break it out  
8 by specialty, you know, cardiology is 237 and  
9 orthopedics is 466. Endocrinology is 13 cents. So, if  
10 you give somebody a 20 percent increase to get them  
11 into town, what's 13 cents out of a PMPM of 235?  
12 Rheumatology comes in at a big -- almost a quarter.  
13 It's the dumbest thing you'd ever want to see, but  
14 you've got to have data to tell the story, and we went  
15 to the FTC, in essence, to gather the data that we felt  
16 was needed.

17 This is kind of a classic chart showing that 20  
18 percent of the patients in the top of the pyramid are  
19 spending 82 percent of the dollars. Who are they?  
20 Diabetics, people with rheumatoid -- the chronic  
21 disease patients. Eighty percent of the people spend  
22 18 percent of the money. So, the very -- we want to  
23 go to the public and say, you know, we're not opposed  
24 to health plans trying to get the costs down. We just  
25 want them to be smart about. And what we think that we



1 that there's some antitrust issue here when hospitals  
2 go out and purchase large numbers of physicians and now  
3 come to the table with these owned hospital networks.  
4 They're allowed to lose money on their physician  
5 networks at very large rates often, and then they also  
6 drive the market in interesting ways, because they say  
7 to the carriers, you know, we've got a hundred doctors,  
8 we've got the hospital, if we get out, you are going to  
9 be over a barrel.

10 I'm not sure we want to drive a lot of the  
11 physicians into these hospital entities, but the way  
12 the rules are set today, it's worth more to the  
13 hospitals to have them and lose money. When we talk  
14 about losing money, a lot of hospitals today are  
15 considering it a homerun if you only lose \$75,000 per  
16 year in operating expenses for every doctor you own.  
17 It was a hundred and a quarter three years ago, but  
18 they have kind of tightened it up a little bit.

19 So, those are my thoughts.

20 MR. BERLIN: Bob Leibenluft, if you will give  
21 your address, please.

22 MR. MATTHEWS: I don't know where you are up  
23 there.

24 MR. LEIBENLUFT: Thank you. I'd like to again  
25 express my appreciation in having the opportunity to be

1 here this afternoon. I'm here on behalf of the  
2 Antitrust Coalition for Consumer Choice in Healthcare,  
3 and it's a long name for something which is composed of  
4 employers, health plans, providers and others, and what  
5 we were really formed to do, this coalition, was in  
6 response to some proposals to create an antitrust  
7 exemption for physician joint negotiation, but the  
8 group has been concerned about ensuring that there will  
9 be competitive markets in health care, and so they in  
10 particular reacted to the Washington State Medical  
11 Association business review letter which came out about  
12 almost exactly a year ago, and that's something that  
13 I'm going to want to address today.

14 By the way, I was just frightened by this  
15 thought, and I still can't get it out of my head, that  
16 doctors, when faced with two decisions about medical  
17 care, will make the wrong one almost half the time.  
18 That just seems staggering. I don't know what to do  
19 going home, actually.

20 MR. MATTHEWS: Drive carefully.

21 MR. LEIBENLUFT: And that raises a whole bunch  
22 of other questions.

23 But let me focus here on the matter at hand,  
24 which is access to information. The Coalition agrees  
25 and I agree certainly with Roxane and others, that





1 opinions that you have to be very careful on how these  
2 are done, and what I'm trying to be here is  
3 constructive in the sense of where there's a real need  
4 for very close analysis. I think here, on the  
5 Washington State business review letter, there are some  
6 things that to me really didn't quite get together.

7           What did WSMA do? They represented 75 percent  
8 of Washington state physicians, and they proposed an  
9 information gathering and dissemination program, and as  
10 I'll explain in the course of this, I think there were  
11 few real good procompetitive justifications for the  
12 program. So, on one side, I don't think the  
13 procompetitive justifications -- if you look at them  
14 closely -- held up, and on the other side, I think  
15 there's a real danger of collusion and stabilization of  
16 prices, and there really were not adequate safeguards  
17 against that.

18           So, the bottom line is that I think it has

1 two types of statistics. One was the average amount  
2 charged for particular services by Washington  
3 physicians, and so that's really what's their average  
4 price charged, and that was going to be done  
5 essentially in a way that would be covered by statement  
6 of the guidelines, the safety zone. So, there were  
7 going to be enough of them, this was going to be data  
8 that was more than three months old, the specific  
9 physicians were not going to be disclosed. That's  
10 something that was not particularly a concern of ours.  
11 That's consistent with the safety zones. We weren't  
12 really raising concerns about that.

13 But the other part we were, and that was they  
14 were also going to be publishing the average  
15 reimbursement for specific services by health insurer  
16 and by geographic region. So, people would be able to  
17 know how much the Blue Cross plan or the Aetna plan or

1 targeting a boycott, identifying who is the lowest  
2 payer across all plans and therefore be a means of  
3 facilitating a boycott, or facilitate an agreement  
4 among physicians on a starting point for negotiations  
5 with insurers.

6           Again, if you are a physician and you know that  
7 the average payment rate was 20 percent more than what  
8 you were willing to accept last year, what are you  
9 going to do next time around? You are going to bring  
10 up your price to what everybody else was charging. So,  
11 it's a price stabilization issue.

12           And these kinds of concerns have been addressed  
13 in the past by enforcement actions by DOJ, one  
14 involving OB/GYNs in Georgia in 1991, another involving  
15 on the purchasing side information about entry-level  
16 wages for nurses amongst health care providers in Utah  
17 in 1994. So, it's an issue that has come up before,  
18 which is why we were, quite frankly, surprised by the  
19 way the business review letter was written.

20           Okay, I'm going to go through -- basically  
21 there were two justifications that WSMA proposed to  
22 justify its conduct. One is it said it's going to  
23 allow a better and less costly comparison of insurers'  
24 fee schedules, and what WSMA said was, "Providers often  
25 do not receive fee schedules from insurers, and they

1 don't know what they're being paid for specific  
2 procedures." That was their assertion.

3 At least the folks in the Coalition that I've  
4 talked to and people in health plans were quite  
5 surprised about that. You know, it is the case that  
6 the average physician, just like the average patient  
7 may not know what a particular procedure is reimbursed  
8 at, physicians do tend to know what Medicare pays, and  
9 they do tend to know what 120 percent of RBRVS is or  
10 what 130 percent is or what 140 percent is. That's the  
11 number they care about.

12 You know, if you're an OB/GYN, you may care  
13 about what is a normal delivery. You know, certain  
14 procedures they may also care about. They know what  
15 that number is, and they look for that in the  
16 contracts, and that number is in the contracts. There  
17 may be revisions. There may be allowed some other  
18 language in contracts that they may not be as familiar  
19 with, but my experience has been physicians know about  
20 -- particularly when payers are paying off of a  
21 Medicare fee schedule, which is very typical nowadays,  
22 they know what a health plan is offering, and that's  
23 what the negotiation is all about, and that's what  
24 they're concerned about.

25 Second, remember, the survey that was going to

1 be done was going to be what are the payers paying  
2 generally on the average for other physicians? So,  
3 it's not going to tell me what a payer is offering me;  
4 it's going to tell me what my competitors are  
5 accepting. So, I'm not quite sure how this really  
6 tells the average physician more about what the insurer  
7 is going to be paying that physician.

8 And thirdly, ironically, Washington State is  
9 one of the few states that has a law that actually  
10 allows for some joint nonprice negotiation on the part  
11 of physicians, and the Washington State Medical  
12 Association has a very active service advising  
13 physicians about contracts and interpretations and so  
14 forth.

15 By the way, I think that's a good idea. That's  
16 an information-sharing role that I think it's  
17 reasonable for physicians to be able to understand  
18 their contracts and information that will explain to  
19 them, as long as it doesn't facilitate collusion,  
20 personally I think is fine.

21 The second justification was a very brief one.  
22 It said it will provide -- I kind of have two quotes  
23 -- three quotes in this quote -- somewhere it starts  
24 and ends, I'm not quite sure -- "will provide  
25 information to other parties, such as insurers,

1 employers and academic researchers, and therefore will  
 2 allow each of them to take better informed actions,"  
 3 but nowhere in the business review letter does it say  
 4 what kind of information, to what parties, why do they  
 5 need it, what are they going to be informed about,  
 6 whether any of these parties have sought such  
 7 information, and most importantly, whether the  
 8 information could be provided in a way with a less  
 9 potential for anticompetitive effects.

10 So, I have some issues with the Dayton opinion  
 11 as well, but Dayton I think, as you heard, it was a  
 12 very clear message here about what the requester wanted  
 13 to do with the information. This seemed to be kind of,  
 14 well, somebody has asked or it might be useful to  
 15 somebody. If there was not( 9 eajToe" )Tjy of these piia

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1 know this -- you have to look at it by specialty and  
2 by location. One can't just say it's an unconcentrated  
3 market statewide, because physicians generally don't  
4 compete in a statewide market.

5 Certainly in rural areas of Washington, there  
6 are very few physicians in some of those areas, and a  
7 very small number of them could constitute 100 percent  
8 of the relevant geographic and product market. So,  
9 that really has to be analyzed on a local basis.

10 Now, in the Dayton opinion, that opinion was  
11 just geared towards Dayton, and again, I don't want to  
12 say one opinion was good and one was bad, but it's just  
13 as a contrast, that advisory opinion was much more  
14 narrowly tailored to one market. This said, generally,  
15 we accept the notion that physician markets are -- or  
16 Washington State, you know, this is a region where we  
17 should have less of a concern because this is  
18 unconcentrated.

19 Lastly here, we see that, you know, Washington  
20 State Medical Association, again, was 75 percent itself  
21 of all doctors, and they said they were going to make  
22 their results available to everybody. So, all the  
23 physicians in the entire state would have access to the  
24 information. The data was going to be at least three  
25 months old, and that was going to be another assurance.



1           Now, I think that may make a lot of sense if  
2 we're talking about wheat prices and, you know, a wheat  
3 price or oil prices, gas prices, three months old,  
4 that's useless to anybody who wants to collude, but  
5 with physician services, those prices tend to be  
6 negotiated at most once a year. So, we're talking  
7 about a price that's three months old, that's likely to  
8 be the current price, and it's likely the price that's  
9 going to be out there for a while, and it's also going  
10 to likely be the market that's going to be -- what the  
11 new negotiations are going to be built on.

12           The next assurance, no individual providers'  
13 data will be disseminated, only the average  
14 reimbursement data will be furnished, but this could  
15 still provide a common starting point for negotiations  
16 and therefore targets for a group boycott. And here, I  
17 think Roxane mentioned the messenger model, which I  
18 think is an interesting thing for us to think about.  
19 Whether or not you agree with the agency's view of the  
20 messenger model, the logic behind a strict  
21 interpretation of the messenger model, which is, for  
22 example, the agencies would say it's not proper under a  
23 messenger model for the messenger to come up with a  
24 starting point or an average and have people opt in, a  
25 number which people could opt in or opt out of.

1           The concern there is everybody comes up to that  
2     number, because they know that number is being used as  
3     sort of a benchmark, and so if you're below that  
4     benchmark, you'd come up. I would suggest that we have  
5     the same concern here. If there's a target out there,  
6     a number out there which gives everybody an average for  
7     a particular payer, then that becomes a useful  
8     benchmark for collusion.

9           And in fact, going back almost 20 years ago, I  
10    looked at some of the older staff advisory opinions,  
11    and you know, WSMA's defense here was that average was  
12    better. Well, this was language suggesting that  
13    dissemination of the average prices charged for  
14    particular procedures can be more troublesome from an  
15    antitrust standpoint as opposed to dissemination of a  
16    range of charges. Why? Because the average price --  
17    and this is involving currently charges, so there's a  
18    distinction, but still provides basically a danger in  
19    the dissemination of average price information to  
20    physicians who currently charge varying prices and may  
21    provide services at varying levels of

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1           For example, price dissemination of an average  
2 price may be part of a competitors' reaching a common  
3 understanding that the stated average will become the  
4 price they usually will charge, or even the minimum  
5 price charged, for a particular product or service.  
6 So, an average to me doesn't solve the problem. It  
7 makes it worse.

8           Another assurance, WSMA said, look, it's going  
9 to be difficult to monitor a price-fixing agreement,  
10 because agreement among physicians is unlikely because  
11 the same service often is categorized by different CPT  
12 codes or combinations of codes. Well, if that's the  
13 case, then what use is the survey at all? I mean, if  
14 what you're saying is that sort of, you know, these CPT  
15 codes and how people code something differs so much  
16 from one physician to the next, then it seems to me  
17 that it's garbage in, garbage out, and you can't have  
18 it both ways. If it's going to be a valuable survey,  
19 you've got to say the CPT code for which you're  
20 gathering the information means something and there's a  
21 common understanding. I think there generally is a  
22 common understanding, and I think for that reason we  
23 have concern about the potential collusion, but you  
24 can't have it both ways.

25           The last concern here is that -- I mean, the

1 payers -- if you talk to insurers, to health plans,  
2 the rates they get when they negotiate with hospitals  
3 or physicians is a real concern, that that's kept  
4 confidential. I mean, the last thing in the world --  
5 they're bargaining with somebody and it's two-way  
6 bargaining when they do bargain with groups, and they  
7 want to have those rates kept confidential, and here is  
8 a mechanism basically where that information would be  
9 disclosed to everybody in the market.

10 So, in conclusion, again, we just want to say,  
11 you know, the coalition has supported the enforcement  
12 efforts of the FTC and the Department of Justice in  
13 ensuring competitive health care markets, and a really  
14 important role of the agencies is providing those  
15 advisory opinions and business review letters, and we  
16 recognize -- I know having been there, it's not easy  
17 always to write these opinions. You have to deal with  
18 them, and people raise the tough questions. We are  
19 just urging that care be given that not a green light  
20 or even a yellow light be sent out that might encourage  
21 providers to engage in anticompetitive activities.

22 Thanks.

23 MR. BERLIN: Thank you very much.

24 I think we will take a ten-minute break, come  
25 back at 3:30 and begin our moderated discussion.

1 (A brief recess was taken.)

2 MS. BOORSTEIN: Okay, everybody, we're going to  
3 get started again, and I think the way we'll start the  
4 discussion is by giving each of our panelists a chance  
5 to respond to everything that they've heard. So, once  
6 again, we will follow the same order, and we'll start  
7 with Roxane.

8 MS. BUSEY: Well, I actually just wanted to  
9 pose some questions and maybe have a little bit of a  
10 discussion, and I would raise the same question that I  
11 raised before, which is in the Dayton letter, where  
12 there was an effort to -- I thought it was identified  
13 as two, but I have been corrected to say all, I think  
14 all insurers?

15 MR. BINFORD: Yes.

16 MS. BUSEY: Why it would need to be provided by  
17 naming the individual insurer rather than by  
18 aggregating the information, and so let me just explain  
19 why I'm confused.

20 It would seem to me that when the purpose of  
21 what you're trying to show is that there is low  
22 reimbursement in the area and that that low  
23 reimbursement has caused a reaction in terms of the  
24 ability to maintain and recruit physicians, and it  
25 doesn't seem to me that you need to show that it's by

1 one insurer or another, it doesn't really matter.  
2 What's most important is that that's the way it is  
3 really from all or substantially all of the insurers.

4 So, my question is, particularly in the area of  
5 the distribution as opposed to the collection,  
6 collection might have to be done from the provider by  
7 individual insurer, but my question is, why in the  
8 distribution can't it be simply an aggregate figure?

1 system in Dayton, we want to be able to actually finger  
2 that provider and tell at least the consumers, the  
3 employer groups, hey, here's a problem, and we've  
4 identified it. We at least want to keep that door  
5 open.

6 If that's not necessary, then I see no need in  
7 doing it, but there's certainly that possibility, and  
8 it may be that that is information which is shared with  
9 employer groups and may not need be shared with the  
10 physicians themselves. That's another decision which  
11 will be made I think going down that road, which would  
12 certainly avoid the issue of boycotting, unless you  
13 have boycotting by employer groups, but I don't think  
14 you're going to have as much of that.

15 Bob?

16 MR. MATTHEWS: Yes, I envision our process  
17 going in a direction where we could go to an employer  
18 and to their employees and say, you know, with this  
19 insurance plan X, we cannot get an endocrinologist in  
20 town, whereas with Y, we can afford at their rates to  
21 bring one into town. Which one do you want to choose?  
22 And here's the importance of managing diabetes and here  
23 -- you know, all that sort of stuff. And you know, we  
24 don't have any endocrinologists in our group. I'm not  
25 out here trying to -- I'm just trying to say that when

1 our doctors are trying to take care of patients and  
2 they don't have that resource available, and I'll add  
3 as an addendum, you know, certain specialties and  
4 certain procedures shouldn't be in every town for  
5 quality and cost purposes, you don't need it, but  
6 endocrinology and rheumatology, you don't want people  
7 driving two hours for that. Rare brain surgeries, they  
8 can drive four hours, but this kind of routine care for  
9 a brittle patient -- so, I would like to be able to  
10 say, yes, this company in particular has taken a step  
11 or action which precludes your getting this care in a  
12 timely basis or at all in this town, and I think that  
13 as a purchaser now I'd like to know that, because  
14 that's pretty important.

15 MS. BUSEY: Do you want me to respond or, Bob,  
16 do you want to respond to that?

17 MR. LEIBENLUFT: I guess I'm questioning as a  
18 purchaser -- I think Roxane's question, by the way,  
19 was right on. I had the same concern, is there a  
20 narrower or less restrictive alternative. Even less  
21 restrictive than that, isn't the key thing that you're  
22 trying to tell the employers is, there's no  
23 endocrinologist in town, how important that is, so why  
24 do you need to know how much the payers are paying for  
25 that? You can just show -- there's data about how



1 many endocrinologists are in town, and you can look at  
2 that, and you can say, here, per hundred thousand  
3 people in Dayton, there are none of these specialties.  
4 That's a real problem, and the employers should care  
5 about that. I'm not quite sure why it's so important  
6 to get to the intermediate step of how much each payer  
7 is paying.

8 MR. MATTHEWS: Well, I would argue the  
9 opposite. I mean, we live in a world of data where as  
10 a tool of analysis could say, you know, cause j0 -2 TD( ld

1 the employer and say, endocrinologists are really  
2 important, and employers understand that. You have  
3 shown them your data. They go to their health plans  
4 and say, we want to have X number of endocrinologists  
5 on our panel, and if the health plans say, gee, we  
6 don't have them, then I would think the dialogue would  
7 be between the employer and the health plan. How come?  
8 Why don't you have more? Maybe they need to raise  
9 their rates so more will come back into town. That's  
10 the way lots of markets work. I'm not quite sure why  
11 you need necessarily to have people surveying what the  
12 payers are paying.

13 MR. MATTHEWS: Well, the reason for the survey  
14 is so that you have the ability to demonstrate that, A,  
15 this is, in fact, the case, we don't have any. We know  
16 they're not in town. B, you have the opportunity to  
17 find out that this isn't the case in other places where  
18 they happen to have endocrinologists. And C, you have  
19 the ability to -- I mean, I experience in situations  
20 where we buy things the opposite of what you're  
21 describing.

22 If Siemens and GE are trying to sell me  
23 something, they're very quick to tear apart the other  
24 guy's product and say it doesn't have this, it does  
25 have that. This is where value can be found in a

1 purchase, and that's part of the search for value in a  
2 competitive marketplace.

3 MS. BOORSTEIN: Just to follow up a little bit  
4 on that, usually you would think -- you were saying  
5 that endocrinologists lead to lower costs because then  
6 you don't have people needing to go to cardiologists  
7 later when they get sick because their diseases aren't  
8 managed, but presumably it costs the insurance  
9 companies more when people get really sick, so why  
10 aren't they internally making those calculations that  
11 will ultimately save them money?

12 MR. MATTHEWS: That's a very good question, and  
13 you know, first off, we haven't finished the whole  
14 thing, but I can tell you what my working hypothesis  
15 is, and I have seen this happen, and I recently had a  
16 conversation with someone who it turns out is in the  
17 audience here today who's eight states away, so there  
18 is no antitrust problem here, and those are situations  
19 where some of the people in health plans are playing a  
20 very short game, quarter by quarter.

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1 year is based on X, you know, from an insurance  
2 company, and again, I think that if you have evidence  
3 or you can accrue evidence that shows through analysis  
4 that to the customer, who in this case is the large  
5 employer, the midsize or the small employer, that  
6 people are making very silly decisions in a short game  
7 against very significant increases in cost in the large  
8 game, then that's something that ought to be brought to  
9 the public attention. So, that's the largest reason I  
10 think.

11 The other -- and it's probably not a whole lot  
12 less nefarious -- that I find is, you know, there was  
13 a time in United States history where there was  
14 actually a collusion between physicians and insurance  
15 companies to bring costs up, because insurance  
16 companies -- and hospitals. Insurance companies got  
17 paid as a percentage of premiums. So, if the rate went  
18 up every year, so did their revenue, and it's been  
19 argued in some recent places where I'm -- that we're  
20 moving more back to that percentage of premium.

21 They have gotten out of the business of  
22 managing care, controlling costs and managing the  
23 quality, and they're just -- you know, if things float  
24 up, they don't like to lose business, but if things  
25 float up and they're on a percent basis -- now, that's

1 pretty nefarious and dark, and I won't make -- say  
2 that I can prove that, but I'm watching decisions be  
3 made which really defy my -- any rational basis, and I  
4 think they -- when we go to the smarter large  
5 employers, they are chagrined about this. It's very  
6 alarming to them.

7 MS. BUSEY: Well, I don't want to dwell on that  
8 too much, but I guess I would just ask one more related  
9 question, which is you both are in the position where  
10 you represent, if I understood it correctly, a  
11 multispecialty group.

12 MR. MATTHEWS: Yes.

13 MS. BUSEY: So, you have the advantage of some  
14 of this information that individual physicians may not  
15 have, and by that I mean the comparison between  
16 physicians, what they're paid.

17 MR. MATTHEWS: Well, we can tell in Dayton what  
18 primary care groups are paid. You know, the large  
19 insurers have told us we're paying everyone on the same  
20 basis a number of times. Someone asked earlier today,  
21 how does everyone know? They may be lying, but that's  
22 what they've told us repeatedly. So, I can look and  
23 see now what primary cares are being paid, and I can  
24 extrapolate from that, but I think that it would be --  
25 if you're going to go out and make a case in public

1 with data and facts, I would like to have a sample size  
2 of more than one group, and I think that even though  
3 the assertion's been made that everyone's treated the  
4 same, we've already discovered that that's not true.  
5 So, when you gather data, you get a chance to show  
6 that.

7 Now, the other thing is to go to markets that  
8 are outside our area and say, is it, in fact, the case?  
9 Now, we've lost three or four doctors who have moved  
10 out of town to other cities where doctors are paid  
11 more, but is that enough proof to assert that there's a  
12 substantial difference, or do you take an average, a  
13 weighted average from our market and you compare it to  
14 a weighted -- you know, some other markets? And you  
15 start to say, yep, that's really true. Because if  
16 you're going to the press or you're going to an  
17 employer and you're going to make an assertion, I  
18 really want to have the facts nailed down pretty hard  
19 to the floor, lest be held liable for --

20 MS. BUSEY: Well, yeah, I understand that.

21 Again, I think that in my mind there's just a

22 difference betus a -ffereat's r( I thioiSe )TjT(

2f's no

1 particular payer helps your case I guess is what I'm  
2 trying to say.

3 In other words, in order for you to be able to  
4 show that physicians are leaving because they're not  
5 adequately paid in comparison to other markets, it  
6 seems to me that's got to be overall. It's got to be  
7 overall in your market they're not paid appropriately.  
8 So, I'm having a problem with that, but again, I don't  
9 want to dwell on it. It's just to me, when I was  
10 reading this, I thought that the way it's set up is  
11 that it seems to me that it could result in a more  
12 anticompetitive effect -- could, you know, that's a  
13 judgment call -- than if it had been set up in a way  
14 that it didn't identify individual insurers, and I  
15 thought that you could achieve maybe not 100 percent of  
16 what you're trying to achieve but a large percentage of  
17 what you're trying to achieve by a more aggregated  
18 approach.

19 Actually, I had the same reaction to the  
20 Washington letter, and I said that before, and I would  
21 just like to spell it out a little bit more.

22 The Washington letter is a little bit more a  
23 mystery because of this -- the point of -- that I  
24 made and then Bob sort of confirmed, which is the  
25 letter says that the doctors don't really understand

1 what their reimbursement is, and Bob even made the  
2 point of saying, well, then, how is this specific  
3 information going to help them?

4 I guess where I would start is from the point  
5 that I think that physicians do need to know whether  
6 they -- how they determine it is the question, but  
7 they do need to know what comparative reimbursement is.  
8 I mean, how can they decide that they're going to  
9 participate in a plan if they don't know what they're  
10 being paid and they don't know how to compare it to  
11 another plan? It seems to me that's something that  
12 they've got to get a handle on.

13 Now, they can get a handle on that  
14 individually, okay, presumably, because they're  
15 contacted by all or most of the plans, or it seems to  
16 me if you're going to go to a mechanism like what was  
17 done for the Washington Medical Association, again, I  
18 don't understand why you couldn't do it by aggregation.  
19 In other words, say to a physician, okay, you're a  
20 primary care physician, and you may not know what  
21 others are being reimbursed, so we are going to tell  
22 you what the range of reimbursement is from all  
23 insurers. We're going to give you the low and we're  
24 going to give you the high, and you're going to have to  
25 figure out what you're reimbursed -- okay, people are



1 shaking their head. Maybe you can -- are they allowed  
2 to comment?

3 MR. BERLIN: No, they are only allowed to shake  
4 their head.

5 MS. BUSEY: All right, you know --

6 UNIDENTIFIED SPEAKER: How are you supposed to  
7 run your business if you don't know what you're paid?

8 MS. BUSEY: Well, no, but why don't you know  
9 what you're paid? You're a physician. You're supposed  
10 -- I mean, you sign a contract. I mean, the physician  
11 organizations that I've been involved with, there's  
12 been a mechanism where you could call and inquire if  
13 you were a physician. So, for example, if you were  
14 told your contract is 110 percent of Medicare schedule,  
15 and you didn't know what that meant, for example, you  
16 could call and find out, and they would actually tell  
17 you. So, I'm a little bit at a loss as to why that's  
18 not possible.

19 UNIDENTIFIED SPEAKER: Health plans can  
20 unilaterally change the fees in many contracts, and  
21 they do so willy-nilly, and they don't tell anybody  
22 about it.

23 MS. BUSEY: Well, that's a separate issue, that  
24 goes to contracting, and I have seen contracts like  
25 that that are one-sided, but those need to be changed.

1 I mean, that's just a simple way to change that.  
2 That's a whole separate issue. Unilateral changes in  
3 contract are hard to believe in any industry, that one  
4 party would say, okay, whatever you change your price  
5 to I'm willing to agree to, but that seems to me to be  
6 a separate issue in terms of how are they going to  
7 figure out what the plan is offering and whether that  
8 is a plan that they want to participate in.

9 MR. LEIBENLUFT: And it's not clear how they  
10 are going to answer that survey if they don't know what  
11 they're being paid either. I guess what Roxane -- I  
12 agree with everything so far that Roxane has said, and  
13 I think, for example, I agree that physicians should be  
14 able to know what they're being paid. There's no  
15 question about that. I think there are procompetitive  
16 ways where somebody could come together and provide  
17 physicians information about what the plans are  
18 offering, what the plans are offering, and allow  
19 physicians to compare apples to apples for a set of CPT  
20 codes, and then physicians can independently decide  
21 what they want to do, but that's different from saying,  
22 here's what people are willing to accept from the  
23 plans, and I think that's the real difference between  
24 what Washington State Medical Association's business  
25 review goes to and what I think a procompetitive way

1 is.

2 I think the procompetitive way is give people a  
3 mechanism for learning what the alternatives are, and  
4 they, as sellers of their services, can decide with  
5 whom they want to contract. That's procompetitive. I  
6 don't see why they need to know what their competitors  
7 are accepting. That's a difference.

8 MR. BINFORD: And I agree with Roxane in that  
9 it is a contractual issue, where you just agree to  
10 accept whatever somebody is going to pay you, although  
11 I have seen it done, but with regard to the fees I have  
12 seen in negotiations where a third-party payer will  
13 share with the group a sampling of their CPguOrRom38hut wTjT(

1 stated justification in the Washington State letter on  
2 the facts as stated in the Dayton letter, and that  
3 justification is to have a better and less costly  
4 comparison of insurers' fee schedules, is that  
5 something that is as useful or as necessary in a market  
6 like Dayton that is, as you've stated, dominated by two  
7 health plans or perhaps as necessary, you know, in  
8 other markets if we've seen, as we have, the amount of  
9 consolidation among payers and whatnot?

10 Is there really that sort of -- and again, I  
11 may be missing something, but is there that diversity  
12 or confusing amount of information out there that it's  
13 truly necessary for this particular point?

14 MR. MATTHEWS: Well, just to make the practical  
15 point -- and there are different ways you can get at  
16 information, but in our -- in contracting with health  
17 plans, both the large players that I deal with in  
18 Dayton, Ohio refuse to show you their fee schedule.  
19 They will show you 10 or 15 codes, and if you beg and  
20 whine enough, they may show you another 10, but they  
21 will not disclose their full fee schedule to you, and  
22 you can say, well, just don't enter those contracts,  
23 but to somebody's comment here, the commercial market  
24 in Dayton is 90 percent controlled by two players.

25 So, either one of them, to your earlier point,

1 by taking an action can pretty much preclude  
2 endocrinology, and at that kind of market domination,  
3 which they were allowed to acquire through mergers and,  
4 you know, whatever in part -- part of it is market  
5 growth, but part of it was United buying Western Ohio  
6 and all of a sudden being a gorilla in town.

7 Now, when it comes to looking at data and  
8 understanding what you're being paid, at one level,  
9 every service you provide produces an EOB, an  
10 explanation of benefits, with a remit, and there is a  
11 way to aggregate up to -- it's costly and  
12 time-consuming and painstaking, and you don't always  
13 know prospectively, you have got to do one to find out,  
14 and so there -- in some form or fashion, you can  
15 figure out what you're getting paid, but that's pretty  
16 expensive and pretty time-consuming.

17 If you are in a small town and you're in a  
18 two-doctor office, the analysis required of that would  
19 be not inconsiderable, and the kind of expertise you  
20 may need on the accounting or business operations side  
21 may be beyond the practical scope of your company. If  
22 you're in a 60-doctor group with CPAs, you know, we can  
23 do it that way, but still, we're paying somebody to go  
24 mine this data out and figure it, and you have got to  
25 look up the original EOB because they break things out

1 and do alloweds and contractuals and self-pays, you  
2 know, patient portion is different case by case, and  
3 you've got to calculate all that. You can  
4 theoretically do it. I don't think it's a very good  
5 way to do business.

6 I guess I understand some of the other Bob's  
7 concerns, but I would say that in a -- you know, maybe  
8 if you're in 150-doctor group in Seattle, this isn't

1 GE knows how much Siemens sells MRIs for, and so it's  
2 not exactly nuts that Dr. Smith or Jones in Walla  
3 Walla, Washington, wants to know what doctors around  
4 the state are doing, because he doesn't probably have a  
5 staff of many, many people to help him sort all that  
6 through.

7 MR. LEIBENLUFT: Can I say a couple things on  
8 that?

9 First of all, I don't think Siemens knows how  
10 much -- who was the competitor, GE?

11 MR. MATTHEWS: GE.

12 MR. LEIBENLUFT: -- is selling --  
13 discounting, what the actual list rates are. They may  
14 know the list price, but I don't suspect they know the  
15 discounted price to hospitals -- you're laughing?  
16 Maybe I'm wrong.

17 UNIDENTIFIED SPEAKER: It doesn't work like  
18 that at all.

19 MR. LEIBENLUFT: Okay, maybe they all don't  
20 negotiate, I don't know, but it seems to me that in  
21 many businesses, people who sell don't let their  
22 customers know what price they're offering to other  
23 purchasers.

24 The second thing is, on the Washington State  
25 Medical, again coming back, if there's a problem with

1 doctors knowing what they're getting paid, that may be  
2 an issue, but you don't solve it by surveying them,  
3 because if they don't know what they're getting paid,  
4 what number are they giving to the survey about the  
5 average reimbursement amount? So, there's a disconnect  
6 here. Either they do know or they don't know what  
7 they're getting paid.

8           Maybe I don't understand what was being  
9 proposed. People are shaking their heads, but it  
10 doesn't seem to make much sense to me for me as a  
11 doctor to figure out what the insurers are offering me  
12 for me to find out what others are willing to get paid,  
13 particularly if you're telling me t





1           MR. BERLIN: To move the topic somewhat away  
2 from I guess one rationale for doing this, and that is  
3 giving physicians a better idea of the rates in Dayton  
4 and negotiating to -- I believe, Greg, this was your  
5 point, that one reason for doing it in Dayton was to  
6 make employers educated consumers.

7           Would it be less restrictive and certainly  
8 raise less antitrust concern if the data collection and  
9 dissemination, aside from what use is made from it once  
10 we have it, but if that is done by some groups other  
11 than the competing providers themselves? So, that's  
12 sort of a theoretical question I toss out there.

13           Then, in terms of specifics, I know in this  
14 morning's session, Monica Noether mentioned that there  
15 is this Medicode data that appears to be collecting  
16 some sort of -- and I talked to her after that -- at  
17 least, if not data on reimbursement, data on fees  
18 charged. Leapfrog I know is at least in the process of  
19 collecting data on some sort of quality factors. It's  
20 my understanding that the HIAA also has a database,  
21 again, that I understand in some way is tied to insurer  
22 reimbursement and across insurers. And then you may  
23 have folks like Towers Parren or other people sort of  
24 in the consulting business practices that, again, I  
25 have some understanding have databases.

1           So, one, I'm wondering whether just as a  
2 theoretical matter it wouldn't be a better thing if we  
3 could have that data coming from some of these other  
4 sources rather than from the competitors, and two, does  
5 anybody on the panel have a knowledge of whether these  
6 other sources do exist, examples I gave, others, and  
7 whether they are -- I'm talking apples and oranges and  
8 they're not useful?

9           MR. BINFORD: Well, from a legal standpoint,  
10 the way the venture has been structured is there is a  
11 separate entity created separate and apart from the  
12 competing physicians, and there will be safeguards  
13 built into the system so that, for example, sensitive  
14 price information is not shared with physicians, and in  
15 fact, I believe much of the data is going to be  
16 collected by a contracted third party.

17           Is that correct, Bob?

18           MR. MATTHEWS: Yeah, and that was part of the  
19 discussion with the FTC, that we would either put  
20 someone in the management role who had nothing to do  
21 with the prices and was out of the market, or we would  
22 get a third party in, but we have decided to go that  
23 way just because it's that much cleaner.

24           MR. BERLIN: Um-hum.

25           MR. MATTHEWS: As to the issues of whether the

1 -- the roll-up statistics or whatever that you get  
2 don't tend to be very helpful, they are often  
3 inaccurate. They have two or three-year lags in them.  
4 They lump things up in ways -- they are not very  
5 practical. They give you sort of a ballpark picture,  
6 but in our particular case, for our purposes, we were  
7 trying to get as precise as possible. We want to go to  
8 employers and be as precise as possible, not, you know,

1 so, in the course of processing these claims and  
2 sorting out who owes how much, they figure out what  
3 other parties are paying upstream, and they gather  
4 data, and they tell me, now, what is so and so paying?  
5 And I say, well, you know, I'm really not going to tell  
6 you that. Well, we know anyway.

7 So, you know, on the one hand, in this context,  
8 the Washington letter is being criticized by Bob and  
9 others because, gee, why would this doctor -- but it's  
10 legitimate, and in the normal course of business that  
11 insurers are sort of trending and watching each other  
12 with respect to these, and I have to tell you, after we  
13 pointed out to one carrier that they were paying  
14 significantly lower than another a couple of years ago,  
15 they trued up to within a penny. Now, that could have  
16 been random, but I don't think so.

17 So, I'm going to guess that there are more --  
18 from the doctor side, the carriers tend to have size,  
19 and the -- now they have more data, and this  
20 Washington letter I think has to be put in  
21 juxtaposition to that advantage, and I would throw that  
22 out for -- as a practical thing. It's not a -- you  
23 guys can hit the law around for me, but that's the  
24 practical side. It doesn't feel like an equal fight to  
25 me.

1           MR. BERLIN: Well, actually, both the  
2 Washington State and Dayton letters mention the  
3 possibility of this facilitating collusion at the payer  
4 level. To what extent was that a concern of yours in  
5 making the request or is it now ongoing in doing the  
6 survey? The letter seemed to answer it, well, if that  
7 were really a problem in this market, you wouldn't be  
8 asking to do this, since it's a provider-run survey, so  
9 --

10           MR. MATTHEWS: Well, my point -- I guess it's  
11 my counter to Bob and to the argument that this letter  
12 is disfavorable to the payer side and gives too much  
13 power to the doctor side, and my argument is, well, the  
14 flip side of it is on a practical -- that the payer  
15 has got at least that much and more.

16           MS. BUSEY: Yes, but actually, understand that  
17 my comment about the aggregation would take care of  
18 that problem, too. If you have specific insurer  
19 information, then you're more likely to have collusion  
20 among the insurers, because it's very specific, and so  
21 they can say --

22           MR. MATTHEWS: I see what you mean, yeah.

23           MS. BUSEY: -- okay, but if it's aggregated,  
24 again, they set some information, maybe some  
25 information they already have, but the aggregation

1 takes care of the problem from the insurer side. I  
2 mean, to the -- so, I'm not really -- I wasn't really  
3 commenting on whether it favored the doctors or favored  
4 the physicians. All I was saying is if it is really  
5 less restrictive, it takes care of both sides.

6 MR. MATTHEWS: And I think for us, that's a  
7 tactical question. If you know things, when do you --  
8 what do you choose to say? And I think we have to be  
9 very careful legally and tactically. We don't want to  
10 rush out and produce a ream of data that gives these  
11 two large carriers a benefit that they don't already  
12 have, because we're not seeing the score as even as it  
13 is.

14 MS. BUSEY: Well, the letter is different, and  
15 the Dayton kind of said that they thought the market  
16 was concentrated from the insurer side, because you  
17 keep saying there are two and they have 90 percent of  
18 the market, and obviously --

19 MR. MATTHEWS: That's pretty common.

20 MS. BUSEY: -- markets are difficult to  
21 define, but let's just take it at face value that  
22 you're right and they have a large market share. You  
23 know, again, the case law coming not in the health care  
24 area but just coming generally is you generally don't  
25 exchange information, certainly not specific

1 information, in markets that are concentrated. So,  
2 you're basically -- the antitrust concern would be  
3 greater in the Dayton insurer market than in anything  
4 else.

5 In the Washington letter, it's not clear. It's  
6 very clearly stated that the physicians are  
7 unconcentrated, and Bob raised some questions about  
8 that, but there isn't really much of a -- there's a  
9 footnote, but there isn't much of a discussion in terms  
10 of what the insurer market is in Washington. But it  
11 could also be concentrated, it's possible, in which  
12 case it seems to me you have as much of a concern as to



1 for markets to work, and all I'm saying is that when we  
2 give the green light about information sharing, we  
3 should look about whether the rationale for it makes  
4 sense, whether there are less restrictive alternatives,  
5 what are the procompetitive implications that they hold  
6 up, and does the information exchanged really address  
7 what the goals are that are being set forth, and so  
8 that was my criticism of the Washington State Medical  
9 Association letter.

10 MS. BOORSTEIN: Let me just ask a question, and  
11 I guess this is kind of a general question, which is I  
12 mean that you stated that you're having trouble with  
13 recruiting, that physicians are leaving, and so you're  
14 getting this survey to increase payments to physicians,  
15 which sounds like a price increase. So, then, why  
16 isn't that something that an antitrust agency should be  
17 concerned about if the ultimate goal is to raise  
18 prices?

19 MR. MATTHEWS: Well, look at it from two  
20 perspectives. If you raise prices for endocrinology, I  
21 would argue you could take your PMPM medical cost of  
22 \$195 and reduce it, those total costs.

23 In other words, there are ways to allocate, and  
24 I've had personally, working on the health plan side  
25 mostly, I've had experience in working with doctors to

1 reduce the total cost of health care, significantly  
2 reduce the total cost of health care, but it's  
3 allocating those resources correctly, and it's -- you  
4 know, so -- now, what I'm saying, also, is that, okay,  
5 we're saving money in Dayton, Ohio by paying certain  
6 doctors a substantially lower amount than Medicare,  
7 which is not common in the rest of the country. There  
8 are a few places, but it's not common.

9           Now, my group is spending \$150,000 to \$200,000  
10 to replace doctors who move out of the market, money  
11 that we're not spending on Six Sigma, that we're not  
12 spending on our new computer system, that we're not  
13 spending on things that could really make the system  
14 perform well. Now, I would argue that if we were all  
15 here trying to move up from the mid-grade Lexus to the  
16 upper-grade Lexus, that is a pure price fix, you know,  
17 but we're trying to say that when you make it difficult  
18 or near impossible for us to invest the money we need  
19 to to meet the kind of quality, it's very well known  
20 that the information technologies that are largely  
21 deployed in the physician side of health care are one  
22 step off vacuum tubes, and you know, one of the reasons  
23 is that doctors didn't think about their businesses in  
24 business ways, they didn't invest capital, and now that  
25 they are, you bring them down to a place that's 20

1 percent below the rest of the country, and they say  
2 they can't, and that, I believe, is driving that \$195.

3 We have enormous problems in health care, and  
4 I'm going to tell you that taking down rheumatology,  
5 endocrinology and primary care is probably driving that  
6 up, not down. There are apparently some people from  
7 medical groups in the audience.

8 MS. BOORSTEIN: And just to follow up, what is  
9 it about Dayton? Why are payments so much lower in  
10 Dayton than, let's say, Indianapolis?

11 MR. MATTHEWS: I have studied this pretty  
12 extensively. A couple of reasons, and I can give you  
13 the 30-second answer or I can give you the minute and  
14 30-second answer, but before I was involved in practice  
15 operations, I was a consultant, and I did work in Indi,  
16 I was in Houston and Chicago, San Francisco and all  
17 sorts of places.

18 Couple of things. Southwest Ohio, Cincinnati  
19 and Dayton, are more or less treated the same by most  
20 of the payers, and they have been on the cover of the  
21 American Medical Association as a place you don't want  
22 to go, and when I call up recruiting, they say, we  
23 can't go there, literally. People who grew up in our  
24 town moved, won't come back, and some of them moved to  
25 Indi and Florida and other places, North Carolina.

1           We have lost doctors to many exciting places.  
2     The employer community is in -- in Cincinnati and  
3     Dayton is a lot more organized. Cincinnati has Procter  
4     & Gamble and General Electric, Aircraft Engines. They  
5     pushed managed care earlier and faster. The same in  
6     Dayton. Indi is a lot of small businesses. No one is  
7     really pushing. The doctors in Cincinnati and to a  
8     very significant extent in Dayton were s1o15idewsged meeeeeeeeeee  
23eeeeept of it. meeeeeeeeeeeeeee24                   And so a combination of

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1 entity aboard a physicians -- and actually community  
2 leaders, we wanted it to be both physician and  
3 non-physician, has been -- or the final people are  
4 being recruited. We formed up questionnaires and  
5 engaged people to go out -- the data has not really  
6 been analyzed at this point, so I -- I think it --  
7 just the fact that we took the step seems to have had  
8 some solicitous benefit. I mean, I think that we made  
9 some pretty strong statements to the two big carriers.  
10 We're going to try to prove that you're hurting this  
11 town and your patients, and they have shown some more  
12 -- I mean, before, they were like, tough, that's --  
13 life is terrible. Now they're a little more concerned  
14 about some of our arguments.

15 MR. BINFORD: From a legal standpoint, though,  
16 the entity has actually not been formed at this point,  
17 so we're really a long way from sharing information.

18 MR. BERLIN: Sure, and Bob, any rumors from  
19 Washington that you know about?

20 MR. LEIBENLUFT: No, I tried to find out, and  
21 somebody from -- on the ground there couldn't tell me  
22 -- oh, I don't know if somebody knows here.

23 UNIDENTIFIED SPEAKER: We actually heard from  
24 Washington State Medical Association, that they are not  
25 moving forward because of problems their State Attorney

1 General was indicating that there were -- it was not  
2 comfortable with it, so that's -- and I think he will  
3 probably submit a letter at some point in the process  
4 or -- it's pretty much not a go.

5 MR. BERLIN: I'm glad we didn't know or we  
6 wouldn't have had a session.

7 MR. LEIBENLUFT: Should have invited the State.

8 MR. BERLIN: Exactly, could have had two  
9 panels.

10 UNIDENTIFIED SPEAKER: We just found out on  
11 Friday, so...

12 MR. BERLIN: A somewhat more technical question  
13 for you, Roxane, and that is do you have a reaction or  
14 amplification on Bob Leibenluft's comment that the end  
15 result, where we came out, where the Division came out  
16 in the Washington State business review letter is  
17 inconsistent with some of the other opinions that have  
18 been issued regarding the messenger or messenger  
19 model's ability to negotiate? I think in particular  
20 you pointed to the opt-in and opt-out starting price  
21 point.

22 MS. BUSEY: Bob, do you want to restate what  
23 you said?

24 MR. LEIBENLUFT: Well, I don't want to

1       which as I understand it drive where the Division are  
2       on opt-in and opt-out on messenger models would seem to  
3       also caution about approving something where you'd  
4       basically be allowing physicians to collectively  
5       disseminate information about an average amount that  
6       they've been accepting. It's not exactly analogous,  
7       but it struck me as there's some tension there about  
8       being concerned about it in one respect and not on the  
9       other.

10               MS. BUSEY: But your focus was on the average,  
11       is that what your concern was?

12               MR. LEIBENLUFT: The focus being on letting a  
13       number being out there about what physicians are  
14       willing to accept, and that's the average.

15               MS. BUSEY: That's the average.

16               MR. LEIBENLUFT: So, for a particular payer.

17               MS. BUSEY: Okay, my reaction to that is I  
18       think that the average is probably consistent with the  
19       policy statements, but I do think historically a range  
20       was viewed as a more procompetitive indicator. Average  
21       tends to suggest a price point, and so if you leave an  
22       average price out there, there might be more likelihood  
23       of collusion around that price point.

24               The same thing with a messenger. I mean, it  
25       seems to me -- I mean, again, I'm not sure we're going



1 with the messenger. A messenger who gives a range  
 2 either to a payer or to, you know, aggregated  
 3 physicians that are in the group seems to be triggering  
 4 less of a concern than an average, but that's -- and  
 5 it's actually -- you know, that's kind of an old --  
 6 an old view, and I don't really -- I mean, I think it  
 7 makes some sense.

8 I've also seen it done with a high, low and an  
 9 average, which is interesting because even though it  
 10 gives you the same price point as the average, and  
 11 maybe that's useful information, it also gives you the  
 12 range. So, maybe the best thing to do is that kind of  
 13 -- I'm not an economist, so I think an economist might  
 14 be able to comment on this more than I could.

15 MR. BERLIN: Any comments or questions?

16 MS. BOORSTEIN: Are there any questions you  
 17 want to ask or --

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 2 opportunity ful 14est Are could.

21 15 MR. BERWeeapprnkiaggeit.ERLIN:o eould.

2 Any comments or que by ther kis yopanelecoestRLIN:ould.

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24 15 Okay.ERWellu kne I twannnouf any combefthiswyou the

ERWaldorf, Marylragnd an

1 morning at 9:15 for the physician IPAs, patterns and  
2 benefits of integration session, and two, somebody's  
3 keys were found in the lobby. So, if these look like  
4 your keys, if you don't have them, then --

5 MS. BOORSTEIN: That's the Washington --

6 MR. BERLIN: There's AMA on it, so there you  
7 go.

8 UNIDENTIFIED SPEAKER: They're mine.

9 MR. BERLIN: Okay, there you go. So, we thank  
10 our panelists very much and thank our audience.

11 (Whereupon, at 4:20 p.m., the hearing was  
12 adjourned.)

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

2 DOCKET/FILE NUMBER: P022106

3 CASE TITLE: HEALTH CARE WORKSHOP

4 DATE: SEPTEMBER 24, 2003

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10 knowledge and belief.

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