

FEDERAL TRADE COMMISSION

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JOINT FTC/DOJ HEARINGS ON HEALTH CARE AND  
COMPETITION LAW AND POLICY

Friday, September 26, 2003

9:17 a.m.

Federal Trade Commission  
601 New Jersey Avenue, N.W.  
First Floor Conference Room  
Washington, D.C.

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

FEDERAL TRADE COMMISSION

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1 and, following our general practice of a very short  
2 introductions to give people more time for their remarks  
3 and for a moderated discussion afterwards, I will just  
4 briefly introduce the entire panel in the order in which  
5 they'll be speaking. You're free to either use the  
6 podium or stay at your seat, depending upon your  
7 preference. We're all about maximizing individual  
8 preferences here in ways large and small.

9 Our first speaker is Professor Carl Ameringer,  
10 who is at the University of Wisconsin-Oshkosh, and has  
11 had a legal career that has taken him from the Maryland  
12 Attorney General's Office working at the Department of  
13 Health and Mental Hygiene to academics.

14 Seated immediately to his left is Dr. Michael  
15 Connair, who is an orthopedic surgeon, a clinical  
16 instructor at a number of hospitals, including Yale-New  
17 Haven, and he's testified in the past on the subject  
18 we'll be considering this morning.

19 Mark Flaherty is a lawyer specializing in a range of  
20 labor and employment law matters.

21 Mark Levy, seated to Steve's left, is the  
22 Executive Director of the Committee of Interns and  
23 Residents. Their, I think, most recent initiative has  
24 been, certainly not recent, but ongoing initiative, is  
25 advocating shorter hours for medical care providers in

1 training.

2 Then, finally, Professor Bill Brewbaker, making  
3 a repeat appearance. He spoke at our very first  
4 workshop, essentially a year ago, although over in a  
5 different building. He's a law professor at the  
6 University of Alabama who has written a number of  
7 articles on health care regulation and liability, and has  
8 most saliently, for our discussion this morning, has an  
9 article in the Journal of Health Politics Policy in Law  
10 on trying to sort out the likely impact of physician  
11 unionization on the performance of the health care  
12 market.

13 There's a much more extensive bio of each of  
14 the speakers and of everyone else who is speaking during  
15 this week and next week's sessions. We could spend all  
16 of our time going through their distinguished  
17 biographies, but you didn't come to hear about them; you  
18 came to hear from them.

19 So, without further ado, Professor Ameringer.

20 If the panel wants to go out and watch the  
21 Power Point and then come back when they want to talk,  
22 that actually will probably make it a lot easier than  
23 trying to turn around look, unless you want to give Dr.  
24 Connair business in his capacity as an orthopedic  
25 surgeon.

1                   **STATEMENT OF PROFESSOR CARL AMERINGER**

2                   PROFESSOR AMERINGER: Good morning. My name is  
3 Carl Ameringer. I'm a Professor of Political Science. I  
4 very much appreciate the opportunity to be here and to  
5 hopefully provide a different perspective, that is a  
6 perspective of a political scientist, which will guide my  
7 analysis. As a political scientist, I am most interested  
8 in the context for union formation and the power dynamics  
9 between unions and organized medicine, which is why I've  
10 entitled this Physicians Unions and Organized Medicine.

11                   The first thing, just to give a brief  
12 literature review, indicated up there, the book by  
13 Budrys, which is the one that is perhaps most widely read  
14 and recognized in this area, Budrys is a sociologist, as  
15 is Elliot Freidson. Freidson has a more recent book. As  
16 many of you know, he published many of his books and  
17 articles in the area of professionalism and physicians  
18 quite a few years ago. This most recent book is a very  
19 interesting analysis, "Professionalism, the Third Logic."  
20 I highly recommend it.

21                   Third is Havighurst, of course, who has written  
22 a great deal in this area, coming from the law and  
23 economics perspective, writing on professional  
24 restraints, on innovation, health care financing. Then,  
25 I don't know that I belong in this esteemed company, but,

1           nevertheless, here's my article from the Journal of  
2           Health Politics, Policy and Law, where I recently delved  
3           into the topic, particularly considering the legislative  
4           efforts back in the early 1980s and then more recently  
5           with the Campbell Bill, in an attempt to analyze those  
6           two legislative efforts with such a large piece of time  
7           separating them.

8                         These are the questions that I want to address,  
9           the ones that I want to talk about here, with respect to  
10          physicians unions. First is, what explains their  
11          appearance. Second is, what have been the barriers to  
12          their success. Third, what does the future hold.  
13          Obviously, there are a lot of other questions which I'd  
14          like to talk about in the session which follows this, but  
15          these are the three main ones that I chose for this  
16          particular presentation.

17                        Okay, first of all, what explains their  
18          appearance. Well, the most common explanation is the  
19          economic, social, and organizational disruptions of a  
20          post-industrial society. That would be characterized by  
21          a shift from a manufacturing to a service economy with  
22          large units of production.

23                        Here we're talking about health care produced  
24          by organizations rather than individuals, technological  
25          innovation, division of labor, and vigorous competition

1 and profitability. This is coupled with an ideological  
2 shift, particularly at the federal level during the  
3 1970s, from regulation to deregulation and the perceived  
4 failure, the perceived failure on the part of many  
5 physicians of organized medicine to respond adequately to  
6 the situation.

7 Now, Budrys says that there are three ways.  
8 The first two can kind of be grouped separately from the  
9 last one: early 1970s, which is a response to government  
10 legislation, Medicare, Medicaid; expanding access to  
11 care; and subsequent efforts at cost containment. Of the  
12 26 physicians unions that organized during the 1970s,  
13 only two survive today.

14 Then she talks about this period from 1983 to  
15 1984 which she calls a response to the perceived crisis  
16 in medical malpractice. Of course, we're going through  
17 that to some extent again.

18 Budrys says that these two efforts at  
19 unionization, they failed to last and were, essentially,  
20 physicians letting off steam. The current way, she says,  
21 is more lasting. She characterizes it as a response to  
22 managed care, a response to managed care. With the  
23 introduction of for-profit medicine, it would more  
24 closely, then, resemble the labor management scenario.

25 I'm very interested in focusing on the



1 perceived failure of organized medicine and the typical  
2 complaints. Now, when I talk about organized medicine,  
3 I'm referring to the American Medical Association and the  
4 Component Medical Society, the state and local medical  
5 societies. So, I want to make that clear.

6 First is a conservative hierarchy, which is  
7 primarily concerned with protecting the status quo;  
8 cumbersome procedures and committee structure, a  
9 gentleman's debating society if you will, making it  
10 difficult to take quick and decisive action; and third is  
11 that professional associations, the complaint has been,  
12 were not structured for collective bargaining, that there  
13 are other goals and missions, of course, such as  
14 scientific research and patient welfare.

15 I like to look at these things from a political  
16 scientist's and a historian's perspective; that is, to  
17 examine it in a broader context. So, when we're talking  
18 about the perceived failure of organized medicine, I  
19 think it's important to point out that collective  
20 bargaining, or collective negotiation would perhaps be a  
21 better word, did not originate with unions. There are a  
22 host of historical accounts.

23 Havighurst has written extensively on this, and  
24 he would argue that collective negotiations have been  
25 taking place since insurance companies began acting in

1 the health care field. Havighurst says that the  
2 underlying reasons why negotiations between insurers and  
3 professional organizations have occurred is the implicit  
4 threat of boycott or related difficulty facing any plan  
5 that departed from accepted practice without first  
6 securing professional approval.

7 More on the broader context, the appearance of  
8 physician unions in the early 1970s was contemporaneous  
9 with the appearance of foundations for medical care, or  
10 FMCs. Now, why is that important? It's important  
11 because organized medicine did respond, but they  
12 responded in a different way.

13 FMCs, of course, were the forerunners to IPAs,  
14 and they were sponsored by state and local medical  
15 societies. Their essential purpose was to protect fee-  
16 for-service medicine, consistent with the notion of  
17 pluralism, I might add, and to deter HMOs from getting  
18 the foothold in certain regions of the country. The  
19 Kaiser-Permanente example, the San Joaquin Valley in  
20 California example that has been used, and the Oregon  
21 Medical Society case would be another example.

22 FMCs were more prevalent than physician unions.  
23 By one account, there were 112 FMCs in or near operation  
in 1972 with 87,664 participating physicians.

1 from a relatively small number of physicians who viewed  
2 them as bureaucratic and a threat to traditional medical  
3 ethics. In other words, FMCs were joining the enemy.  
4 This group of physicians who were opposed included  
5 unionized physicians.

6 So, it's not surprising, then, that among the  
7 barriers to union formation was organized medicine  
8 itself, which saw unions as a threat to professional  
9 unity, meaning professional turf, and as antithetical to  
10 professional values of individualism and autonomy. This  
11 does seem somewhat ironic considering that organized  
12 medicine's history of collective action, as was  
13 previously mentioned.

14 The AMA's formal pronouncement against  
15 physician unions occurred in 1973 and was repeated on  
16 several occasions until it apparently reversed course in  
17 1999. This is itself a subject of some dispute.

18 A second barrier to union formation is

1 consistently opposed to union formation, which instills a  
2 socialization process, of course, instills a high degree  
3 of individualism and autonomy that views union  
4 involvement as undignified.

5           According to Budrys, the identity long  
6 associated with American unions, which is grounded in  
7 industrial unionism, organizing by firm, calling for a  
8 working class solidarity and restricting individual





1 favorable and unfavorable to physicians unions. The  
2 first being weaker resistance from organized medicine.  
3 Organized medicine, that is the AMA in this particular  
4 instance, has essentially gone into the union business  
5 with the formation of PRN, Physicians for Responsible  
6 Negotiations, which it won't call a union. This tends to  
7 undercut previous arguments opposing union formation  
8 based on notions of professionalism.

9 In addition, I know it's a bit early, but PRN  
10 has had a bit of a bumpy road. The AMA Board of Trustees  
11 cut its funding in the wake of the Kentucky River  
12 decision. It's since been restored, but PRN has a  
13 relatively small number of sustaining members, 200 by  
14 last count.

15 Another reason why organized medicine is not as  
16 opposed as it once was is that membership in the AMA as a  
17 percentage share of physician population continues to  
18 decline. It stood at about 60 percent when unions first  
19 started to appear in the 1970s, and today it stands at  
20 about 25 percent. It's trying to attract young  
21 physicians, many of whom favor unions or have been  
22 involved or were very much involved in pressuring the AMA  
23 to go that direction.

24 A second observation is that professional norms  
25 and values have been slowly adjusting to the corporate

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1                   My second unfavorable concern the trend toward  
 2 self-funded employers who have also been increasing and  
 3 the potential for direct contracting which can place  
 4 integrated physicians networks in direct bargaining  
 5 relationships with employers.

6                   The third is the flip side of the coin from the

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1 the Federation of Physicians and Dentists and the  
2 National Union of Hospital and Health Care Employees,  
3 both affiliates of AFSCME and the AFL-CIO.

4 You might ask how did a surgeon from a  
5 Republican family end up organizing other Republican  
6 physicians into labor unions. Let me tell you about two  
7 of the defining events of my professional life. The  
8 first was being extorted by Blue Cross of Connecticut,  
9 the major commercial insurer. They're now called Anthem  
10 Blue Cross. The second was being subpoenaed and deposed  
11 and possibly having my phones tapped by the Department of  
12 Justice for helping to organize a labor union of  
13 orthopedic surgeons in Delaware.

14 Let me tell you about the first of the two  
15 events. A very nice lady from Blue Cross came to my  
16 office, Blue Cross had been my indemnity insurer about  
17 six or seven years ago for the most part, and she said  
18 our future relationship with you will be by contract.  
19 We'd like you to sign this contract. You have no  
20 opportunity to negotiate it. In fact, the same group of  
21 people threatened one of the hospitals with withdrawal of  
22 all Blue Cross patients if they didn't sign the contract.

23 The terms of the contract were not very  
24 generous. They gave the insurance company control over  
25 patient care, which they shouldn't have, and they paid

1       rather poorly for that time. I had no choice. I signed  
2       the contract so that I would not be excluded, as she  
3       threatened, from future products. Basically, if I didn't  
4       sign the contract, I would be out of business, since that  
5       represents more than 20 percent of the commercial  
6       business in Connecticut, much more.

7               Well, over the next two to three years, this  
8       company dropped the terms of reimbursement on several  
9       occasions at will -- the contract specifies that can be  
10      done -- repeatedly. Synchronously with others, Blue  
11      Cross is supposedly independent doing the same thing and  
12      in the same manner but at slightly different times.

13              I was very frustrated and angry. I called  
14      around to organized labor and I found the Federation of  
15      Physicians and Dentists, which was experimenting with the  
16      third party messengering system which had been described  
17      by the FTC.

18              As you may or may not know, the system allows  
19      each and every doc to have a representative who can  
20      analyze a contract for him, analyze the financial impact,  
21      and then pass information between the doc and the  
22      insurance company, make offers back and forth, analyze  
23      group data, publish it in the aggregate so that everybody  
24      knows what the insurer is paying in general.

25              The nice thing about this system, unlike some

1 of the other structures described by the DOJ and FTC, is  
2 that it doesn't limit the number of docs who can  
3 participate. So, potentially, every doc in the community  
4 can have the same basic information on how good or bad a  
5 contract is, what the insurers are paying in general and  
6 how the proposed fee schedule will compare with the other  
7 insurers. It gives docs more power than they have,  
8 certainly not nearly as much power as with true  
9 collective bargaining. But for private docs, it probably  
10 works better than anything else when the system is pushed  
11 to the limit.

12 We had some successes in Connecticut in dealing  
13 with one of the major insurers, so other groups of docs,  
14 especially orthopedists, around the country began  
15 imitating it. The doctors of Delaware were confronted by  
16 Blue Cross. The orthopedic surgeons were told we have to  
17 drop your fees, boys, by 20 percent in order to remain  
18 competitive. There was no chance to negotiate this.

19 One of my former residents was down there and  
20 several of us formed a labor union. Almost every single  
21 orthopedic surgeon in the State of Delaware joined the  
22 orthopedic union. Very strictly by third party  
23 messengering, each and every doc had his contract  
24 analyzed, had the fee structure analyzed and decided that  
25 he would not participate with the Blue Cross contract



1 with a system they consider profit oriented and not  
2 responsive to the needs of docs or certainly their  
3 patients. The physician walkouts in New Jersey and West  
4 Virginia were not just about soaring medical liability  
5 premiums.

6 One reason that doctors in more than 40 states  
7 are having difficulties paying their liability insurance  
8 and other office overhead now is that doctors cannot  
9 effectively negotiate with health care insurers that pay  
10 them for their services. The bargaining power of the  
11 single physician, even large, corporately related groups  
12 of physicians, is dwarfed by the bargaining power of the  
13 HMOs.

14 As a result, these insurers have been able to  
15 strong-arm physicians into signing one-sided contracts  
16 that give managed care insurers the legal right to deny  
17 care, compromise optimal care, and unfairly squeeze  
18 doctors financially. As their overhead goes up, rates  
19 continue to go down. Medicare, by the way, is one of the  
20 biggest offenders and some of the commercial insurers  
21 take their cue from Medicare.

22 Physicians don't have any choice. They have to

1 intransigent. Docs are leaving Philly because, in part,  
2 of this monopsony power. Blue Cross says if you don't  
3 want the contract, you know, go away, and you go out of  
4 business. More than 1,000 docs have left the Philly area  
5 because of the high malpractice and the failure of the  
6 monopsony to yield. It can get away with it, and it  
7 does.

8 If docs don't sign the contracts, they run the  
9 risk of losing a large block of their patients, in some  
10 areas almost all of their patients, and perhaps going out  
11 of business. Doctors as well as patients are harmed.  
12 It's not just squeezing docs; it is the contractual terms  
13 which harm patient care.

14 Some of the more egregious issues in the  
15 contracts is that docs are powerless. Right now there  
16 are contracts that discourage primary care docs from  
17 referring to specialists, bureaucratic barriers that  
18 prevent timely and proper care, forcing patients to  
19 change docs or hospitals because of contractual term  
20 manipulation by the HMOs, capitation schemes that  
21 actually pay docs not to care for patients, they earn  
22 more if they don't see the patients, contracts that allow  
23 doctors to be fired or de-selected, as it's  
24 euphemistically called, without cause, forcing their  
25 patients to go to someone else who they don't want to go



1 to, and contracts that unilaterally can be changed at  
2 whim.

3 Now, there's a clause unfortunately in these  
4 contracts that we're forced to sign that says the  
5 contract can be changed at any time by the insurers,  
6 which is astounding. When docs get paid less per  
7 patient, they see more. They spend less time per patient  
8 in the office, which increases the chances of errors  
9 occurring, especially errors of omission.

10 The antitrust laws were written to prevent  
11 large companies from putting small companies out of  
12 business with unfair business practices and from hurting  
13 consumers with high pricing. Ironically, those laws are  
14 now being used and enforced by the DOJ and FTC to prevent  
15 physicians from effectively bargaining for their patients  
16 and for their own financial survival.

17 Public policy over the past three decades has  
18 encouraged the existence of managed care as a solution to  
19 ever-rising costs. The ERISA laws have immunized  
20 insurers from suit, and the vigorous antitrust  
21 enforcement laws have nurtured managed care, which seemed  
22 to be a good idea initially.

23 I had the opportunity to testify for  
24 Representative Campbell in the House Judiciary hearings  
25 for true collective bargaining rights. These would allow

1 health care providers to participate in contract  
2 negotiations that are real negotiations and not simply  
3 acceptance of a take-it-or-leave-it contract imposed by a  
4 cost- and profit-conscious HMO.

5 The medical liability reform, if and when it  
6 ever comes, won't prevent docs from going out of  
7 business. Doctors need to recover all of their overhead  
8 costs routinely, automatically, without having to  
9 struggle and without having to go to some legislature for  
10 relief. If they don't, they go out of business. And the  
11 care, each doc typically takes care of several thousand  
12 patients. Every lost doc is a significant loss to the  
13 community.

14 What a shame to lose even one physician, now  
15 that the cost of four years of medical school is  
16 approaching \$200,000 and exceeds \$200,000 at Georgetown.  
17 It takes seven to ten years to train a doc and they're  
18 leaving in frustration. Some of the most experienced  
19 docs who have the most to offer patients and medical  
20 students are leaving. Public policy should focus on ways  
21 to retain every single physician as the population ages  
22 and as the demands for medical services increases.

23 John Sherman certainly did not envision his  
24 1890 antitrust legislation being used by huge companies,  
25 like the HMOs, to impede patient access to medical care.



1 fear of liability passing on to the AMA, which has deeper  
2 pockets than these little unions. Until the matter was  
3 resolved by consent decree, the AMA was terrified of even  
4 dealing with the unions.

5 Certainly, there's some ossification which is  
6 gradually melting away in the upper echelons of the AMA,  
7 but fear that DOJ and FTC enforcement policies by docs in  
8 the AMA has given the HMOs free reign.

9 Thank you.

10 (Applause)

11 MR. HYMAN: Thank you, Michael.

12 Mark.

13 **STATEMENT BY MARK FLAHERTY**

14 MR. FLAHERTY: First, let me say I'm pleased to  
15 be here, pleased to have been invited, and particularly  
16 pleased to be in the company of Mark Levy and Dr.  
17 Connair, both of whom have done so much for physician  
18 collective bargaining in this country.

19 I'm a labor lawyer. I have been in practice  
20 for more than 25 years. The first 19 of those were on  
21 the management side exclusively. I think that provides a  
22 rather unique perspective to the discussion here today,  
23 not just on the management side but on the management  
24 side in health care where I've represented a number of  
25 large and national clients in the health care industry,

1 including hospitals, HMOs, nursing homes, emergency  
2 medicine, ambulance services throughout the United States  
3 in their collective bargaining.

4 I was not a union buster. I definitely  
5 wouldn't be sitting here if I were that. I was typically  
6 the lead negotiator for large national health care  
7 companies who had a mature and productive collective  
8 bargaining relationship with the labor organizations who  
9 represented their employees and who wanted to maintain  
10 that productive working relationship by reaching  
11 collective agreements with the representatives of their  
12 employees.

13 My practice changed in early 1998 when I was  
14 hired as national labor counsel for the American Medical  
15 Association and requested to advise the AMA on the  
16 possible formation of an AMA-affiliated labor  
17 organization dedicated to representing physicians in  
18 collective bargaining with employers and others as  
19 permitted by law.

20 The impetus for that effort were requests from  
21 the AMAs resident and fellow section, who accurately  
22 anticipated that the NLRB would eventually permit  
23 residents and fellows to collectively bargain with the  
24 teaching hospitals that employ them. The support also  
25 came from the self-employed physicians who hoped for some

1 help in negotiating with payers.

2 After substantial wrangling, some of which has  
3 been referenced here today, between the AMAs Board of  
4 Trustees and its, decidedly, more interested House of  
5 Delegates, the effort to form a labor organization was  
6 approved and funded in the summer of 1999.

7 Immediately thereafter, a labor organization  
8 named Physicians for Responsible Negotiation -- you've  
9 seen it and heard it referenced here already today as PRN  
10 -- was formed and I became the general counsel to that  
11 organization. I continue to serve in that capacity. In  
12 addition, I represent, either through PRN or directly, a  
13 number of physician organizations in the United States,  
14 including IPAs and faculty practice groups. That's my  
15 background.

16 Before I opine on the two specific questions  
17 that I understood we were to address today, I want to  
18 provide a little sketch of the legal landscape in which  
19 we operate. Perhaps when we move into the question and  
20 answer section, that will be helpful to all of us, at  
21 least I hope it will be. Before this session is over  
22 today, someone is bound to ask me if something is legal  
23 or not, and I just feel compelled to sketch the rather  
24 complex legal situation that confronts us here.

25 The laws that regulate physician collective

1 bargaining divide physicians into two major groups, the  
2 employed physicians and self-employed physicians. The  
3 overwhelming block of the laws that regulate physician  
4 collective bargaining regulate the first group, employed  
5 physicians, in simple terms, those who get a paycheck  
6 from an employer. Some of you will be surprised to learn  
7 that we have 52 different sets of laws that regulate  
8 collective bargaining by employed physicians, and each of  
9 the 52 sets is different.

10 The first set of laws is under the National  
11 Labor Relations Act. That law regulates collective  
12 bargaining of physicians employed in the private sector.  
13 Typical physician employers in the private sector are  
14 hospitals and bricks and mortar HMOs.

15 The second set of laws that regulate collective  
16 bargaining of physicians are those that regulate those  
17 employed by the United States Government. This includes  
18 the Veterans Administration, the Public Health Service  
19 and the Bureau of Prisons. Then we have the 50 sets of  
20 states laws that regulate the collective bargaining of  
21 physicians who are employed by the 50 states and their  
22 mini-political subdivisions. Typical employees in the  
23 state public sector are state hospitals, including state  
24 university teaching hospitals that employee residents and  
25 fellows, state mental hospitals, and city and county

1 health services. That's the landscape for regulation of  
2 collective bargaining by employed physicians.

3 With respect to the self-employed, their  
4 regulation is provided by this agency, the Federal Trade  
5 Commission. In certain states, particularly Texas and  
6 New Jersey, the regulation is provided by the state  
7 attorney generals in those two states.

8 Within this self-employed group, which even  
9 today is approximately one-half of the actual practicing  
10 physicians in the United States, there's still two major  
11 groups, those who have joined together with other  
12 physicians in a jointly-owned group practice that shares  
13 financial risks among the owners. The second group of  
14 self-employed are those physicians or groups of  
15 physicians who are financially and clinically independent  
16 but who have associated themselves together for group  
17 credentialing, group purchasing or some other related  
18 purpose.

19 The former group, those commonly-owned  
20 physician group practices, are generally permitted to  
21 negotiate with payers and others as a group, that is, as  
22 the group practice, while the latter, those who are  
23 independent, not financially or clinically integrated,  
24 are not, except under the limited exceptions presented in  
25 Texas and New Jersey, not permitted to collectively



1 negotiate with payers.

2 With this somewhat lengthy background, which I  
3 hope will be a benefit to all of you as we proceed, I'm  
4 going to address the specific questions that were  
5 addressed, at least to me, and I believe to the other  
6 speakers. The first question is, what is known about the  
7 effects of unionization, if any, on the cost, quality and  
8 availability of health care to consumers.

9 Let's start by taking the words effective  
10 unionization out of that question and ask it again. What  
11 is known about the cost, quality and availability of  
12 health care to consumers generally? We know a lot about  
13 cost, particularly about cost of health care for patients  
14 covered by Medicare and Medicaid programs.

15 We know a lot about how physicians are  
16 distributed throughout the United States and which  
17 geographic areas are overserved and which are  
18 underserved. With respect to quality of care, we  
19 certainly have gross indicators, largely in the form of  
20 comparisons with other industrialized nations. But  
21 currently, and particularly from non-hospital-based  
22 physician care, there is, in my view, little hard  
23 scientific evidence concerning the quality of care  
24 available to U.S. consumers.

25 I note that the Center for Medicare and

1 Medicaid Services is making a commendable effort to  
2 correct this lack of data, particularly in the ambulatory  
3 care setting with respect to the Medicare and Medicaid  
4 programs. But their data is generally not yet widely  
5 aggregated or available.

6 Now, let's go back and ask the original  
7 question: What is currently known about the effect of  
8 unionization, if any, on the cost, quality and  
9 availability of health care to consumers. Number one, to  
10 my knowledge, there is no scientific evidence either way  
11 on the effect of unionization with respect to the cost,  
12 quality or availability of health care for consumers.

13 I think that we can say with great confidence,  
14 particularly the Committee of Interns and Residents and  
15 Others, efforts to improve excessive work hours for  
16 resident physicians has, in a practical matter, even if  
17 not yet scientifically measured, improved the quality of  
18 medicine practiced in teaching hospitals throughout the  
19 United States. Being as candid as I can, I believe that  
20 little else either way can be said on this point.

21 Now, the second question: Does collective  
22 negotiation focus on enhanced quality, higher salaries  
23 for prices for the services that are being provided, or  
24 both? Based upon my personal experience representing  
25 physician groups and collective bargaining under the NLRA

1 and otherwise, the answer is both.

2 In my first NLRA negotiations on behalf of  
3 physicians, the first proposal made to the employer and  
4 the bulk of the negotiations were over quality of care  
5 issues; that is, the recognition of the parties of  
6 patients' rights in the collective bargaining agreement,  
7 the right of the physicians to make all decisions related  
8 to the practice of medicine, and the participation of  
9 physicians in all decisions related to health care where  
10 the primary issues were collective bargaining.

11 There was also bargaining over due process for  
12 physician discipline and discharge. There was no effort  
13 made by the physicians to increase their physician  
14 compensation or benefits. In the context of non-NLRA  
15 bargaining, and particularly with respect to faculty  
16 practice groups, the issues are similar.

17 When economic issues arise in that context, it  
18 is typically in the area of physician participation or at  
19 least access to information concerning the billing and  
20 collection practices of the faculty practice group or the  
21 sponsoring academic institution.

22 Those are my answers to the two questions  
23 posed, and I will reserve my other comments for the  
24 question and answer session.

25 Thank you.

1 (Applause)

2 MR. HYMAN: Mark, do you want to sit or stand?

3 MR. LEVY: I'll sit.

4 **STATEMENT OF MARK LEVY**

5 MR. LEVY: I knew a long time ago I should have  
6 written a response to the Budrys book. It's flawed in a  
7 number of ways. It looks mainly at one union. One of  
8 the ways that it is incorrect is that it says that there  
9 were only two unions that survived, and that's just not  
10 true. Budrys, in fact, announced the death of my union  
11 in that book, and we weren't dead, far from it. There  
12 were other unions also.

13 But anyhow, thank you for inviting me here this  
14 morning. My name is Mark Levy. I think I'm the one on  
15 this panel who has on the union side the most traditional  
union experience. I'm happy to talk from that

1 in large, multi-title, generally public sector units.  
2 That would mean that about 15,000 out of 100,000 interns  
3 and residents are currently covered by collective  
4 bargaining contracts.

5 Just in case anyone is not familiar with these  
6 terms, let me just give a few definitions. Interns and  
7 residents have finished medical school, have completed  
8 their MD or DO degrees. They are addressed as doctor.  
9 They give critical care. Hospitals are reimbursed for  
10 their services. They are in apprenticeship-like training  
11 for specialty and subspecialty certification.

12 I use the term attending to describe those  
13 licensed doctors who practice outside of residency  
14 generally in hospitals but in a range of clinical  
15 situations. For the most part, attending physicians are  
16 board eligible or board certified in a specialty.

17 CIR has been a national affiliate of SEIU for  
18 probably six years now. We work closely with Doctor's  
19 Council, our sister, doctors, local and SEIU. Doctor's  
20 Council represents post-residency salaried attendings,  
21 where CIR represents the residents.

22 CIR and Doctor's Council were both originally  
23 founded back in the 1950s. Doctor unionism didn't start  
24 in the 70s. It actually didn't start in the 50s. If you  
25 look closely, there are other events before. But CIR and

1 Doctor's Council have been around since the 50s.

2 Each of us has been growing the past number of  
3 years. Both of us regularly receive phone calls from  
4 frustrated and upset doctors who want to join a union.  
5 I've been at CIR for over 20 years. I've seen many  
6 health care changes dramatically and generally adversely  
7 impact on both residents and attendings.

8 A number of things that I'm going to say have  
9 already been said, but let me say them fairly quickly so  
10 that more of the discussion can be had later.

11 Let me start by saying the world is full of  
12 doomsayers. Every time I've been involved in an  
13 organizing campaign, I've heard the employers say, oh,  
14 my, if the doctors unionize, it will shut the hospital.  
15 When the NLRB said a few years ago that residents had  
16 rights as employees, hospitals opposed that decision and  
17 said that it would end medicine as we knew it.

18 When residents and medical students went to  
19 OSHA, then Congress last year to seek legislation for  
20 rational work hour limits, we said that regularly working  
21 80, 100, 120 hours was bad medicine. The doomsayers  
22 again predicted catastrophe if hours limits with  
23 governmental enforcement would become law.

24 None of those predictions came true. I know of  
25 nowhere that collective bargaining, either by residents

1 or attendings, closed the hospital. Residency programs  
2 did not collapse when residents achieved collective  
3 bargaining rights under the NLRB. State hours  
4 regulations have existed in New York State for a number  
5 of years and did not lead to any of the predicted  
6 catastrophes.

7 But the doomsayers who opposed those changes  
8 that we sought, in fact, went right ahead and instituted  
9 all sorts of their own kinds of changes. Managed care  
10 and other industry changes have led to a dramatic speed  
11 up, to borrow a term from industry. There are more  
12 admissions and discharges for each doctor to handle as  
13 the length of stay in hospitals decrease. There's  
14 dramatically more paperwork to fill out as insurance  
15 forms and regulations proliferate.

16 Acuity is greater and treatment is more  
17 complicated as the growing number of uninsured delay  
18 their coming for care. Work is more intense for doctors  
19 every second a patient is in a hospital these days, as  
20 new technology and new treatment options expand.

21 Salaried attendings worked under productivity  
22 schemes that force them to cut corners. They shorten  
23 their time with each patient. Surveys of CIR members  
24 also indicate that attendings are spending less and less  
25 time with residents. Residents are made to work much

1 more on their own time. As nurses, transporters,  
2 translators and other staff are laid off, or otherwise in  
3 short supply, like nurses and pharmacists, somebody has  
4 to do their work. It gets passed, then, to the already  
5 harassed and overworked interns and residents.

6 Compassion and creativity are often squeezed  
7 and seldom awarded in the current system. Let me use  
8 some 2000 data I found from a large teaching hospital in  
9 New York. The numbers are three years old, but they  
10 still paint a vivid picture. The CEO proudly said, we  
11 have driven our outpatient activity from 875,000 visits  
12 in 1993 to 1.7 in 2,000. That's an increase of 100  
13 percent or a doubling of outpatient visits.

14 He goes on. Our hospital admissions have gone  
15 from just under 40,000 in 1990 to more than 50,000 in the  
16 year 2000. That's an increase of 25 percent. This  
17 enormous growth, he says, in inpatient activity was made  
18 possible by a concomitant reduction in our inpatient  
19 length of stay. During this period of time when overall  
20 clinical activity increased, he says, the work force  
21 declined by 4.5 percent. This is the trend in lots of  
22 hospitals these days. Fewer people are now having to do  
23 much more work.

24 On top of this industrial-like speed up, many  
25 hospitals are also lessening employee benefits and



1           introducing all sorts of cost cutting schemes. In a  
2           factory, you would expect workers on a sped up assembly  
3           line to react under similar conditions. They would be  
4           objecting to the wear and tear on their bodies, to the  
5           dangerous situations they work under, and to the  
6           degradation of their product.

7                        CIR and Doctor's Councils are unions of highly  
8           skilled professional employees. We negotiate on wages,  
9           benefits, due process and all the other traditional  
10          issues generally concerning U.S. workers. We also  
11          advocate around quality concerns related to patient care,  
12          staffing and professional development.

13                       The union provides a structured format through  
14          negotiations or through labor management meetings for

1       you as a student and deny you union membership and the  
2       right of collective bargaining. If you later work as a  
3       salaried attending, employers want to classify you as a  
4       supervisor or manager and deny you union membership and  
5       the right of collective bargaining. If you work fee-for-  
6       service or in some other form of group practice, you're  
7       classified as an independent contractor and denied union  
8       membership and the right to collective bargaining.

9                If doctors want a change of conditions they  
10       work under, the society tells them to go join your  
11       medical or professional society. But in those  
12       organizations, doctor workers, if I can use that term,  
13       and doctor CEOs are lumped together. Those organizations  
14       are thus prevented from doing collective bargaining for  
15       their members.

16               All these legal fictions drive me a little  
17       crazy. Somebody out there in the real world is doing  
18       doctor work, taking care of sick people. Even for  
19       collective bargaining purposes, most of them are labeled  
20       student, manager, supervisor or independent contractors.  
21       It makes me want to shout sometimes, will the real doctor  
22       please stand up.

23               On a parallel issue, as others have mentioned  
24       here, to use another term from industry, not only is the  
25       uneven playing field dramatically tilted to favor

1 employers and insurance companies, one side isn't even  
2 allowed to form a team if all those definitions are  
3 applied.

4 In your invitation to me today, you asked a  
5 couple questions that have been addressed by other  
6 people, but let me take a look at one thing from another  
7 point of view. I think I'll answer those questions.

8 Doctors no longer provide care within the old  
9 constricts of some ancient or imagined cottage industry  
10 that once was medicine. Like the craft workers after the  
11 Middle Ages, doctors have been gathered together into a  
12 building that they don't own. They use expensive tools  
13 and equipment that they don't own. They work in  
14 conditions that they have less and less control over.  
15 Times and conditions have changed. Crafts became  
16 industries. Guilds became unions.

17 In the real world of the 21st century, hospital  
18 systems, insurance companies, group purchasing companies,  
19 pharmaceutical corporations, government programs, and all  
20 the rest so dominate the working conditions of doctors  
21 that it's both unfair and unreasonable to not allow hard  
22 working doctors to move forward to have a better balanced  
23 playing field.

24 I'll skip some pieces on general ideas about  
25 care. I know two things from sitting at the table with

1 employers. Internists and residents and salaried  
2 attendings pay in benefits relatively small factors in  
3 the overall budget of the institution, which also  
4 includes big items like advertising, capital  
5 construction, debt interest, administration, and  
6 executive compensation.

7 I also know, and we have to remember this on  
8 all levels, that whatever is eventually settled is a  
9 product of discussion and compromise and must be mutually  
10 agreed upon by both sides.

11 Like Mark Flaherty, if you asked me: Do  
12 negotiations focus on quality or compensation or both?  
13 The answer clearly and accurately is both. Each is truly  
14 a struggle. Employers generally want to give less pay  
15 and fewer benefits. Employees want better pay and  
16 improved benefits. Nothing is new or unusual here.

17 When we try to negotiate about the quality of  
18 care, administration screams, management writes and wants  
19 to avoid such discussions. But then, we generally waive  
20 those aside. We push beyond that first reaction and try  
21 to find real solutions to real problems.

22 I have a long list of examples of patient care  
23 issues we have fought for over the years and have  
24 actually won. They include funding for safety net  
25 hospitals, more nurse and other support staff, better

1 equipment, better access to patient information. In a  
2 number of our hospitals, residents have allocated a piece  
3 of their pay to purchase equipment for the hospitals.

4 The longest and bitterest and most important  
5 resident fight to improve quality care has been a  
6 struggle for shorter hours. Every advance on that level  
7 has followed something that CIR has done. The medical  
8 errors epidemic along with hospital infections, has been  
9 cited as the leading cause of death in the U.S. Those  
10 studies don't even count the near misses, errors actually  
11 made but caught by someone else. Exhaustion is a major  
12 cause of error. Our union has been leading and often  
13 only voiced to limit resident hours.

14 To me it makes good sense from a health care  
15 policy perspective to have an organized and independent  
16 countervailing voice of health professionals to balance  
17 the bottom line drive of the insurance companies,  
18 hospital chains, academic medical centers and the others.  
19 I would urge these agencies to review existing policies  
20 so that the definition of employee is broadened rather  
21 than narrowed. I think doctors should have rights to  
22 join.

23 In closing, let me ask, what are the fears,  
24 what are the objections to doctors forming unions? Some  
25 say that doctors make too much money so they shouldn't be

1 allowed to have unions. Airline pilots and many  
2 professional athletes earn more than most doctors and  
3 they can form unions.

4 Some say that doctors provide essential  
5 services and shouldn't be allowed to have a union.  
6 Police and fire fighters provide the essential services  
7 and they are allowed to join unions. Some say that  
8 doctors are independent contractors and shouldn't be  
9 allowed to join unions. A range of others from musicians  
10 and movie stars to electricians and carpenters are  
11 independent contractors in ways and they can join unions.

12 Some academics say that doctors shouldn't be  
13 allowed to join unions because doctors can't prove that  
14 doctor unions would guarantee the improvement of quality.  
15 Nurses, teachers, auto workers are not held to that  
16 standard and they are still allowed to join unions.

17 Some worry that doctors would be too powerful  
18 if they could join unions, but you have to look at the  
19 power on the other side of the hospital system, the  
20 chains, the insurance companies, academic medical  
21 centers. The business organizations are the really  
22 powerful ones.

23 Working docs have families to support. They  
24 have concerns about their own health insurance, benefits,  
25 and pay. They want to work in a safe workplace. They

1 want due process and fair treatment. They want an  
2 effective voice and protection to speak out without fear  
3 of retaliation about quality issues. If docs want  
4 pensions or parking spaces and have to fight for them  
5 alone, they're really up against an unfair system.  
6 Unions generally fight around those issues. In my  
7 experience, that's what doctor's unions do, too.

8 Thank you.

9 (Applause).

10 MR. HYMAN: Thank you.

11 Finally, Bill is going to speak. He has a  
12 Power Point presentation. After Bill is done, we'll take  
13 about a 10-minute break and the we'll come back and have  
14 a moderated discussion.

1 physician unions. That feature is this, that many  
2 proponents, and I would note with some approval this  
3 wasn't entirely the case this morning, but many  
4 proponents have argued for physician unions on the basis  
5 that physician unions would be good for patients and  
6 consumers and had been reluctant to talk about physician



1 physician unionization is likely to be.

2 Well, let's begin with efficiency, and let me  
3 define the term a little bit here. What I have in mind  
4 is economic efficiency. We count on markets in virtually  
5 all sectors of the economy to allocate resources to  
6 people who value them the most. One of the benefits of  
7 free markets is if I've got a limited amount of money to  
8 spend, I've got lots of choices out there. I've got  
9 people who are offering to fulfill my desires in those  
10 markets in various ways. As a consumer, I can go spend  
11 my money freely, according to my own judgment, about how  
12 these things work.

13 Now, the reason I want to begin with that is  
14 one of the main claims that's been made about physician  
15 unions is that they'd actually improve market efficiency.  
16 That we've got some problems with health care markets  
17 that relate to the fact that health plans are basically  
18 monopolists on the buyer's side of the equation in  
19 physician services markets. The fancy word for that is  
20 monopsony or monopsonist. A monopsonist is just someone  
21 who has monopoly power who happens to be a buyer of  
22 services rather than a seller.

23 Now, from an economic efficiency perspective,  
24 monopsony is a bad thing. Monopsony is bad because a  
25 monopsonist, that is a person who has market power, can

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1 what's actually going on in the market, taken by itself.  
2 There are three, at least, I suppose, potential causes  
3 for reductions in prices in any market. One is  
4 monopsony. So, it is certainly possible that when we  
5 observe a price decrease for inputs in any market, this  
6 would include physician services, that one of the things  
7 we're observing is the exercise of inappropriate market  
8 power by a buyer.

9           There are two other possibilities here, though.  
10 One is simply the introduction of competition into a  
11 market where no competition had existed before. To apply  
12 this directly to physician services markets, you might  
13 imagine 15 or 20 years ago a market where physicians were  
14 reimbursed on a usual, customary, reasonable fee schedule  
15 on an indemnity basis and largely they could name their  
16 own price.

17           Price competition enters that market and, not  
18 surprisingly, physician fees go down. That can happen  
19 without the presence of any particular market power in  
20 that market. It can just be a function of the  
21 introduction of price competition into the market through  
22 selective contracting.

23           Again, we could have a situation where we have  
24 excess capacity, excess physician supply in some markets  
25 where we have physicians who we might prefer working in

1 other geographic areas or in other specialties. The  
2 market sends a signal that there are not as many of a  
3 particular kind of provider or there are too many of a  
4 particular kind of provider in a community, and this  
5 happens in all sorts of other markets.

6 Inefficient providers are weeded out. That's  
7 very painful to the individual provider that has to move,  
8 very hard on the individual doctor, just as it is hard in  
9 other sectors of the economy, but we count on markets to  
10 deal with excess capacity problems. We count on markets  
11 to provide consumers low prices by price competition all  
12 over the U.S. economy.

13 So, we can't just assume that because prices  
14 have gone down, we've got a problem on our hands. We may  
15 find markets doing exactly what we want them to do. What  
16 we would need to observe in order to begin to suspect  
17 that monopsony is a problem is not only reduced prices  
18 but also reduced output in the market. Mark Pauley has  
19 made some suggestions about how we might measure that.

20 Let me just say, in the interest of time, there  
21 are going to be some things I'm not going to talk about  
22 that appear on these slides. We can get to them in the  
23 discussion if you want.

24 What about market share data? This is the  
25 second other source of evidence about health plan market



1 go to see my boss and demand a pay increase, and they  
2 sort of roll their eyes, appropriately, I suppose.

3 By the same token, the University of Alabama  
4 Law School is, as far as I know, the only employer of law  
5 professors in Tuscaloosa, Alabama. Does that make them a  
6 monopsony buyer of law professor services? No. Why not?  
7 Because academics know that the job market is sort of a  
8 nationwide enterprise. If my dean treated me bad enough,  
9 even though my folks live two hours down the road and I  
10 like Tuscaloosa a lot, and the football team is going to  
11 get better one of these years, I would consider going  
12 somewhere else if I had to.

13 So, this plays out in the subject at hand today  
14 in a couple of different directions. Number one, there's  
15 a tendency -- and you can see the first tick under the  
16 second box here, insurance markets versus physician  
17 services markets -- there is a tendency to equate market  
18 power in the insurance market with market power in the  
19 physician services market. Those actually are two  
20 distinct markets. While certainly there's a close  
21 connection between the two, that tends to overstate  
22 market power in the purchasing market.

23 Secondly, you often see statistics about market  
24 share that say X, Y, Z insurance company has a market  
25 share in a particular state of a certain amount. That is

1 an economically meaningless number in most cases because  
2 most physician services markets are local. They're not  
3 all entirely local, but mostly they are. Sometimes you  
4 see health care market data broken out in terms of HMO  
5 market, PPO market, and so on, as if HMO products, PPO  
6 products, POS products, employer direct contracting,  
7 etc., didn't have anything to do economically in terms of  
8 competing with each other. So, you just want to make  
9 sure as you evaluate these issues that the numbers you're  
10 dealing with are real numbers, that they're meaningful  
11 numbers.

12 With that said, I think it's fair to say that  
13 there's no strong evidence that health plan monopsony is  
14 a widespread problem. Am I claiming it doesn't exist  
15 anywhere, that it's not something we ought to worry  
16 about? No. But I don't think there's evidence to  
17 support the contention that we've got a pervasive problem  
18 with health plan monopsony in the United States. This is  
19 based on two sets of studies.

20 By the way, this is written up in an article in  
21 the Journal of Health Politics Policy and Law. It's the  
22 same issue with Carl's article if you got the cite from  
23 his presentation.

24 But these studies tend to neglect the output  
25 component, I mentioned before. The ones that tend to

1 show monopsony power, just assume that because we observe  
2 a reduction in price, that we therefore see monopsony  
3 power. The only study that I know of that's equated or  
4 measured both price and output simultaneously is a  
5 Feldman and Willey study from 2001. That study showed no  
6 evidence of monopsony power, at least in any strong sense  
7 across the board.

8 The AMA study of market share data is probably  
9 the one that's gotten the most attention. It was  
10 originally produced in 2001, revised last year. For the  
11 sake of argument, for the sake of argument, let's look at  
12 the data that they've generated on combined HMO/PPO  
13 markets in 70 MSAs.

14 Now, if we were to have a long discussion, I'd  
15 want to qualify this by saying that these figures  
16 overstate market power among the providers by suggesting  
17 that, again, traditional commercial insurance, direct  
18 employer contracting, Medicare money, and so on, has  
19 nothing to do with the power that health plans exert in  
20 markets.

21 But for the sake of argument, let's accept  
22 their data. In order to conclude that we've got a  
23 widespread problem with health plan monopsony, we've got  
24 to accept a 30 percent threshold, 30 percent market  
25 power threshold, as an indicator of when a health plan



1 can exercise monopoly power and create these sorts of bad  
2 efficiency effects that physician unions are said to be  
3 able to remedy.

4 That is, by all accounts, a very, very low  
5 threshold. And probably, the leading Section 2  
6 monopolization case, the Alcoa case, Judge Hand deals  
7 with this question about how much market power you have  
8 to have in order to demonstrate monopoly. He says 33  
9 percent, clearly not enough; 90 percent, clearly enough;  
10 50 percent, maybe sometimes.

11 Well, the courts are a little more liberal now  
12 than Judge Hand was, but suffice it to say that 30  
13 percent is the bare minimum, and courts are going to ask  
14 a whole lot of questions before they conclude that  
15 someone that's only serving 3 out of 10 folks in a market  
16 can dictate the terms on which that takes place.

17 So, again, I don't mean to suggest that there  
18 may not be monopsony power exercised in some insurance  
19 markets, but I do want to suggest that the idea that our  
20 health care system would be improved by exerting  
21 widespread countervailing economic power in the name not  
22 of fairness to physicians or distributional equity pay  
23 issues or compensation issues, but in the name of this  
24 would be better for health care consumers is just not  
25 supported by the evidence that we have about market

1 share. We can talk about switching costs in the  
2 discussion. That might be an interesting topic for us to  
3 have.

4 Now, are unions a good solution to the  
5 efficiency problem? Basically, the argument here is that  
6 what we can do with the physician union is we can move  
7 from a situation where we have a monopoly purchaser in  
8 the market, a monopsonist who is dealing with a  
9 competitive market on the seller side to a situation  
10 where we have bilateral monopoly. That is, a monopoly on  
11 both sides of the equation.

12 What economists will tell you, and I'm not one  
13 so I just have to rely on people that are and what I  
14 read, is that bilateral monopoly is not necessarily more  
15 efficient than monopsony is. It's conceivable in some  
16 circumstances that physician unions and health plan  
17 monopsonists might have a negotiation which is output  
18 increasing. They might agree to enlarge the pie and  
19 share more of it and so on.

20 We'd all hope that that were the case if we  
21 were to allow that to happen. But, in fact, it's just as  
22 likely that we would see an additional economic welfare  
23 loss from the addition of the second monopoly on the  
24 seller's side.

25 Certainly, bilateral monopoly is less efficient

1           than a competitive market. That suggests that what we

1 bad, maybe, as I think.

2 I do think that argument, though, is a problem  
3 if the point of the union is to actually serve as a  
4 countervailing economic weight. I used to represent  
5 hospitals and doctors, and anybody that spends much time  
6 doing that is sensitive to the competing incentives that  
7 different sorts of doctors have in different situations.  
8 Not to say there's nothing in common, but certainly it's  
9 not obvious that they all share the same incentives.

10 Okay, well, I'll move along quickly here.

11 The second question: "Will physician unions  
12 improve health system quality?" Again, two claims. One,  
13 market failures are basically permitting plans to provide  
14 lower quality than consumers would prefer, something  
15 that's very hard to measure. I don't think we have any  
16 data about this, but basically what's implicit in this  
17 argument is that physician unions will go in, they will  
18 assist consumers in rewriting their insurance contracts  
19 in ways that consumers will appreciate. They'll provide  
20 terms that consumers, if they were empowered, would have  
21 chosen for themselves. They're just not empowered, so  
22 what we need to do is let the doctors negotiate on behalf  
23 not only of themselves but, in essence, on behalf of  
24 consumers.

25 Here I think the question is, are physicians



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1           The difficult question, though, here has to do  
2 with not whether in the abstract consumers prefer, once  
3 they're insured, more care to less care but whether the  
4 places at which the quality cost tradeoffs would be made  
5 by doctors line up with the places where the quality cost  
6 tradeoffs would be made by consumers.

7           One issue, one place this comes out, and we  
8 heard again some of this this morning, in the issue of  
9 physician autonomy in the practice of medicine. In the  
10 abstract, I think many of us like the idea that doctors  
11 ought to make medical decisions.

12           The question, and it's a serious question, it's  
13 not a flippant question, is whether consumers have  
14 anything to gain from the restriction of position  
15 autonomy. I think we can talk about this later, but I  
16 think there's some reason to think that consumers do have  
17 some things to gain. Do they have some things to lose?  
18 Yes, also.

19           Again, how are we going to resolve those  
20 tensions? Is the answer simply to turn the system back  
21 over to professional control. One of the things that I  
22 appreciated about Carl Ameringer's presentation was the  
23 recognition that collective bargaining is not a new  
24 feature in the American health care system.

25           I think this is really one of the, one of the

1       burdens that is on physician union leaders, is the result  
2       of the track record of organized, medicine for the better  
3       part of the 20th century. I don't want to take anything  
4       away from the track record of committed doctors during  
5       the 20th century, the medical scientific advances. But  
6       one of the reasons this is an uphill battle, I think, for  
7       physician union proponents is if you look at economic  
8       issues in American Medicine, the 20th century, and you  
9       look at the positions the AMA took systematically to do  
10      things like limit the physicians supplied, to suppress  
11      alternatives, to make it difficult for non-physician  
12      providers to provide reasonable services, the suppression  
13      of early HMOs in any forum, the history of boycotts and  
14      so on, it becomes very difficult to believe in a benign  
15      vision of physician unions here at the beginning of the  
16      21st century.

17                 Fairly or unfairly, I think that track record  
18      has to be addressed. Frankly, some of the positions that  
19      organized medicine has taken in the legislative debates  
20      have not helped themselves in that front. In connection  
21      with the Campbell Bill, some opportunities, for example,  
22      and the AMA particularly was saying, this isn't about  
23      money. An amendment was offered to make the Campbell  
24      Bill not about money. What happened? One can only  
25      suppose with the lobbying approval of the medical



1 community, that amendment was defeated.

2 I should also point out that I don't think  
3 anybody thinks there's any antitrust risk in negotiating  
4 collectively about quality issues. So, why don't we see  
5 more of that already. In other words, that's perfectly  
6 permissible already. If helping consumers is the issue,  
7 do we need physician unions to do that?

8 Finally, will physician unions improve access  
9 to care? Affordability, of course, is an important  
10 component of access. I don't think there's much doubt  
11 that increased fees to physicians, deserved or  
12 undeserved, will increase prices to consumers. That does  
13 affect access.

14 Choice of physician, I think this is a place  
15 again where physician union interest, physician interest,  
16 and consumer interest may be aligned. Strikes, I don't  
17 frankly think strikes are a particularly big concern.  
18 Maybe some day we can see a big change in doctors'  
19 attitudes, but I think doctors are committed to their  
20 patients.

21 I should throw in that I'm married to one and  
22 I'd get shot if I didn't say that. But I don't think too  
23 many of us are seriously worried that doctors are going  
24 to strike all the time and not care whether people get  
25 the care that they need.

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1 That's when we apply the per se rule. So, it's not clear  
2 to me that if you're probably not going to get per se  
3 treatment if you're bargaining about quality and you're  
4 not going to get per se treatment if you're integrated  
5 and are doing some incentives for efficiency that might  
6 benefit consumers, why would you back off the per se rule  
7 any other time? Maybe we can talk about that during the  
8 discussion.

9 The demonstration projects again, one of the  
10 interesting things about the demonstration projects, and  
11 then I see my time is up so I'll be quiet, is -- one of  
12 the things the U.S. Attorney General is supposed to do  
13 under this legislation is to give a report about how the  
14 demonstration projects are going. Interestingly, if you  
15 look at the things the Attorney General is supposed to  
16 report about, it includes quality, choice of provider,  
17 and insurance enrollment.

18 Guess what is not included in the report?  
19 Cost, cost. Now, you know, the bill hasn't been through  
20 Committee and may be amended. But I think that's a  
21 rather striking omission, frankly, again, one that I  
22 think doesn't help the rhetorical prospects for getting  
23 anybody interested in that sort of legislation.

24 With State legislation, similar issues are  
25 presented. A very interesting thing on the FTC web site,

1 their comments on the Alaska state legislation. If  
2 you're interested in that issue, I'd suggest you have a  
3 look at that report.

4 Again, increased antitrust scrutiny of health  
5 plan mergers, increased attention to actually identifying  
6 real monopsony, a worthy goal, I think something that has  
7 been accomplished through the physician union movement.

8 Finally, two conclusions. I think, at least I  
9 want to argue, I have argued that physician unions are  
10 likely to increase health care costs without  
11 substantially improving quality, access or efficiency.  
12 There's no documented reason to believe that they would.  
13 They might, nevertheless, be justified on distributional  
14 grounds. That's left untouched. In other words, if we  
15 want to treat physicians like auto workers, or airline  
16 pilots, or nurses, we could always amend the National  
17 Labor Relations Act to do that.

18 I do appreciate the sort of blunt presentations  
19 today that acknowledge that that's a lot of motivation  
20 behind this movement. It's an argument that deserves to  
21 be considered and debated. So, thanks.

22 (Applause)

23 MR. HYMAN: We'll take about a 10-minute break.

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

25 MR. HYMAN: Since everybody has carefully

1 observed the property rights in their time, we have lots  
2 of time for discussion. So, I'm going to let Steve kick  
3 off and then we'll probably go back and forth.

4 I think the first thing we wanted to do,  
5 though, was to give individual panelists that spoke early  
6 the opportunity to comment on things that were said  
7 later, agreeing, disagreeing, or expanding on. I just  
8 ask that you keep your remarks of reasonable length so  
9 that we will have time for some questions. So, let me  
10 just start again in the order in which we did and run  
11 across the room.

12 So, Carl.

13 PROFESSOR AMERINGER: A couple of things,  
14 actually quite a few things, struck me so I will try to  
15 narrow this down to items that I feel were important or  
16 significant.

17 There are essentially two arguments that are  
18 being made for physicians unions. One is that there's a  
19 response to concentration or monopsony powers has been  
20 mentioned. The other thread, as Dr. Connair has  
21 mentioned, has to do with the contract practices pieces  
22 of it and the exclusivity or the exclusionary, rather,  
23 practices of HMOs or MCOs. I think it's worth following  
24 up on that a bit in the sense that that was something  
25 that was emphasized a great deal at the Campbell

1       hearings, hearings on the Campbell Bill. It does go to  
2       the access issue which Bill Brewbaker talked about at the  
3       end.

4               There is an argument here that can be made, it  
5       seems to me, from the access side of it that physicians  
6       unions would increase access in certain areas of the  
7       country, particularly urban areas. It's not entirely  
8       surprising that the National Medical Association, made up  
9       of minority physicians, spoke out very strongly in favor  
10      of the Campbell legislation. So, I think that that's  
11      something to consider and has a bit of an access piece to  
12      it.

13              I'll respond in other respects when we get the  
14      conversation going. I don't want to take up too much  
15      more time. I do have a question for Dr. Connair with  
16      regard to Philadelphia, which he focused on, in terms of  
17      physicians leaving that area. Perhaps this goes to the  
18      entire State of Pennsylvania. I'm wondering to what  
19      extent that has to do with the medical malpractice  
20      crisis.

21              I've certainly been reading a good bit about  
22      that. My home state of Wisconsin, it turns out, is one  
23      of the best places for physicians to go to because of the  
24      lower premiums. As a result, I think I even read in the  
25      AMA news not too long ago, physicians from Pennsylvania

1 are going to Wisconsin for that reason.

2 At any rate, I would have some question about  
3 that.

4 DR. CONNAIR: Two of the ER residents just came  
5 back from a Spine Fellowship in Philadelphia. The docs  
6 in that group are now up to over \$400,000 per doc per  
7 year for malpractice insurance, which is a murderous  
8 overhead cost that can only be compensated for with  
9 massive volume. In orthopedics, fortunately, some of the  
10 insurers are going to pay us so that those costs can be



1 costs of increases of rubber and glass and employee  
2 benefits. We can't.

3 If there is a mechanism for direct pass-  
4 through, a direct pass-through surtax, if you will, to  
5 the consumer or to the payer, malpractice wouldn't even  
6 be an issue. You know, so it goes up \$100,000, it  
7 doesn't matter. You know, each office visit is now going  
8 to generate another \$10. But I can just hear consumer  
9 groups and insurers objecting to that. Collective  
10 bargaining would take care of the PLI, I think.

11 MR. FLAHERTY: Yes. I have just a few comments  
12 about the issues raised in the presentation that perhaps  
13 will set the stage for further discussion back and forth.

14 During Professor Ameringer's comments about  
15 Physicians for Responsible Negotiation and their current  
16 status, it's been well publicized that there have been  
17 battles back and forth between the AMA Board and the AMA  
18 House of Delegates over funding, where I want to correct  
19 the information with respect to the number of sustaining  
20 members of PRN. PRN has both individual sustaining  
21 members as well as groups of sustaining members that  
22 represent over 180,000 doctors in the United States.

23 With respect to Professor Brewbaker's comments,  
24 I think it's possibly worth discussion on the question of  
25 when a monopsony begins to both drive pricing down as

1 well as output, that if we include quality of care as a  
2 component of output. Perhaps in some markets we have  
3 seen that, both the driving down of the price as well as  
4 the quality of care.

5 With respect to his comment that market share  
6 of a particular health plan is irrelevant, meaningless I  
7 believe was his word, I believe that it would be fair to  
8 say that there are physicians in his home State of  
9 Alabama who would be concerned that Blue Cross Blue  
10 Shield has 90 plus percent penetration in the HMO market  
11 is something other than meaningless to them.

12 With respect to his comments related to what is  
13 a meaningful threshold for analysis of monopoly power in  
14 a particular market, he noted 30 percent as a bare  
14

1 are all areas where physicians acting as groups, not  
2 necessarily bargaining units but acting as the AMA and  
3 the Federation of Medicine, have made tremendous strides.  
4 If you look at each of those examples from the  
5 perspective of the individual physician, it's absolutely  
6 contrary to their interests. I mean, if their interest  
7 was to have more patients, then no one would wear a seat  
8 belt. If their interest was to have more patients, we  
9 wouldn't have clean water, we'd have everyone sick all  
10 the time. I can go on and on with those lists. I would  
11 ask for some consideration of those points.

12 My final comment would be to mention that his  
13 comment was there have been two arguments advanced for  
14 physician unions, response to monopsony power and  
15 contracting practices. I would submit, and we can get  
16 into it, that there are certainly a number of other  
17 arguments for physician unionization beyond those two.

18 Thank you.

19 MR. HYMAN: Mark.

20 MR. LEVY: I think the one little piece that I  
21 would like to add is that in Professor Brewbaker's  
22 presentation, I guess the fantasy or fear that I hear is  
23 that if doctor unionization were allowed 100 percent,  
24 that all the doctors would run out and join a union in  
25 one form or another and have such power that they would

1 screw up the whole health care system.

2 I mean, I'm not proud of this, but at the  
3 height of the labor movement in the United States, all  
4 workers, I think the highest number was somewhere around  
5 30 percent. I think the general numbers of members in  
6 unions now are probably below 15 percent. I think it's  
7 just one of those fears that says you can't even start,  
8 you can't have any rights, you shouldn't be able to do  
9 it. You know, you start out arguing backwards and  
10 therefore, nobody is allowed to join the union.

11 I don't see it as -- if doctors unionized, you  
12 know, as somebody mentioned, there are some docs who  
13 join, some who won't, some have religious reasons, some  
14 have professional reasons, some will be scared out of  
15 their minds by their employer, which would probably be  
16 affecting most of them, but some would join. So there  
17 would be negotiations and things would move on as they do  
18 in other collective bargaining. It's a very different  
19 kind of view, I think, that I have than what he was  
20 presenting.

21 MR. HYMAN: Bill.

22 MR. BREWBAKER: Well, I hardly know where to  
23 start. I guess that's what I get for --

24 MR. HYMAN: It's a target rich environment.

25 MR. BREWBAKER: Okay, well, as the target, I

1       tried to take notes. Let me begin with the points that  
2       Carl made. Let me begin with the point, first of all,  
3       that I agree with the criticism that you made. It's  
4       actually a point that I make in the article that a lot of  
5       this comes from.

6                There is some evidence of de-selection of  
7       physicians related to service in medically underserved  
8       areas. I think everybody or most people are probably  
9       quite concerned about that. I certainly am. There are a  
10      number of ways of addressing that problem, but I think  
11      certainly that's an important issue.

12              The other question, I'll use the category of  
13      switching costs to address it. This is a theory that  
14      actually the Department of Justice used in the Aetna  
15      merger case. I don't think it was ever adopted by a  
16      court, but the Clinton-Justice Department argued that  
17      even in some situations where the market share statistics  
18      were low, that health insurers might be able to exploit  
19      doctors in an economic sense because it would be  
20      difficult for doctors to make up the lost capacity if,  
21      for example, they were de-selected by a provider that  
22      accounted for 20 percent or more of their patients.

23              They might hang on with an insurer that they  
24      didn't want to do business with because they were  
25      concerned about continuity of care, etc. You know,

1 obviously we're talking about serious hardship for  
2 physicians in situations like that and some things we'd  
3 all like not to see.

4 I think one of the questions that I think has  
5 got to be confronted, though, by union proponents is to  
6 distinguish between the economic problems physicians face  
7 as independent business people and the problems faced by  
8 other ordinary regular independent business folks.

9 I was chatting with Dr. Connair during the  
10 break and I told him a story. I don't think my dad will  
11 mind me passing this along. My dad is in the automobile  
12 business and has a contract with one of the GM lines. He  
13 was involved on their dealer council which is the closest  
14 thing, I guess, to a labor union those guys have. GM was  
15 squeezing the margins of the dealers and doing all sorts  
16 of things to make their life more expensive and less  
17 remunerative.

18 My dad called me on the phone and said, we came  
19 up with an idea to deal with these guys. We're not going

1 But I think it would be a little inconvenient to take the  
2 grandkids over to watch you cut the grass on the golf  
3 course over there.

4 You know, I could draw an analogy there, I  
5 think, because my dad has got 150 employees, he's got a  
6 plant that probably represents a several million dollar  
7 capital investment. At some point, he's got to make a  
8 choice between using that capacity in a non-optimal way,  
9 that is making some money but less money than what he  
10 wants, or sending this particular brand home and hoping  
11 he can find somewhere else to fill it in a situation  
12 where it's not easy to do. You know, you don't just call  
13 up a car manufacturer and order up a franchise,  
14 particularly if there's already a competing franchise  
15 down the street.

16 So, I think one of the understandable  
17 difficulties doctors are having in this environment is  
18 shifting from basically a non-market environment or a  
19 market in which they've enjoyed substantial protections  
20 from ordinary market forces into one where they have to  
21 act more like other independent business folks.

22 You know, I think rhetorically and on the  
23 merits there needs to be some effort made to explain why  
24 the sorts of hardships that we're talking about in terms  
25 of switching, etc., are relevant for physicians and are

1 not relevant for other sorts of people that own  
2 businesses of all kinds.

3 So, that would be one response. I bet I'll get  
4 some answers to that question in a minute.

5 Mark Flaherty made a couple of interesting  
6 points. The first one on the relationship between price  
7 and output in connection with monopsony, wouldn't we see  
8 a diminution in quality as indication of a diminution in  
9 output. I would say yes, that's true.

10 Again, though, I think the question of  
11 benchmark is important and very difficult. I mean, it's  
12 not easy to answer that. I'd want to concede that  
13 objection but then say that not all quality decreases are  
14 bad. I mean, the question we have to sort out and we  
15 hope that health care markets help us sort out is when is  
16 quality worth paying for and when is it not worth paying  
17 for.

18 So, for example, you can imagine a market where  
19 you've had a traditional indemnity sort of physician  
20 services market and all of a sudden managed care comes  
21 in. You see immediately reduction in price and you do  
22 see, I would imagine, a reduction in output, probably  
23 both in terms of volume and in terms of quality by some  
24 measure.

25 Is this just the market rationalizing pricing



1 quality or is this the sort of output decrease we ought  
2 to worry about? Those are hard questions to sort out  
3 empirically but I do think that that's the right way to  
4 frame the issue.

5 The other interesting point, insightful point,  
6 relates to the 30 percent standard in the enforcement  
7 policy statements. I think there what you're dealing  
8 with, and this does tie back into the whole question, is  
9 the difference between the cartelization concerns that  
10 are reflected in Section 1 jurisprudence in the Sherman  
11 Act where the agencies are concerned not only about  
12 aggregating market power in a single negotiating unit but  
13 the facilitation of collusion within that market. In  
14 other words, it's easier for four physician groups with  
15 25 percent of the market each to get together and set  
16 prices than it is for 10 groups of 10 percent each.

17 Now, let's flip that back on the insurance side  
18 of the equation, because obviously one of the concerns  
19 with insurance companies having large market share,  
20 particularly if more than one of them does, is the  
21 possibility that they could collude. There you've got a  
22 slightly different question than the monopsony question.

23 Of course, any sort of collusion on prices by  
24 insurance companies is also a per se violation of Section  
25 1. If it can be discovered as actionable and there's no

1       doubt, no defense about that for the same reason that the  
2       per se rule applies on the other side. So, I think what  
3       you've got there is a dual concern not only about the  
4       aggregation of market power but about facilitation of  
5       price fixing.

6                The comment about market share being  
7       meaningless, I did say that, I think. I would say Blue  
8       Cross' 90 percent market share in the HMO market in  
9       Alabama is meaningless. Their 80 percent market share in  
10      the market for commercial insurance generally is not  
11      meaningless. So, they've got 75 or 80 percent of the  
12      commercial insurance market. I don't think that's a  
13      meaningless figure.

14               I do think that because someone is shopping for  
15      an HMO product, the question is if they can't get that,  
16      can they find a substitute either by engaging in direct  
17      contracting if they are an employer or can they use a POS



1 and the AMA controlled the shape of health care delivery  
2 in the United States. Some of the features of that  
3 situation were good for consumers and some of them  
4 weren't.

5 I'm taking too much time, so I'll be quiet.

6 DR. CONNAIR: I'd like to ask just two  
7 questions with respect to what Attorney Brewbaker had to  
8 say. He referred to the prescription against price  
9 fixing, even amongst insurers who have some immunity from  
10 antitrust constraint.

11 If you look at what goes on within a state or  
12 across state lines, there truly is a synchronous  
13 ratcheting down of physicians, again within a state,  
14 amongst the Blues, across the nation. Yet, it's very  
15 difficult to prove that one CEO is calling up another and  
16 saying, you know, it's time for our 10 percent reduction  
17 again this year. How vigorous is the DOJ in pursuing  
18 that or interested in pursuing it?

19 The other matter that was brought up by  
20 Attorney Brewbaker is that he referred to physicians  
21 collective ability to -- this isn't the exact wording --  
22 to insist upon quality issues. Yet, technically, the  
23 current enforcement prevents collective bargaining about  
24 anything, whether it's financial or purely nonfinancial,  
25 the case of drive-through deliveries.

1           It took nearly an act of God to have those  
2 prohibited through legislative action and lobbying by  
3 physicians. Yet, collective action in that purely  
4 quality of care issue could have been taken care of  
5 within weeks by physicians collectively threatening  
6 insurance carriers.

7           Would the DOJ enforce in that situation against  
8 docs who did that purely in the interest of patient care?

9           MR. KRAMER: I'll be happy to address those.  
10 Perhaps we can do that at the end or I can do it now. It  
11 doesn't matter to me. But there are a number of more  
12 general questions that I'd like to raise here.

13           Let me address them very quickly to say the DOJ  
14 is very much interested in situations involving collusion  
15 by insurers in terms of what they pay physicians or any  
16 other health care provider. That activity is  
17 emphatically not immune from antitrust challenge by the  
18 McCarran-Ferguson Act, as we've said for a number of  
19 years despite claims to the contrary. If there is  
20 information that goes beyond parallel pricing, which  
21 occurs in every industry in the country, and obviously  
22 occurs in this industry, then we're interested in hearing  
23 about it.

24           In terms of quality of care, collective  
25 negotiations, it's a complicated issue. I want to ask

1 Professor Brewbaker a question about that in terms of his  
2 statement, as I understood when he was talking, there's  
3 no antitrust risk in negotiating on quality issues.  
4 Well, the holding of Federation of Dentist's case  
5 certainly shows what may be quality in the views of some  
6 may not be viewed as quality in the eyes of others.  
7 There are antitrust risks in specific situations.

8 I can't speak for the Department in terms of  
9 what the Department would do in any particular matter.  
10 There's room for a considerable give and take on issues  
11 that are not obviously related to competitive concerns  
12 that potentially can work to the clear detriment of  
13 consumers.

14 So, let me leave that at that for this point,  
15 if I may, because I certainly didn't come here today to  
16 try to explicate the Department's position on issues.

17 Although, before I depart from that, I do want  
18 to say one other point briefly. That is, I also didn't  
19 come here today to re-litigate the facts of the  
20 Federation of Physicians and Dentist's case. So, by my  
21 not taking you on on some of your characterizations,  
22 which were brief on the facts there, it shouldn't be  
23 understood that I necessarily agree with those  
24 characterizations.

25 Finally, I wanted to compliment David, who,

1           without any input from me, organized a very nice variety

1           may be the nub of the issue.

2                       PROFESSOR AMERINGER: My understanding of the  
3           Campbell Bill is that there were at least three aspects  
4           to it that made it somewhat different from the typical  
5           situation regarding employees under the NLRB. One is  
6           that the NLRB would not apply. There would be no  
7           government oversight.

8                       A second feature was that the bargaining unit -  
9           - that physicians would bargain with the health plan but  
10          not with multiple firms. Then, of course, the other  
11          feature is the fact that we're talking about self-  
12          employed providers or independent contractors.

13                      So, those three features made it stand out. I  
14          think does give some impetus to the comment that Bill  
15          recently made with regard to an attempt to reestablish a  
16          guild type system. There are certainly some aspects to  
17          that analysis which would indicate that that might be the  
18          case.

19                      MR. BREWBAKER: If I suggested that I thought  
20          there were currently different rules for doctors than for  
21          everybody else, then I misspoke, because that's not my  
22          view.

23                      So, on the quality issue thing, I guess, you  
24          mentioned that as well, Steven. I certainly think, just  
25          to say, perhaps I was a little exuberant, to say there's



1 no antitrust risk is not correct. I'm recalling, though,  
2 at one of the Campbell Bill hearings a conversation that  
3 Chairman Pitofsky was having with the committee about the  
4 enforcement posture of the FTC at that time.

5 Unfortunately, I don't have total recall, but I  
6 think it's safe to say that prosecutorial discretion  
7 would be used in situations like that. It wouldn't  
8 surprise me, particularly in a situation where we weren't  
9 talking about a so-called quality issue that just happens  
10 to be completely convergent with physician's economic  
11 interest.

12 But that's what I had in mind when I said that,  
13 and I appreciate your calling me out on it.

14 DR. CONNAIR: As for differential treatment  
15 goes, I don't think there is differential treatment.  
16 Unfortunately, the antitrust laws that were intended for  
17 John Rockefeller and Alcoa have been rather awkwardly  
18 tailored to deal with the professional issues of  
19 medicine. Enforcement sometimes doesn't seem entirely  
20 rational in that the laws perhaps weren't intended for  
21 use in this situation.

22 I do recall very well the comments of the  
23 judiciary hearings with Mr. Pitofsky and the first  
24 comments out of John Conyer's mouth after Chairman  
25 Pitofsky's recitation of the current FTC guidelines was.

1 It was, and I quote, "You're screwing doctors." He  
2 challenged Chairman Pitofsky to cite one situation in one  
3 state where the regulations and guidelines had adequately  
4 protected physicians.

5 MR. LEVY: Not directly on the Campbell Bill,  
6 but two sort of images that I would just like to mention  
7 that are related to the whole question of whether this  
8 fairness in treatment.

9 A couple years ago I had a hip replacement. It  
10 was successful, good orthoped, really nice. But when I  
11 would see him, he worked at Columbia Presbyterian. So I  
12 went in to the building where all the docs were and there  
13 were shared files areas, they shared secretaries, they  
14 paid rent to Columbia Presbyterian, and they sent me for  
15 tests downstairs. It didn't look like just a group of  
16 independent docs who didn't have any other interest with  
17 Columbia Presbyterian. They were forced to pay a certain  
18 amount of rent and tithes and whatever, whatever,  
19 whatever.

20 I mean, there's no end to the kinds of  
21 impositions, like the reference to malpractice costs go  
22 up and you can't pass that cost along. I mean, it was  
23 the same thing. When Columbia Presbyterian would want to  
24 charge more rent or charge a bigger share for all the  
25 other services, the docs technically couldn't talk to

1 each other on the same floor where they were sharing  
2 offices and say, this isn't right.

3 That's a little odd to me. It goes back to the  
4 fiction that they are independents, that the antitrust  
5 law was really built to protect the public policy and  
6 prevent the two docs from talking to each other, when I  
7 really think antitrust laws came from another area.

8 I think they really are differentially applied.  
9 There's a case that's floating around out there where  
10 three residents are filing an antitrust suit against the  
11 combined weight of all organized medicine. Without sort  
12 of commenting on the content of that case, basically,  
13 what they're alleging is that through the interlocking  
14 directorate -- AMA gets to appoint so many people to be  
15 on somebody else's board and the American Hospital  
16 Association gets to appoint so many people on the Match  
17 Board, and they all appoint people to each other's boards  
18 -- they're never supposed to talk to each other or  
19 collude.

20 But somehow, resident pay across the country  
21 and resident work hour across the country are really  
22 resistant to change, but all these people who appoint  
23 people to each other's boards never talk about those  
24 things. It's been the burden of private individuals to  
25 bring such a suit, whereas nobody else took a look to see

1           whether there was that kind of collusion going on.

2                         One of the reasons that my union has not taken  
3 a position on that suit is that whatever a judge is going  
4 to decide in an antitrust suit can really shake up the  
5 industry in ways that are not expected. I think  
6 collective bargaining where employees and employers sit  
7 down and talk things out can make better decisions in  
8 that kind of forum than in an antitrust forum.

9                         But I really think that there are many visible  
10 aspects of this kind of interconnectedness in an industry  
11 and it didn't come to the Department of Justice's  
12 attention to do that. Whereas, a couple of people in  
13 Delaware or Connecticut get together and say this is  
14 really terrible, and that comes to their attention. I  
15 really do think it's unequal in that kind of way.

16                         MR. FLAHERTY: Steve, I want to address  
17 directly your question, how will we respond to your  
18 observation that the Campbell Bill would have conferred  
19 some special treatment for physicians. I can see that  
20 point. I do think it should be viewed in a larger  
21 context, however. I kind of viewed the Campbell Bill as  
22 almost a Hail Mary response by the federation of medicine  
23 to what was going on at the states.

24                         So, we have two very different regulatory  
25 systems. We have the states regulating the insurance

1 industry. We have the Federal Government regulating the  
2 collective efforts of physicians. So, I understand your  
3 position and your cause for concern.

4 What I don't understand, and I would seek your  
5 insider comment, is when the physician collective  
6 bargaining bills are presented at the state level, New  
7 Jersey, Texas, Alaska, wherever, and there we have a  
8 state regulatory scheme over the insurance companies,  
9 it's largely hands off. If the states are regulating it,  
10 then largely you let them go.

11 What is the Department's position or how does  
12 the Department justify having a different position if the  
13 states want to regulate physician bargaining with those  
14 very same insurance companies?

15 MR. KRAMER: To make this very quick, I don't  
16 believe the Department is opposed to the Federal Trade  
17 Commission. As you know, we do speak with one voice at  
18 times, but I don't believe the Department has taken a  
19 position on any of those state bills. So, I feel very  
20 uncomfortable as a staff attorney at the Department  
21 postulating on that point.

22 MR. FLAHERTY: I appreciate that.

23 MR. HYMAN: Here's where I put my academic hat  
24 on and say I'm only here part time. It would be above my  
25 pay grade even when I'm here. I think the Commission



1 same across multiple markets, what's the upside of  
2 cartelizing the physician market where there isn't  
3 monopsony on the insurance side.

4 What are the benefits and costs associated with  
5 a universal role out of physician unionization if Mark's  
6 relatively pessimistic assessment of the prospects that  
7 30 percent in the best of times, down around 12 percent  
8 now, is inaccurate and physicians are actually keen and  
9 enthusiastic advocates of unionization?

10 So, I think that's basically the question. If  
11 you could target this to markets where there's monopsony,  
12 that's a rather different scenario than if it's going to  
13 be rolled out across the country.

14 DR. CONNAIR: Even where there's not true  
15 monopsony, like Alabama or Philadelphia, the insurers  
16 behave synchronously whether it's by parallel pricing or  
17 by some secret phone call. So, there is parallel  
18 ratcheting down because there is absolutely no  
19 counterbalance on the other side. They all take  
20 advantage of that one-sided strength that they have to  
21 ratchet down.

22 So, I'm not sure whether it makes a difference.  
23 I think where the prices are badly depressed, where the  
24 insurer or insurers have taken most advantage of their  
25 combined or single power, those are the markets where

1 physicians will be most willing to let go of their  
2 traditional unwillingness to even consider a union. It  
3 takes them a few hearings to even consider joining a  
4 union.

5           It's funny how it works. They finally decide  
6 that if it's good enough for some of my workers, perhaps  
7 it's good enough for me. They really have to bleed  
8 badly. Some of their colleagues have to have left town  
9 or have been forced out of business before they will even  
10 consider a union. But I think it's in the most severely  
11 forcibly depressed reimbursement areas that they'll do  
it, not the monopsony alone.



1 join an IPA. That is a very different professional  
2 appearance.

3 To the extent that those IPAs can clinically or  
4 financially integrate themselves to the extent that they  
5 are permitted to then act collectively, I find no  
6 hesitation on the part of physicians to join those  
7 organizations that are permitted under the current  
8 standards to respond to a dominant payer in a particular  
9 market.

10 DR. CONNAIR: But when they join an IPA, they  
11 really want a union. They finally get over the U word.

12 MR. HYMAN: If I can just have a follow up,  
13 that was really my next immediate response to that, is  
14 well, isn't an IPA an adequate substitute. If it isn't,  
15 as Dr. Connair's observations suggest, where do you go  
16 from there? Why is the messenger model, an existing IPA,  
17 not sufficient to address the problem?

18 DR. CONNAIR: Well, just the market share  
19 that's allowed for a non-integrated IPA. A third of the  
20 market isn't enough to really influence reimbursement.  
21 The nice thing about the messenger model is as it's  
22 described, there's not a prohibition against 100 percent,  
23 if you can get it, of docs being educated appropriately  
24 by a messenger.

25 So, even though it's relatively weak through a

1 comparative collective bargaining, at least it includes  
2 all the docs and not just a third of the market.

3 MR. FLAHERTY: My response is different than  
4 Mike's. I think that if the messenger model is the  
5 alternative, then it resolves almost none of the  
6 advantages of collective action permitted under the NLRB.  
7 There's no, at least as I read, the messenger model rules  
8 on fee or fee related issues, no collective action  
9 permitted.

10 MR. LEVY: I'd just like to comment about docs  
11 joining organizations. I think all doctor unions now use  
12 words like committee or federation or association.  
13 Nobody uses the U word. If you went through the whole  
14 AFL-CIO, I bet you a lot of those unions don't use the U  
15 word either.

16 I'm always caught in an odd position because  
17 I've worked with other employees. I've worked with docs  
18 for many years now. When I try and explain docs to non-  
19 docs, I use industrial terms. When I talk to docs, I  
20 don't want to sort of embarrass them or use those other  
21 terms.

22 But truth tell, docs are just like other  
23 citizens. Somebody said docs are conflict adverse. So  
24 is everybody else. Somebody said docs don't like to go  
25 on strike. Look at the statistics. No other workers

1 want to go on strike.

2 When I go to meetings, whether it's with  
3 residents or attendings, the same questions that come up  
4 when I used to work in electrical manufacturing or when I  
5 worked with groups of other hospital employees come up --  
6 what are the dues? If somebody else goes on strike, am I  
7 going to have to go on strike? Who makes the decisions?  
8 Who are the officers? They're the same questions.  
9 They're absolutely the same questions.

10 We know what it takes to build a union or have  
11 a union function, get people, busy people, to  
12 participate. Docs are really busy and it's hard to get  
13 them to participate, but in a hospital worker's union  
14 where there's somebody who has got three kids and a  
15 single parent, it's hard to get them to participate.

16 A lot of the issues are really very much the  
17 same. But then this whole other dialogue, almost all the  
18 issues that either Professor or Lawyer Brewbaker,  
19 Attorney Brewbaker, brought up, I don't understand why  
20 these are questions that even exist before you say should  
21 a doc have a right to join a union. That's just a whole  
22 area of dialogue that I think just isn't appropriate. I  
23 mean, I understand why it's there, because the laws have

23

1           So, it's easy to justify the status quo by  
2           developing all these very sophisticated kinds of  
3           arguments. To me, they just don't make any sense. They  
4           don't make sense. I know where they're coming from. You  
5           said it. You're opposed to docs having unions. So, then  
6           you can develop all sorts of arguments to get to that  
7           point.

8           But I really think you have to get through some  
9           of that and get to some of the realities of what doctor's  
10          unions are like, the issues that doctors care about.  
11          Whether auto workers do care about making safer cars, I  
12          think they do. I think the way some of this discussion  
13          goes is beyond my imagination.

14          MR. KRAMER: I think before we ask another  
15          question, we'll give Mr. Brewbaker an opportunity to  
16          respond to that last statement.

17          MR. BREWBAKER: I don't have anything to add to  
18          what I've already said.

19          DR. CONNAIR: Can I just jump in here? Your  
20          comments are interesting, and I want to start with the  
21          first part of what you said, and that's with respect to  
22          physicians are the same as ordinary citizens, or  
23          something to that effect.

24          That's one of the difficulties that perhaps a  
25          lot of folks have with thinking about physicians and

1 unions, just as they would with lawyers and unions or any  
2 other particular professional group. It gets also to the  
3 issue of how do you separate reimbursement from quality.

4 In other words, in the union context when  
5 you're negotiating a contract, you're negotiating a  
6 contract which is going to pay people or groups of people  
7 at a certain amount, certain levels. Whereas, in this  
8 particular context, physicians as individuals are  
9 different, just as lawyers as individuals are different.  
10 To some extent, what you earn or what you make reflects  
11 quality, is some indication to the consumer as to the  
12 quality of the service that is to be provided.

13 Isn't that one of the problems here, the fact  
14 that you really can't separate reimbursement from  
15 quality? Then, when you try to move it into the union  
16 context, you're indeed trying to do that.

17 MR. LEVY: I think you can. I said in my  
18 presentation that all agreements are agreements that have  
19 to be mutually negotiated and agreed to. It takes the  
20 other side to agree to it. So, if part of what you're  
21 talking about is setting certain standards, that could  
22 be, from the employer's side, all sorts of industries,  
23 whether it's productivity standards or other kinds of  
24 standards. They're on the table as part of the  
25 negotiations and something gets worked out.

1                   How you measure quality? I don't know. I  
2                   mean, I do have some ideas but how do you set that up so  
3                   that it cuts across the board evenly. That's something  
4                   for the parties to negotiate. I don't think it drives  
5                   prices any more out of whack than what I see some of the

1 hospitals. I mean, you just see that happening all the  
2 time.

3 Where's the balancing effort in this situation?  
4 I think they are the same in the kinds of ways that are  
5 important. I think there are safeguards in the  
6 collective bargaining process because both sides are  
7 obligated to put on the table whatever they want to put  
8 on the table.

9 DR. CONNAIR: I think what physicians would  
10 really like is the balanced sort of structure that a  
11 guild used to represent, which is a professionalism piece  
12 in there which deals with the concern for our patient's  
13 care. But then there is a hard core union piece there,  
14 too, which deals with the contractual issues and the  
15 financial issues.

16 Docs need both. They really need a combination  
17 of hard core labor union for their contracting needs and  
18 the functions of a medical society, which they already  
19 have. They can't do what it has to do because it's  
20 prohibited and emasculated by not being able to have that

2 IF7E(2 If the union needs to complete the job that docs need and)Tj-5.7

15

1 the CIO news so that he shouldn't be able to say that he  
2 can't find instances of where a doctor's union has fought  
3 around and even won on issues of patient care.

4 MR. BREWBAKER: Let me express my gratitude for  
5 that. Thank you.

6 MR. FLAHERTY: Carl, I have one response to  
7 your question. The implication behind it, I believe, is  
8 that at present there is a recognition in the current  
9 reimbursement system for quality. Let me say, and I'd  
10 welcome Mike's inputs as well, that is not my experience  
11 in representing a large number of physicians around the  
12 country. It's common that there is no distinction from  
13 provider to provider within a particular geographic area.

14 The quality measure that I see has to do with  
15 volume. That is, the better docs aren't getting paid  
16 more per procedure. It's that they're perceived by  
17 patients as better doctors so they have more patients.  
18 That's what I perceive as the current situation.

19 MR. KRAMER: In terms of assessing the  
20 monopsony issue, Professor Brewbaker, what do you make of  
21 Dr. Connair's statement that doctors don't have any  
22 choice but to sign contracts in relation to the offers  
23 they're receiving?

24 MR. BREWBAKER: Well, I think there's a certain  
25 amount of truth to it and a certain amount of falsehood



1 to it. Are doctors often put in situations they'd rather  
2 not be in in connection with transactions with health  
3 plans? Certainly, they are. How different is that from  
4 situations we find ourselves in in other aspects of the  
5 economy? Not very different.

6 So, I wouldn't deny that this is a serious  
7 issue from the perspective of the individual doctor. I  
8 wouldn't want to deny that for a minute. The question is  
9 a matter of policy. Do you want to displace market  
10 forces? Do you think you're going to get a better  
11 overall result by avoiding that hardship through some  
12 intervention, whether it's regulatory or for the union  
13 than just accommodating some of the dislocations that  
14 markets bring?

15 So, again, I refer back to the example I gave

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1 recover all their costs. That actually sounded a lot to  
2 me like the kind of language you'd hear when you're  
3 talking about a public utility who needs to be entitled  
4 to a guaranteed stream of income to cover their costs and  
5 provide sufficient resources to invest in new capital.  
6 But the difficulty is, obviously, public utilities are  
7 not the sort of thing we depend on competitive markets to  
8 handle.

9 So, do I understand you to imply, and maybe  
10 this more general an observation, is health care special  
11 in that we should just fork over whatever their costs are  
12 plus a sufficient amount or is it subject to competitive  
13 forces because car companies, to continue the metaphor,  
14 would like to cover their costs and more, but there's no  
15 guarantee. Sometimes they sell at a loss.

16 So, it goes back to the basic issue, is health  
17 care special. Should it have separate rules and not be  
18 subject to the market?

19 DR. CONNAIR: Of course, there is a public  
20 utility aspect to medicine. There are free market  
21 components to it. I wouldn't call it truly a free  
22 market. I don't know what Professor Brewbaker thinks  
23 about that.

24 We are not in the position to make demands of  
25 powers much greater than us when attempting as individual

1 physicians to negotiate a contract, if you can call it  
2 negotiate, with Blue Cross. Blue Cross threatens even  
3 one of the two large hospitals in my area with  
4 discontinuation of contract and forcing half the patients  
5 in town to switch to the other hospital if they don't do  
6 as Blue Cross demands.

7 So, it's not a real market in that there is no  
8 counterbalance and real market unions provide some help  
9 for the helpless individual worker, preventing him from  
10 being taken advantage of. I truly think we are, when it  
11 comes to our contracting needs, no better off than grape  
12 pickers or steel workers and at the mercy of United Fruit  
13 or Bethlehem Steel.

14 MR. FLAHERTY: David, I think you've raised an  
15 excellent question. I believe there are substantial  
16 aspects of regulated industries with respect to medicine  
17 as a whole. I mean, there's substantial amount of  
18 rationing of medical resources by both the state and  
19 federal governments through certificate of need programs,  
20 through anti-dumping statutes, through minimum hour  
21 requirements in emergency rooms, which then get pushed on  
22 to doctors as on call requirements.

23 So, I think you start to touch on a very  
24 important question and that is, how do we juggle this  
25 industry that has certain aspects that are treated like a

1 regulated industry and certain other aspects as a non-  
2 regulated and purely competitive industry. If I had  
3 answers, I would give them, but I think you're raising  
4 the right question.





1 treatment and aren't just treating patients the way  
2 they've always treated them, without the information  
3 that's required, then I think those are places where some  
4 intervention could be helpful.

5 I would go ahead and add that one of the  
6 potential dangers of physician unions is probably a  
7 visceral impulse to preserve physician autonomy in ways  
8 that might impede advances in quality assurance. I think  
9 if you look at the quality assurance literature, most of  
10 the trend is to think that we do better working on  
11 systems than identifying individual, bad apple doctors in  
12 the bunch.

13 To the extent that that involves intrusion on  
14 physician autonomy, it involves the mandating of  
15 physician and non-physician teams and so on, I would be  
16 quite concerned if unions had the unintended consequence  
17 of making those sorts of improvements harder to achieve.  
18 So, that's what I had in mind by the comment.

19 DR. CONNAIR: As much as I hate to agree that  
20 managed care does do some good, it certainly does have  
21 the potential for doing a great deal of good. As far as  
22 imposing the standards on patient care, for instance  
23 preventive care, mammography, bone density scanning, and  
24 immunization. There should be some limitations on the  
25 autonomy of physicians when it comes to such issues.





1 patients being uninsured and not having access to the  
2 best care when they need it.

3 MR. HYMAN: I see that our time has run out.

**AFTERNOON SESSION**

1  
2 MR. ELIASBERG: Good afternoon, and welcome to  
3 the Health Care Competition of Law and Policy Hearing  
4 Session on Group Purchasing Organizations. My name is Ed  
5 Eliasberg. I'm an attorney with the Antitrust Division  
6 of the United States Department of Justice. I'm one of  
7 the co-moderators of this session. The co-moderator of  
8 the session is Matthew Bye from the Federal Trade  
9 Commission, who is sitting to my right, to your left.

10 Before we go any further, now that we've had  
11 the introductory welcome, why don't we all just take a  
12 moment to be sure that our cell phones are turned off and  
13 all that. Now would be a good time just to check to be  
14 sure so we can try to avoid that sort of disruption.

15 While you're doing that, let me just sort of  
16 set the framework here. Today we're going to be looking  
17 at group purchasing organizations from the perspective of  
18 health care competition law and policy. I guess the next  
19 thing I want to be sure to do is to thank each of our  
20 seven panelists for taking time out of their busy  
21 schedules to come to speak to us and give us their  
22 insights, perspectives and learning upon this topic.

23 If you haven't had a chance yet to look at the  
24 agenda that's on the web site, I would urge you to do so  
25 when you have a chance when you go back to your office

1 later today or shortly thereafter. It sets out some of  
2 the questions that we were hoping to gain insight and  
3 perspective on today.

4 For example, when is bundling procompetitive,  
5 when is it anticompetitive? How do you determine if the  
6 duration of a sole source contract is procompetitive or  
7 anticompetitive? Indeed, are there instances when a sole  
8 source contract with no term limit is nonetheless  
9 anticompetitive? If so, when, why? How appropriate is  
10 the analysis of Statement 7 of the Health Care Policy  
11 Statements, particularly the 35 percent safety zone test  
12 in the context of group purchasing situations? Also,  
13 which is very important for us at the Agencies is, where  
14 do things now stand with respect to these practices in  
15 the competitive sector of the economy of group purchasing  
16 organizations?

17 The format today is going to be this. Each of  
18 the seven panelists is going to be giving approximately  
19 15-minute presentations. They will be giving it in the  
20 order in which they are sitting, starting from my right,  
21 your left, with Merrile Sing.

22 Following that, we'll take a short break and  
23 then we'll have a moderated roundtable discussion with  
24 Matthew and I asking questions. Now, to get a little bit  
25 ahead of myself, you'll be hearing shortly Merrile is

1 from the General Accounting Office. She'll be speaking  
2 first about a study that they've recently done concerning  
3 the GPO industry.

4 After her will be Bob Bloch, who is an attorney  
5 in private practice in town. Bob is going to give a  
6 little bit of what are some of the leading cases in the  
7 area of things like bundling, exclusive contracts, things  
8 of that nature. So, there's something of an analytical  
9 framework from which the other speakers can or cannot, as  
10 they think it's appropriate, guide their comments and  
11 their thoughts concerning competition law and policy.

11

1 and handing on to future generations, of your experience  
2 here at the sessions, and which has the biographies of  
3 all the folks who were here today.

4 Basically, and I'm again going quickly,  
5 starting to my far right is Merrile Sing from the General  
6 Accounting Office; Bob Bloch from Mayer, Brown, Rowe and  
7 Maw; Mr. Said Hilal who is the CEO of Applied Medical  
8 Resources Corporation.

9 Then to my immediate left is Mr. John Strong,  
10 who is CEO of Consorta, which is a GPO. Then to his left  
11 is Mr. Lynn James Everard, who is a health care business  
12 educator and supply chain strategist. I will divert from  
13 what I was saying before and tell you something that is  
14 in his resume in that wonderful bound volume. He's also  
15 a certified purchasing manager. So, we'll have that  
16 perspective.

17 Elizabeth Weatherman is a managing director of  
18 Warburg Pincus. Then, Gary Heiman is CEO of Standard  
19 Textile, a company that makes reusable products for  
20 health care facilities. I think we're also going to hear  
21 that he is or has been on the board of directors for a  
22 hospital.

23 So, with that, let's turn to the business at  
24 hand. Merrile, if you would do us the honors.

25 MS. SING: Thank you.

1                   MR. BYE:  If the speakers want to move to the  
2                   first row, I think it might make it a bit easier for  
3                   their presentation.

1 innovation, and create barriers to entry for small- and  
2 medium-sized manufacturers of medical surgical products.  
3 These concerns were also expressed by some witnesses at  
4 hearings the Subcommittee held on GPOs in April of 2002  
5 and, more recently, in July of 2003.

6 The GPO industry is concentrated. The top  
7 seven GPOs account for more than 85 percent of hospital  
8 purchases through GPO contracts. The two largest GPOs  
9 account for 70 percent of the top seven GPO's total  
10 medical surgical purchasing volume.

11 The General Accounting Office's study on GPOs  
12 focused on seven large national group purchasing  
13 organizations. We also focused on the contracts that  
14 these GPOs negotiated for hospital medical surgical  
15 products, which include commodities such as bandages and  
16 cotton balls and clinical preference products such as  
17 pacemakers. These are products for which clinicians may  
18 express a particular preference for a certain model or  
19 brand.

20 So, we excluded contracts that GPO negotiated  
21 for drugs and capital equipment and other products that  
22 hospitals purchase. Our methods included interviews and  
23 a literature review. We interviewed representatives from  
24 group purchasing organizations, manufacturing industry,  
25 people in distribution industry, and people from the







1 tiered commitment levels. These are contracts that give  
2 customers the option to purchase, for example, a group of  
3 products at 90 percent, 80 percent and, hypothetically,  
4 70 percent commitment levels, with more favorable pricing  
5 available to those who agree to purchase 90 percent of  
6 the products in the specified group versus those who  
7 purchase 70 percent versus those who don't make any kind  
8 of commitment at all.

9 In our study, bundling links price discounts to  
10 purchases of a specified group of products. Bundling can  
11 occur for complimentary products such as protective hats  
12 and shoe coverings which are used in hospital operating  
13 rooms. It can also occur for groups of unrelated  
14 products that are offered by a single manufacturer. In  
15 our study, we refer to this type of bundling as a  
16 corporate agreement. By unrelated products, we mean  
17 things like IV solutions, medical film, and patient gowns  
18 bundled together.

19 The third type of bundling we looked at was  
20 structured commitment programs which are programs that  
21 bundle products from different manufacturers and require  
22 customers that choose the program to purchase a certain  
23 minimum percentage from the product categories specified  
24 in the bundle to obtain the discount.

25 For example, one structured commitment program



1 commitment programs accounted for 20 percent of the  
2 purchasing volume of one of the two largest GPOs. We  
3 found some evidence that GPO's use of bundling  
4 arrangements may be declining, particularly during the  
5 past year. One of the GPOs in our study reported  
6 decline, specifically a decline in the percent of  
7 contracts that were corporate agreements of the contracts  
8 they had in effect on January 1st, 2001 versus January  
9 1st, 2003.

10 In addition, one of the manufacturers we spoke  
11 with and two of the distributors we spoke with told us  
12 that they've observed a decline in bundling. The two  
13 distributors actually told us that they observed that  
14 some of the bundles that GPOs have offered have actually  
15 been torn apart.

16 With respect to contract duration, we found  
17 that the two largest GPOs typically award contracts with  
18 longer terms, typically five years compared with the  
19 other five GPOs which typically had contracts that were  
20 three years long. We included potential renewal periods  
21 in our definition of contract period.

22 As in the case with bundling with respect to  
23 contract duration, we found some evidence that contract  
24 duration may be declining. For example, in the first  
25 quarter of 2003, one of the two largest GPOs began

1 excluding the optional contract extension periods from  
2 its new contracts.

3 So, to summarize what we learned about GPO  
4 contracting strategies, such as sole source contracting,  
5 bundling, commitment and contracts that are five years or  
6 longer, from the literature review, we learned that  
7 contracting strategies have the potential to reduce  
8 competition when used by GPOs or manufacturers with a  
9 large market share.

10 Some GPOs, including the two largest, use sole  
11 source contracts extensively. The two largest GPOs used  
12 either contracts or programs that bundle multiple  
13 products for a notable portion of their business.

14 For additional information about our study, it  
15 can be downloaded at the web address indicated above.  
16 I'll also have some copies available during the break.  
17 You can also go into GAO's web site and search for the  
18 report by the report number which is the last part of  
19 that web address, GAO-03-998T.

20 Thank you.

21 (Applause)

22 MR. ELIASBERG: Thank you, Merrile. We will  
23 also try to have a link to the GAO report from the web  
24 site for these hearings.

25 Bob.

1

STATEMENT BY ROBERT BLOCH

For The Record, Inc.  
Waldorf, Maryland  
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1 services are purchased through these contracts. It is  
2 estimated that hospitals save between 10 and 15 percent  
3 of what they would otherwise have paid on their own by  
4 buying through a GPO.

5 Finally, it is estimated that it would cost  
6 hospitals on average about \$155,000 per hospital annually  
7 to replicate the functions performed by a GPO. GPO is a  
8 cooperative of buyers that aggregate their purchasing  
9 power in order to bargain with manufacturers of medical  
10 products, drugs and other types of products and services.

11 GPOs do not buy or sell anything. Typically,  
12 they are a buyer's agent that enters into contracts with  
13 manufacturers which specify the prices, discounts, terms  
14 and conditions under which their members can choose to  
15 purchase from the manufacturers. I say choose because  
16 most GPOs are voluntary.

17 GPOs offer their members increased efficiency.  
18 They eliminate wasteful administrative duplication and  
19 they increase competition between rival GPOs,  
20 manufacturers and their member hospitals, all of which  
21 can translate into lower prices and higher quality for  
22 consumers.

23 Nevertheless, GPOs have been under attack on  
24 several fronts. Some small manufacturers claim that GPO  
25 contracting practices, like sole source contracts and

1 multi-product or bundled discounts, favor large,  
2 established manufacturers foreclosing smaller innovative  
3 products from the nation's hospitals.

4           These concerns led to two Senate hearings since  
5 April of last year. The New York Times ran a lengthy  
6 series of critical articles about the industry last year.  
7 Several private antitrust cases have been filed involving  
8 GPO contracts and programs in which plaintiffs allege  
9 that they were foreclosed from being able to sell to  
10 hospitals.

11           In a 2002 GAO pilot study, the one which  
12 proceeded the one that Merrile talked about, raised  
13 questions about whether GPOs always get the lowest prices  
14 for their hospital members, a study which I believe was  
15 flawed, had major flaws in it.

16           So, having said all this, what are the key  
17 antitrust issues related to GPO contracting? I think  
18 there are several. In my view, they are: whether the  
19 types of contracts that GPOs enter, especially sole  
20 source contracts, are expressly or de facto exclusive  
21 contracts; second, whether these contracts, when coupled  
22 with discount programs, such as bundling and high  
23 commitment levels, reinforce the exclusive character of  
24 these contracts or have any competitive effects; third,  
25 whether GPOs have helped manufacturers monopolize various



1 product markets to exclude their rivals; and fourth,  
2 whether it matters that these contracts and bundling  
3 programs are being sought by buyers rather than being  
4 initiated by suppliers.

5 This last question, I suggest, is really a  
6 crucial one, which has been obscured in this whole  
7 debate. It should not be overlooked in the analysis. It  
8 is crucial because buyer-initiated discount programs are  
9 driven by the economic interest of GPO member hospitals  
10 in obtaining lower prices and quality products, not by  
11 the more typical seller interests of resisting lower  
12 prices and discounts and increasing market share.

13 When viewed through the buyer's lens, the  
14 concern about whether a GPO's contracting practices are  
15 anticompetitive should be greatly diminished and are  
16 rarely likely to present a problem from an antitrust  
17 point of view.

18 Let me say a few words about the contract  
19 discounts and commitment levels that underlie these  
20 issues. Most GPOs negotiate contracts that try to  
21 balance pricing and discounts against member demands for  
22 quality products and choice. In some instances, a GPO  
23 may enter into a sole source contract with a supplier in  
24 order to obtain a larger discount.

25 Under a sole source contract, the GPO commits

1 to contracting with only one supplier for a particular  
2 product. A sole source contract in this context is not  
3 an exclusive contract. In an exclusive contract, the  
4 purchaser commits to purchasing only from the contracting  
5 supplier and from no one else.

6 In most sole source contracts that we're  
7 talking about here with GPOs, there are no commitments by  
8 a hospital, the actual party which is doing the  
9 purchasing, to buy from only one supplier, since member  
10 hospitals are almost always free to use or not to use the  
11 GPO contract.

12 Thus, by entering into a sole source contract,  
13 a GPO may be selecting the best low bidders as preferred  
14 vendors that are available to member hospitals through  
15 that GPO, but it is not limiting the ability of any

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1 purchase discounts provide that the member hospital can  
2 get rebates based on the percentage of the hospital's  
3 total volume that is purchased from a particular vendor.  
4 This differs from volume discounts which are based solely  
5 on the quantity of purchased product.

6 Multi-product discounts provide a purchaser  
7 with additional discounts on the condition that the  
8 purchaser buy more than one product. They are a means by  
9 which a GPO can often get a larger discount from  
10 suppliers and then, in turn, offer them to their members.

11 In short, offering commitment programs are  
12 often important to voluntary GPOs that cannot and do not  
13 force their members to buy off their contracts. The fact  
14 that if a GPO cannot generate significant cost savings in  
15 volume of sales through contracts, it will be unable to  
16 negotiate low prices, and it will become ineffective as a  
17 cost cutting vehicle for its members.

18 So, when a plaintiff alleges that a GPO sole  
19 source contract is exclusive in fact or effect, it  
20 carries a heavy burden of proof to show that buyers or  
21 their agents, as distinguished from manufacturers or  
22 sellers, have harmed competition in a relevant market.

23 This may sound straightforward, but these cases  
24 are even harder to prove against buyers, as evidenced by  
25 the fact that there has never been a verdict for such a

1 claim sustained against the GPO. The reason is  
2 relatively simple; GPOs are not your typical defendants.  
3 Sellers don't typically sue their customers or their  
4 agents when they are trying to obtain quality products at  
5 lower prices.

6 The touchstone for such an analysis centers  
7 around, I think, two crucial inquiries, in addition to  
8 defining the correct relevant market. First, you have to  
9 determine whether a GPO has market or monopsony power in  
10 the relevant market and second, whether the GPO has  
11 exercised that power to substantially foreclose a would-  
12 be supplier that is a competitor of the incumbent  
13 preferred supplier from access to the market. So, it  
14 would not be a competitor of the GPO.

15 In conducting this analysis, it's important to  
16 bear in mind that the incumbent supplier may have beat  
17 out a would-be supplier in a competitive bidding process.  
18 It is also likely that while the preferred supplier may  
19 have a three-year contract, almost all GPO contracts can  
20 be terminated on 60- to 90-days notice.

21 In addition, very few GPO contracts today are,  
22 in fact, exclusive. Hospitals that belong to GPOs like  
23 Novation are always free to purchase off contract, and  
24 frequently do so. Many hospitals often belong to more  
25 than one GPO, so switching costs are not significant.

1 All of these factors are critical in assessing whether a  
2 GPO contract has anticompetitive consequences in a  
3 properly defined relevant market, not just simply to an  
4 individual competitor.

5 Let me say a word or two about defining the  
6 markets affected here because this, too, is very  
7 important. First, it will almost always be the case that  
8 a GPO will not have market power in the overall market  
9 for the goods and services purchased through GPO  
10 contracts. There are so many GPOs today that even  
11 Novation has only about 15 percent of such a market.

12 Second, if the market is defined more narrowly  
13 to consist of the market for the product which is  
14 involved or at issue, a GPO cannot be responsible for  
15 potentially foreclosing more than the total purchases  
16 that are represented by its members relative to all  
17 purchases of the product at issue.

18 In each of these scenarios, a GPO by itself  
19 almost never will be able to foreclose a market to a  
20 would-be supplier because its share of the relevant  
21 market is almost always below 35 percent and because most  
22 of its members do not buy exclusively off GPO contracts.

23 These facts, coupled with the factors I  
24 mentioned a moment ago, particularly the ability to  
25 terminate these contracts on short notice, almost

1           invariably lead to the conclusion that GPO contracts  
2           involving a single product, even with a substantial  
3           discount, are not anticompetitive.

4                       That isn't the end of the story. Critics have  
5           also alleged that discounting programs are even more  
6           exclusionary when they involve multiple unrelated  
7           products which are bundled together that must be  
8           purchased by hospitals at high commitment levels, for  
9           example, 90 percent, in order to receive a particular  
10          discount.

11                      Excluded suppliers in these situations assert  
12          that they cannot compete against the bundle of products  
13          when they are offering only one product. That is what  
14          cases like Smith-Kline, Ortho Diagnostics and the recent  
15          LePage's case in the Third Circuit were all about.

16                      Yet, there are two big exceptions to these  
17          cases as they relate to GPOs. The first is that all of  
18          these cases involved competitors suing each other over  
19          claims that one competitor is trying to eliminate the  
20          other. By contrast, the bundles being put together by  
21          GPOs are being put together by a buyer or its agent in  
22          order to get lower prices from the manufacture where  
23          GPO's members are free to participate in the bundled  
24          discount program, they are free to buy outside the  
25          bundled discount program, or they are free to buy off

1 contract all together.

2 Under such circumstances, antitrust policy  
3 would be turned on its head if it prohibited such  
4 programs that were initiated by buyers who were simply  
5 trying to get lower prices because they were willing to  
6 commit to higher purchase levels.

7 The second exception is that in almost all of  
8 these cases, the manufacturer had products with a  
9 monopoly market share and was trying to leverage that  
10 market share into a product market where it did not have  
11 a monopoly market share. It faced competition from a  
12 rival, which is not the case here with GPOs.

13 It may be that a GPO's bundled discount program  
14 of unrelated products contain some products that have  
15 very high market shares, for example, 70 to 90 percent.  
16 But that doesn't mean that the entire market for that  
17 product is foreclosed by a GPO whose members purchases  
18 only represent a small percentage of the total purchases  
19 of that product.

20 The lesson from the LePage's and Ortho cases is  
21 that a seller who is a monopolist of a product that  
22 bundles a product with unrelated additional products and  
23 offers discounts conditioned on high purchase  
24 requirements better have a good business justification  
25 for this pricing scheme other than driving a rival from

1 the market. This is true even if the monopolist is  
2 offering its products above average variable cost.

3 The same warning might also apply to a GPO that  
4 is a monopsonist. But this conclusion does not translate  
5 easily to GPOs, largely because no GPO is a monopsonist.  
6 So, what is the legal standard to analyze GPO multi-  
7 product bundles with high commitment requirements when  
8 some products have very high market shares within the GPO  
9 itself and within the product market, especially where  
10 the claim is that these buyer-initiated programs are  
11 alleged to exclude would-be suppliers or where a  
12 plaintiff contends that the GPO and the preferred  
13 manufacturer are actually working together to keep the  
14 would-be supplier out of the market?

15 Extrapolating from the Ortho and LePage's cases  
16 in a Section 2 Sherman Act context, I believe this is the  
17 correct test where a GPO is not a monopsonist, that is,  
18 it has less than 35 percent of the GPO market and the  
19 product market at issue as well, but offers unrelated  
20 products both as a bundle and individually, some of which  
21 have monopoly market share.

22 By that, I'm talking about 80 percent or more  
23 of their respective markets. And they are offered  
24 through GPO contract at deeply discounted prices,  
25 conditioned on the purchase of a high volume, like 80



1 percent or more. And a plaintiff which offers only one  
2 product in the bundle is claiming that it must  
3 effectively absorb the differential between the bundled  
4 and unbundled prices at which the monopoly products are  
5 being offered by the GPO, and, as a result, is being  
6 unfairly excluded from the product market and an  
7 efficient channel of distribution.

8 That plaintiff has to prove three things.  
9 First, that the incumbent supplier has priced its  
10 monopoly product below average variable cost to the GPO,  
11 which is passing it on to its members. Second, that the  
12 GPO forces, forces its members to buy at these prices,  
13 leaving its members no other practical alternative.  
14 Thirdly, the plaintiff is at least as efficient as the  
15 incumbent supplier of the competitive product.

16 As a result of this pricing scheme, the GPO has  
17 made it unprofitable for the plaintiff to stay in  
18 business or, alternatively, that the plaintiff has been  
19 foreclosed from a substantial part of the market, at  
20 least 40 percent, as a result of this pricing scheme. To  
21 the extent that the plaintiff still has sufficient  
22 alternative channels of distribution, even though they  
23 may not be the most efficient ones, as a matter of law,  
24 the Section 2 claim should fail.

25 The bottom line point here is that any alleged

1 foreclosure or inability to compete must be directly tied  
2 to the bundling scheme and must affect competition in the  
3 market as a whole, not just simply an individual  
4 competitor.

5 If a rival is foreclosed because it is not as  
6 efficient or it is not as competitive as the incumbent  
7 supplier, which may be caused in part by the bundling,  
8 the benefit of any doubt should go to the buyer and to  
9 consumers. Any other rule would entail a substantial  
10 risk that the antitrust laws would be used to protect an  
11 inefficient competitor, not of the GPO but of the  
12 incumbent supplier against price competition that would  
13 otherwise benefit consumers.

14 I think I'll stop at this point because that's  
15 really the framework. I do have some thoughts on the 35  
16 percent rule, but I'll be happy to answer that during  
17 questions.

18 (Applause)

19 MR. ELIASBERG: Thank you, Bob. Incidentally,  
20 Bob has a paper that covers his discussion today that's  
21 on the web site, or will be on our web site. For  
22 example, for those who are interested in the citations or  
23 finding or looking at the Ortho case that he mentioned or  
24 the LePage case, there are citations to it there.

25 MR. BLOCH: There are some outside, too.

1 MR. ELIASBERG: There are some outside that  
2 I've forgotten, nicely bound versions, I believe,  
3 something like this.

4 So, with that, Mr. Hilal.

5 **STATEMENT BY SAID HILAL**

6 MR. HILAL: Good afternoon. Just a simple  
7 question, if the GPOs have happened upon a purchasing  
8 model that is so brilliant, are we to expect that that  
9 model is going to apply to other industries and across  
10 board? Can we imagine a free market operating under that  
11 model? If it is truly a useful model, then how come it  
12 is unique to one industry? No other industry buys into  
13 this. No other industry buys like that.

14 First and foremost, I would like to thank  
15 Chairman Muris, the staff of the FTC, Assistant Attorney  
16 General Pate, and the staff of the Department of Justice  
17 for having singled out health care antitrust as a top  
18 priority enforcement issue. We continue to appreciate  
19 your efforts and those of Chairman DeWine and Ranking  
20 Senator Member Khol for putting the emphasis on what is  
21 going on here.

22 A few years ago, Statement 7 was put in place  
23 with good intent. Today, it has no application and no  
24 connection to market realities. Today the U.S. medical  
25 device market is closed. Ladies and gentlemen, I will

1 share with you our view of it as a young, vibrant,  
2 innovative company attempting to bring nothing more,  
3 nothing less, than better medicine at a better value. We  
4 are shut out. We are more shut out in the U.S. than we  
5 are in foreign markets.

6 Let me tell you a little bit about Applied now,  
7 lest we sound as if we are just a whiny little company.  
8 We are a full U.S. company with 500 people. We're fully  
9 integrated, although we operate globally, we manufacture  
10 here in the U.S. Ninety-nine percent of our products  
11 come out of southern California.

12 We have one of the most competitive cost  
13 structures despite the fact that we do not have the  
14 higher volumes and the larger market shares. We put a  
15 disproportionate amount of our revenues back into  
16 research and development, committing over 20 percent of  
17 our revenues to our R&D commitment and it's paid  
18 handsomely.

19 We own over 380 pending or issued patents, with  
20 a phenomenal utilization rate of 52 percent. In 2002, we  
21 were recognized as one of the most innovative, 50 top  
22 most innovative companies in the U.S. under \$100 million.  
23 The last two years in a row the Society of  
24 Laparoendoscopic surgeons singled out Applied and three  
25 other companies, but we're the one company with two years

1           in a row, as I understand it, that have had the most  
2           innovative products award.

3                         With accomplishments like this, you would think  
4           we were building the momentum like you would not believe.  
          In a free market, sut believe.

1 efforts there. Ninety percent is in the U.S. In the GPO  
2 markets, we are shut out from 80 percent of the market by  
3 just a handful of GPOs. You just heard the GAO report,  
4 seven GAOs control 85 percent of the business.

5 In May 2002, just to give you an idea about how  
6 closed this market is, we went out in a 300,  
7 approximately \$300 million market, and we approached 40  
8 large players. We offered them prices for trocars that  
9 were 60 percent below their contracted prices. Not one  
10 taker. As a matter of fact, we were amazed at how  
11 quickly GPOs responded to quash that campaign.

12 Nearly \$300 million market would have been  
13 priced at \$150. You would think there would be takers.  
14 There were none. Why? Well, many reasons. For one, at  
15 least, three percent on half markets is a lot less than  
16 three percent on fully priced, inflated priced, markets.

17 Teaching centers, university hospitals where  
18 our young surgeons train, where they get exposed to new  
19 modalities, new procedures, new technologies, those are  
20 the most closed, most protected. We cannot give products  
21 free in there. So, what is going on? Why can't an  
22 innovative supplier offer better medicine and better  
23 value and be received?

24 We've tried to answer that question in many  
25 ways. We've developed many models and looked at it, and

1 the answer still eludes us. I will share with you three  
2 models and I'll ask you to think about them and reflect  
3 on it.

4 The first model, monopoly multiple. A handful  
5 of GPOs can control 80 percent of the demand channel, and  
6 they do. One supplier can require 90 percent compliance.  
7 I'd like you to participate in simple math. Ninety  
8 percent of eighty percent, ladies and gentlemen, is 72  
9 percent of the market share. That's monopoly. That is  
10 achievable within the life span of a contract.

11 Once it happens, it's not easy to dislodge.  
12 Once it happens, it's an amazing maze because for the new  
13 contract to be offered to a newcomer, the customers would  
14 have to be familiar with that product. For them to be  
15 familiar with that product, that newcomer must have  
16 access to the market and, therefore, once in, they're in.  
17 Once in, it's a monopoly.

18 Now, how can a supplier really reasonably  
19 mandate 90 percent compliance from 80 percent of the  
20 demand channel? Come on. Those are folks that are  
21 trying to help our patients. Well, let's take a look at  
22 an actual example, and this is especially painful for  
23 Applied because we live it day in and day out.

24 J&J started out with a near monopoly in  
25 sutures. Near monopolies or monopolies are absolute shoe

1           horn for what you're seeing here for new monopolies. J&J



1           percent or the 12 percent.   Examine the suture market.

1 going to go to \$3 billion because it's shoved in the  
2 faces of those who can make it cost less.

3 Let me give you another example, pulse-oximetry  
4 market. Here's an innovative company called Masimo. It  
5 comes up with a better technology that can save life and  
6 save children from going blind for excess oxygen. They  
7 could not get into the market.

8 Eventually, it gets a contract from Novation  
9 and Premier, a bit too late, though, because that  
10 monopoly is already in place. Through simple bundling  
11 and through simple inertia, Masimo now has to fight for  
12 every inch.

13 Not only that, but it is now discovering that  
14 the bundling that was going on at the GPO level, the  
15 bundling that we heard is now declining at the GPO level,  
16 is spreading bad things like you wouldn't believe. As  
17 we're sitting here, the bundling practices are shifting  
18 to the IHNs and the IVNs and the local hospitals. It  
19 worked in one place. Why not have it work in another and  
20 another?

21 Let's talk a little bit about the union model,  
22 very quickly. Like unions, GPOs were tasked with  
23 collective bargaining. Like unions, GPOs were given  
24 exempt -- unlike unions, I should say, GPOs were given  
25 exemptions from anti-kickback laws.

1           But two fundamental differences between GPO  
2 collective purchasing and union collective bargaining,  
3 one is the fees for unions never come from those  
4 negotiating across the table from unions. They come from  
5 members.

6           Second, the duties, the fiduciary duties, have  
7 not split, nor are they conflicting between maximizing  
8 owner's wealth and taking care of membership. Unions  
9 have a clear fiduciary duty. I wonder what the GPO is  
10 going to do about resolving that issue.

11           Let's talk about the other model, third model,  
12 franchiser model. GPOs are not really collective  
13 bargainers. From where we sit, they are rather  
14 franchisers. The franchisers are often exclusive or de  
15 facto exclusive. You heard about the 80 percent, the 90  
16 percent, the 70 percent from GAO. It is a fact that  
17 what's left, if what is left is 10 percent, it is neither  
18 sustainable nor obtainable to go and try to get 10  
19 percent of trocars or 10 percent of clip appliers. It  
20 just simply doesn't happen. It might as well be 100  
21 percent. It is de facto exclusive. It is a franchise.

22           GPOs also upsell other services to franchisers.  
23 So you sign up with them. They want you to sign up for  
24 e-commerce. You buy from them. They want you to buy  
25 their privately-branded OEM products. So, they're not

1 hands off. They are buyers and sellers.

2 Why would hospitals allow franchisers -- come  
3 on, why would a hospital say come on in and make my life  
4 harder? Well, perhaps if they're part owners of the  
5 franchising operation, or if the income is excluded from  
6 reimbursement computation, or if they're convinced of the  
7 savings, although the GAO and others believe that that's  
8 a disputed saving.

9 Why would suppliers agree to a franchise  
10 license? Well, if you'd like to exclude your  
11 competition, you would. If you covered the monopoly, you  
12 would. Very simple. It comes down to protection.  
13 Absent the exclusion, absent the protection of exclusion,

1 J&J declined to participate. What happened next? The  
2 other dominant player got the contracts. From our  
3 standpoint from where we sit, that's how the world looks.  
4 It may look fine and dandy and happy. From our  
5 standpoint, from the patient's standpoint and the cost  
6 standpoint, it doesn't look that way.

7 In conclusion, this is a time for change. The  
8 nation has 42 million uninsured. Cost is going up. We,  
9 as providers of insurance, saw a 19 percent increase last  
10 year. Fourteen percent of it is in rates. The other  
11 five or six percent went to our people in the form of  
12 higher deductibles and higher co-payments.

13 This nation needs to address this issue for two  
14 reasons. One is health care is a noble cause and it  
15 needs to be addressed with a full heart. We're  
16 appreciative of anybody that is attempting to help out in  
17 this situation.

18 Secondly, this is not a free market. Health  
19 care has been conditioned to accept price increases,  
20 enough so to where we see people defining favorable  
21 outcomes as not too big a price increase. On the other  
22 hand, a lot of high technology areas are benefitting from  
23 better productivity.

24 Innovation is not more expensive. We're a  
25 nation proud of our productivity. Our productivity comes

1 from innovation. If innovation is allowed to go free to  
2 the marketplace, it's going to help with better clinical  
3 outcomes and better cost outcomes.

4 I thank you very much.

5 (Applause)

6 MR. ELIASBERG: Thank you very much, Mr. Hilal.  
7 Mr. Strong.

8 **STATEMENT BY JOHN STRONG**

9 MR. STRONG: Thank you, Ed. It's nice to be  
10 here this afternoon. I have four principal objectives.  
11 I'd like to spend just a minute familiarizing you all  
12 with who Consorta is, give you a little overview and  
13 background on the company, and talk a little bit about  
14 our contract management philosophy. I think it's  
15 important for you to understand what we represent there,  
16 and really spend the balance of my time talking about the  
17 strategy itself as it relates to bundling, contract term  
18 and sole source contracting, and then give you a couple  
19 of final thoughts on what we see as the reality of the  
20 medical device marketplace today.

21 Consorta is wholly owned by 12 Catholic health  
22 care systems. We're a for-profit cooperative.  
23 Cooperatives are not unique to health care. I would  
24 offer up some other examples, such as Ace Hardware and  
25 True Serve Corporation, which serves independent hardware

1 stores; Sunkist; Farmland Industries, which serves farmer  
2 interests, they buy and market on their behalf; and also  
3 Certified Grocers of Illinois, which is actually a coop  
4 of grocers in the State of Illinois that serves small  
5 independent grocers. So, this is not something that's  
6 unique to health care.

7 Our purchase volume right now is about \$3  
8 billion annually, which puts us in the top seven. Our  
9 Board took a look at matters a year ago with the Senate  
10 Subcommittee hearings and we drafted our own code of





1 1.1 percent.

2 I think it's important to note that contract  
3 administrative fees, or CAF, are paid by suppliers for  
4 group purchasing services that we render. Some of these  
5 services include allowing the supplier to have one  
6 contract in the market versus literally hundreds for  
7 individual health care facilities. We provide marketing  
8 and contract visibility. We also provide contract  
9 implementation support. We do an extensive amount of  
10 contract evaluation.

11 We are a contract administrative fee-funded  
12 model. As you can see, our revenue this year is  
13 projected at about \$45.5 million. We'll deduct the \$14.1  
14 million of operating expense and the \$31.4 million goes  
15 back to our owners to help them reduce their supply cost.

16 If you flip this around, as some would suggest  
17 that our owners should be picking up the tab, this would  
18 result in them paying out of their pockets about \$14.1  
19 million to operate the coop. Some people in previous  
20 testimony have also suggested that that \$45.5 million  
21 could translate to pure discounts that would somehow  
22 lower the cost of products. We don't believe that  
23 there's any evidence to support that whatsoever. In  
24 fact, we think that most of that \$45 million would  
25 disappear, would probably be retained by the suppliers,

1 and our owners would be left holding the \$14.1 million  
2 expense, which inevitably would drive up the cost of  
3 care.

4 We've been very serious about returning a high  
5 margin for our owners since the inception of the company.  
6 We began in 1999 and returned about \$9 million to them  
7 and a 60 percent rate of return. As you can see, this  
8 year that rate of return is going to be about 71 percent  
9 and about a \$31 million return.

10 One of the key things that has made Consorta  
11 work is the fact that our shareholders all have a voice,  
12 every single one of them. It's committees of all  
13 shareholders in Consorta who make all of the contracting  
14 decisions and, in fact, all of the contracting awards.

15 They decide which suppliers get the contracts,  
16 what their compliance requirements are going to be,  
17 because they're the ones that have to do it, and also the  
18 type of contract that's going to be awarded, whether it's  
19 a sole source contract, a dual source contract, or a  
20 multi-source contract. Every shareholder has a seat on  
21 our Board of Directors. They see financial statements  
22 every month, and they help us set the budget.

23 They also have a seat on every single  
24 contracting body. You can see on the lower right hand  
25 corner there, we have 11 contracting bodies who make

1 recommendations to a contracts and programs committee.  
2 That is a group of owners, that is all of the owners, who  
3 get together on a regular basis and make the contract  
4 awards. Staff does not do that.

5 As I said earlier, quality products and best  
6 price are really our key initiative, and we prefer having  
7 all of the value placed on price. But that's not always  
8 available. In some cases, to get the best value, we have  
9 to request rebates.

10 We also don't bundle any disparate product. We  
11 have no private label program, which is something that's  
12 been an issue in the past. Our administrative fees have  
13 been capped at three percent since the inception of the  
14 company. We've never exceeded the three percent cap.

15 I think you have to take a look at the health  
16 care marketplace and recognize that it's made up of many  
17 sub-markets. We believe sincerely that the only way to  
18 really get at those sub-markets is to do large scale  
19 clinical evaluations and really try to prove to our  
20 owners what the best route is.

21 It's the willingness of members to move volume  
22 from one supplier to another who are going to drive the  
23 best price at the end of the day. If you can't do that,  
24 you have no credibility with the suppliers, and you're  
25 not going to get the best price. So, it's something

1           that's absolutely critical.

2                       As I said, we don't bundle disparate products.  
3           We're not suggesting that it's wrong; we just don't do it  
4           because we don't believe in all cases it yields the  
5           lowest price for the best value. It may end up having  
6           products on the contract that aren't products that our  
7           shareholders find the best value in.

8                       It also tends to make it difficult for us to  
9           look at all of our contracting options on an all-  
10          inclusive basis. We like to say that we include every  
11          manufacturer who has a viable product. If you bundle too  
12          many products together, it gets a little bit challenging  
13          when you try to manage that.

14                      We do bundle similar products together  
15          sometimes, however. Our owners want the ability to have  
16          full-line product contracts because they need assurance  
17          that these products are going to work well together, that  
18          they can train their staff and their patients  
19          effectively, and that there's a product and process  
20          standardization route through the contract.

21                      We also make no bones about the fact that  
22          occasionally we'll bundle generic pharmaceutical products  
23          with branded items. That effectively is the only way we  
24          can get discounts on some of those branded items. So, we  
25          create bundles to try to offer a better price for our

1 owners.

2 With regard to contracting term, I think if you  
3 look at our contracts, generally we award three-year  
4 contracts. However, in certain cases, it shouldn't be  
5 surprising that we want to do a longer term contract if  
6 we can lock in a lower price in a market that's  
7 characterized by relatively increasing prices.

8 We also have to look at the cost that we incur  
9 when we evaluate products. There's GPO cost, which you  
10 can see on the left hand side of the screen. Our members  
11 also incur significant cost when they help us evaluate  
12 products.

13 We've also done two other things so that long  
14 term contracts don't have to impede competition. I think  
15 Bob alluded to some of this. We've included new  
16 technology provisions in all our contracts on a go-  
17 forward basis since the inception of our Code of Conduct.  
18 It allows us to go outside a contract with a manufacturer  
19 for new technology.

20 In virtually all of our contracts, with perhaps  
21 one or two exceptions, we have a 90-day termination  
22 provision. That allows us to cancel a contract if we  
23 can't come to terms and move forward and contract for  
24 that new technology.

25 One of the things that I found interesting in

1 this entire debate is the fact that in many cases, it  
2 seems to be the manufacturers who are saying that they  
3 have new innovative technology. We don't believe that  
4 it's the manufacturers who should be determining whether  
5 something is new and innovative. They certainly play a  
6 role in that.

7 However, it's the clinicians and the other  
8 product users who at the end of the day we feel really  
9 make that final determination. They do it three ways,  
10 either through quality improvement, through improved  
11 patient outcome or through some other cost benefit  
12 scenario that's available to them.

13 Let's talk for a minute about what a really  
14 large clinical evaluation looks like. This happens to be  
15 the results from an evaluation we conducted last year on  
16 suture and endoscopic product. This is a product  
17 category and these numbers reflect just the work that we  
18 did to get to the contract decision point to show our  
19 shareholders what they were thinking.

20 The evaluation took 18 months. Our direct  
21 costs were over \$150,000. That's not the opportunity  
22 cost. We looked at product utilization in over 8,500  
23 surgical cases in 60 of our facilities with over 2,100  
24 surgeons participating. At the end of that evaluation  
25 process, our owners said this was too much work to award

1 just a three-year contract to. In the end, they decided  
2 to award a five-year contract.

3 We also looked at the marketplace and found  
4 that there were only two full-line manufacturers, the  
5 Ethicon Division of Johnson and Johnson, which represents  
6 probably a 70 percent market share, and the United States  
7 Surgical Division of Tyco International, which probably  
8 had about a 20 or 25 percent market share.

9 Because of that dynamic and the fact that we  
10 did go to market for both sole and dual contracts, we  
11 decided to award a sole source contract. Here are the  
12 results. We were pretty satisfied with these results in  
13 terms of creating competition.

14 First of all, we found out that U.S. Surgical  
15 had a 98 percent clinical acceptability rate in our  
16 facilities. So, the two products were viewed by surgeons  
17 as being pretty comparable. If you take a look at the  
18 blue line, you'll see the proposal we received from  
19 Ethicon. Not surprising that it's going up in a market  
20 that is dominated by a single supplier.

21 On the other hand, U.S. Surgical offered a  
22 five-year fixed contract, and that led to the conclusion  
23 that over five years we could save \$58.3 million,  
24 probably one of the single biggest cost savings that  
25 we'll ever achieve as a group purchasing organization.

1           We don't think that sole source contracts have  
2 to lock out suppliers at all. First of all, our  
3 shareholders decide who they want to deal with. It's not  
4 us that's out calling those shots. As other people have  
5 pointed out, having a contract with a GPO doesn't  
6 guarantee that that business is going to move anyway.  
7 There is no penalty at Consorta for noncompliance anyway.

8           Generally, and not surprisingly, suppliers  
9 reward for higher levels of compliance because they're  
10 offering increased dividends in exchange for volume.  
11 That's what it's all about. They're looking for that  
12 compliance to meet their volume projection.

13           Our shareholders also want commitment across  
14 their systems. They want product standardization because  
15 it leads to lower inventory costs, the ability to  
16 standardize patient care, leading to better quality,  
17 better staff education and improved safety. I think they  
18 would tell you that it's consistent with the way most  
19 U.S. businesses operate today. If you take a look at Wal  
20 Mart and Cosco, they certainly have made their mark in  
21 the logistics business by standardization.

22           Finally, a couple of thoughts on marketplace  
23 reality. First of all, health care procurement really is  
24 unique. The product requester isn't always the person  
25 who is paying the tab. If you take a look at the slide,



1 the sale cycle kind of begins on the right there with a  
2 supplier who tries to sell to a physician, creating  
3 demand. The physician demands a specific product. Along  
4 the way, he may influence some of his partners or peers  
5 to purchase that specific brand. The hospital buys it on  
6 their behalf.

7 They can do it one of three ways. They can  
8 either use a GPO contract, they can write their own  
9 contract, or they can simply pay market price. All too  
10 often, they simply pay market price because there is no  
11 contract governing the transaction at all. The hospital  
12 initially pays for the product, but it's also worth  
13 noting that ultimately those costs all get passed on to  
14 the payer.

15 Now, I think it's also worth noting that  
16 physicians can receive payments from suppliers for  
17 services that are rendered. We're not suggesting that  
18 this is wrong, because suppliers do need physician input  
19 for product development, educational support and for  
20 other purposes.

21 In considering this, about the only place that  
22 leverage is created in a high clinical preference area is  
23 with a contract back over on the left. If that leverage  
24 isn't created, it can lead to some very costly outcomes.

25 This is an actual example of what's going on in

1 one of our facilities. There's a paid supplier  
2 consultant, who is a physician, and he influences about  
3 300 surgical cases a year. He has two partners, who he  
4 also influences. So, the sphere of influence here is  
5 about 800 surgical cases.

6 Back in November, we awarded contracts to a new  
7 supplier for surgical kits. The price previous to the  
8 award with the former supplier was \$1,344. The new  
9 supplier came in with a price of \$1,282. Things were  
10 fine until the supplier consultant was told by the  
11 administration that he needed to move along with the rest  
12 of the physicians. He's resisted doing that. As a  
13 result, the hospital is now forced to pay \$1,893 more per  
14 procedure or about \$1.5 million annually. That's for one  
15 hospital. So, this can have a significant impact.

16 I think you have to remember that each medical  
17 device market has dramatically different attributes. You  
18 look at the number of manufacturers for a product, the  
19 stage of the life cycle, a whole host of different  
20 variables. Each one requires a unique contracting  
21 strategy.

22 We believe that universal rules that govern all  
GPOs could with Ily dilidical

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1 the meaningful attributes are that they want to takTh e  
2 of their patients.

3 I think you also have to recognize that every  
4 GPO is different. We have different contracting  
5 strategies, different size, different ownership models  
6 and so forth. At the same time, suppliers are not  
7 standing still.

8 This is a quote from an article that appeared  
9 in the September 3rd Wall Street Journal that was  
10 headlined "Orthopedic Firms Latch Together." I think  
11 there was one really good point in here. Two recent  
12 deals in the medical devices sector are a testament to  
13 how companies reckon beefing up their size will help them  
14 demand higher prices and therefore better margins.  
15 That's why we feel that healthTh e needs strong group  
16 purchasing, because the suppliers are also gaining. We  
17 need to be able to group our purchases together just like  
18 they're grouping their sales together.

19 Finally, if you takTa look at the Fortune 500  
20 list of healthTh e manufacturers in this country, about  
21 \$364 billion of their overall volume was without a group  
22 purchasing contract in 2001. Only \$56.8 billion of their  
23 overall revenues came from purchases that were covered by  
24 a GPO contract. So, we believe that we need to be able  
25 to stand up to that as well.



1 after the head of what I consider probably to be the  
2 shining example of the best kind of GPO delivers a  
3 presentation like that. So, for the purpose of this  
4 conversation, we're going to assume that we're not really  
5 talking about Consorta here, but there are other ones  
6 that we can talk about.

7 Before I begin, I would like to thank Chairman  
8 Muris and his staff at the FTC and also Assistant  
9 Attorney General Pate and his staff at the Department of  
10 Justice. I think I'd also like to thank Senator Khol and  
11 Senator DeWine for keeping this issue at the forefront.

12 There are some issues that we're going to need  
13 to deal with as we move forward. My concern today is  
14 that although we have many legal wranglings and many  
15 legal discussions, what we have to look at is what is  
16 really important. What I believe is what's really  
17 important is answering the question, does Health Care  
18 Policy Statement Number 7 protect patients and  
19 caregivers. I believe that the answer to that question  
20 as it stands today is no.

21 Now, we have a real train wreck approaching as  
22 our Congress struggles to figure out what to do about  
23 health care. We've got 4,000 different numbers about how  
24 long Medicare will last, how long social security will  
25 last. I think we know this much. We know that we have

1 millions of baby boomers, many of us in this room it  
2 looks like getting close to that point. We have 41  
3 million uninsured who are all going to be requiring high  
4 volumes of health care services. We're going to have to  
5 find a way to pay for that.

6 In order to do that, we're going to have to  
7 live in a health care marketplace that is very, very,  
8 very competitive, much more competitive than it is today.  
9 We're also going to need innovation. We're going to need  
10 small companies, large companies, innovators who are  
11 going to create the new generations of products that,  
12 when given opportunities in the marketplace, will be able  
13 to generate not only better care but also lower cost.

14 Let's take a quick look at examples of some of  
15 the GPO practices that block innovation and also block  
16 lower costs. Some examples are supplier paid fees, sole

1       There's a lot happening in the health care supply  
2       marketplace, and we need to get the Policy Statement  
3       caught up.

4                   It's not simply a matter of what is legal. I  
5       know that you're here looking at legal issues, but we  
6       also have to look at the impact on patients and  
7       caregivers and on whether or not, for example, doctors  
8       are able to choose what products they will use in terms  
9       of treating patients.

10                   If the doctors don't get to choose the

1 suppliers with market power the ability to choose when  
2 they do and when they do not want to compete. If they  
3 don't want to lower a price, even if there's a good  
4 reason to do so, they can cite the most favored nation's  
5 clause as the reason why they do not have to offer a  
6 lower price. Also, it creates a legal burden of proof  
7 for harm that it is so high that it cannot possibly  
8 provide protection to the public.

9 Bundling limits competition and it is imposed  
10 at two levels. First is the primary GPO corporate level.  
11 An example of that would be Novation's opportunity  
12 program. In that particular case, the hospital has to  
13 purchase multiple products from multiple suppliers and  
14 stay within that very rigid framework or it's not going  
15 to receive the promised rebate at the end of the program.

16 At a secondary level, manufacturers with market  
17 power are able to exclude competitors, in some cases with  
18 the GPO support and in some cases without. For example,  
19 a multi-line supplier might be able to go to a hospital  
20 who is considering buying a product from a small company  
21 like Applied and say, you know, you might be able to buy  
22 that product and you're right, you're free to do it.

23 However, if you choose to buy from that  
24 supplier, you're going to lose significant discounts on  
25 all the other products that we sell to you. So, yes,



1 possible is free, but no, the hospital is not really as  
2 free as one might think.

3 Then we end up in a situation where the  
4 hospital has to choose between its own financial survival  
5 and doing what's best for patients and caregivers. I'm  
6 not sure that's a choice that hospital CEOs should be  
7 forced to make.

8 Next is the case of a multi-line supplier with  
9 a GPO mandate, an example of that would be that a small  
10 manufacturer might have an opportunity to sell to a  
11 particular hospital system, but the GPO may have a clause  
12 in the contract in place that would make the volume of  
13 purchases required to use that contract so high that  
14 barely a handful of hospitals would qualify to use that  
15 supplier. There are other examples as well.

16 Long term sole source contracts limit  
17 competition. Now, sole source is not a bad thing. If  
18 you look around the world, you will see that many  
19 companies utilize sole source contracts. That's not the  
20 issue. A single hospital IDN utilizing a sole source  
21 contract is normally going to get the best price. That's  
22 how you do it.

23 The problem comes when you have a large GPO or  
24 multiple GPOs with strict compliance requirements that  
25 bridge across multiple geographies. Now you're creating

1 a situation of scope and scale that is such that all a  
2 dominant supplier has to do is win two or three or four

1           So, in discussing whether or not the GPO can do  
2 both, I'm going to leave that up to those of you in this  
3 room to decide that.

4           Let's look at the long term impact of GPO  
5 bundling and sole source contracts. Now, over time, a  
6 GPO's relationship, especially a large GPO  
7 interrelationship with a supplier with market power, over  
8 time, I think what we're seeing in this industry is that  
9 we have a smaller impact of price discounts and a larger  
10 impact of fees.

11           So, as that market power supplier gets more  
12 powerful, they can reach a point that I'm going to call  
13 the competitive tipping point, and that's the point at  
14 which the GPO who previously had the market power on  
15 behalf of the buyer members is suddenly put in a  
16 situation where it cannot use that buying power because  
17 without realizing it, it has played a role in reducing  
18 competition and now is faced with the terrible prospect  
19 of having a contract with only one bidder that isn't  
20 going to reduce much in terms of price or it's going to  
21 have to face another supplier that really wants to take  
22 that over.

23           So, I think it's really important that we look  
24 at this and we understand that there are consequences.  
25 Just to give you an idea of life in procurement outside

1 of health care, a director of procurement's  
2 responsibility, one of their primary responsibilities is  
3 to ensure competition.

4 Many companies in various industries actually  
5 give a small piece of business or a reasonable size piece  
6 of business to a number of suppliers just to make sure  
7 they're still in the game because someday that primary  
8 supplier may not be able to supply or may be in a  
9 situation where they could raise the price as buying  
10 power is transferred to the sellers, becoming selling  
11 power.

12 So, why would this happen? The safe harbor  
13 establishes GPOs as a taxing authority over the  
14 activities of the health care supply chain. I know  
15 that's a rather strong statement and you're probably  
16 wondering how I can make that. Well, a taxing authority  
17 is someone who takes a percentage of transactions. When  
18 you go and you pay sales tax, what is sales tax? It is a  
19 percentage of the transaction. GPOs do that, too.

20 Now, we call it fees when they do it in terms  
21 of a contract that they negotiated, but a number of GPOs  
22 have a practice that requires suppliers to pay them fees  
23 on contracts the GPO did not negotiate. I wouldn't call  
24 that a fee. I would call that a tax.

25 For years we've been hearing that hospitals

1 don't have to pay for the cost of using GPOs. So, who  
2 really does pay for the cost of using GPOs? Well, let's  
3 look at this. Congress passed the safe harbor. GPOs are  
4 permitted to collect fees. GPOs award contracts to  
5 sellers. Sellers pay fees to the GPOs.

6 Now, those fees are included in the price of  
7 the product to the hospital. Why is that? Because  
8 manufacturers don't have a magic bucket of money that  
9 they can take money out of and say, okay, this is what  
10 we'll use for fees but everything else over here is okay.  
11 They would have a real problem complying with Sarbanes-  
12 Oxley if they operated that way. So, we know that they  
13 don't.

14 Those fees are reported by the hospital or in  
15 the product price to Medicare. Medicare establishes a  
16 payment rate to the hospital and sends the hospital a  
17 check. Guess what? Medicare is funded by an  
18 appropriation from Congress, and at the end of this what  
19 we see is that tax dollars pay GPO fees.

20 So, let's now ask the question, do fees provide  
21 a good return on investment for taxpayers? If GPOs  
22 really lower product prices, why are there no scientific  
23 studies to prove the cost savings claims? All we ever  
24 get is one opinion poll after another.

25 Why is there no cost savings reporting standard



For The Record, Inc.  
Waldorf, Maryland





1 all venture investing last year. While I cannot provide  
2 you with a detailed analysis of Health Care Policy  
3 Statement Number 7 and the safety zone provision, I'm  
4 here today to shed some light on the realities of growing  
5 start-up life sciences companies in the U.S. today.

6 I hope my insight will enlighten the Federal  
7 Trade Commission and the Department of Justice about the  
8 daunting course of new technology companies to get their  
9 products to patients and the immense risk associated with  
10 investing in these companies.

11 The venture capital community exists in part

1                   Over the past 30 years, the venture community  
2                   has financed 1,324 innovative medical companies with more  
3                   than \$20 billion in start-up capital. These companies  
4                   now have sales of tens of billions of dollars, employ  
5                   more than two million people, and, most importantly, have  
6                   revolutionized medical care for nearly all Americans.

7                   It is fair to say that virtually every U.S.  
                  citizen born during the 1.

1           But venture investors do not and will not  
2           accept unnecessary and unfair risks. We need to provide  
3           our investors with justification that substantial capital  
4           investment can result in successful product development  
5           and financial gain. Thus, we have no interest in  
6           products that can be blocked from fairly competing for a  
7           share of a market, even after a long, expensive and risky  
8           product development cycle.

9           Venture capitalists will increasingly stay away  
10          from many investments in long term, high risk medical  
11          breakthroughs where anticompetitive business practices  
12          are likely to artificially limit access to medical  
13          markets.

14          The possibility of anticompetitive practices in  
15          the medical sales and distribution sectors serves to  
16          erode venture capital confidence in fair access to  
17          medical markets and unnecessarily increases the risk that  
18          a new medical technology will fail to run what is already  
19          frequently a fatal gauntlet to market.

20          Simply put, any company subject to or  
21          potentially subject to anticompetitive practices will not  
22          be funded by venture capital. As a result, many of these  
23          companies and their innovations will die, even if they  
24          offer a dramatic improvement over an existing solution.

25          The anticompetitive practices of GPOs disrupt

1 the already highly entrepreneurial and risky process of  
2 bringing medical innovation to market. The reality is  
3 that GPOs as a whole are now financed and thereby  
4 controlled by large medical product companies rather than  
5 by the hospitals they're intended to represent.

6 So, clearly, Mr. Strong has made a case that  
7 that is not the case with his particular GPO, but we must  
8 keep our focus on the majority of the GPOs where, in  
9 fact, let me repeat, GPOs are financed and thereby  
10 controlled by large medical product companies rather than  
11 by the hospitals they are supposedly the agents for.

12 While the government would not tolerate such  
13 practices in any other sector of the economy, for it to  
14 tolerate the situation in medicine is very disturbing,  
15 because one of the clear effects is to impede innovation.  
16 That is certainly not the government's intent. In  
17 medicine, in contrast to any other sector, reduced  
18 innovation ultimately affects patient's lives and health.  
19 There's no doubt that patient's health have suffered as a  
20 result of GPO activities as a whole.

21 In light of this, the anticompetitive  
22 activities of the GPO should be viewed with even more,  
23 not less, skepticism. The usual arguments in favor of  
24 permitting hospitals to form buying associations, or  
25 GPOs, must be weighed against the reality that these

1 buying associations are de facto national monopsonies but  
2 are easily influenced by the very sellers they buy from.

3 Fees and other incentives running from large  
4 medical manufacturers to GPOs allow such manufacturers to  
5 inappropriately influence the buying policies of the  
6 GPOs, because the compensation of most GPO management is  
7 almost always based on this fee income rather than on the  
8 real savings to hospital members, which, by the way, is  
9 essentially impossible to calculate.

10 A large manufacturer selling numerous products  
11 may be willing to slightly discount temporarily one  
12 stream of monopoly profits to protect another key product  
13 line from ruinous competition from a small innovator. In  
14 fact, the mere possibility that this could happen might  
15 prevent the innovator from ever being funded in the first  
16 place. But the existence of GPOs makes anticompetitive  
17 contracting incredibly easy and efficient for these large  
18 manufacturers who would have to negotiate separate  
19 contracts with thousands of individual hospitals instead  
20 of with three or four large GPOs.

21 So, the GPOs provide a very efficient vehicle  
22 for the large manufacturers to throw their weight around  
23 in the market. We recognize that there are true economic  
24 benefits of cooperative buying arrangements and that it  
25 is difficult to weigh these benefits against the cost of

1 decreased competition.

2                   However, the influence of supplier fees running  
3 directly from medical product's vendors to the manager of  
4 the GPO buyers completely confounds any such analysis and  
5 creates such an appearance of unfairness and corruption  
6 as to deter many venture capitalists from funding new  
7 innovators in these markets.

8                   The venture capital community believes that  
there are es(diw)Tj-5.es opcren mlanat

1 significantly.

2           If you peel back another layer and you look at  
3 the absolute dollars that are going into medical devices  
4 and medical technology right now, it's roughly the same.  
5 It's not statistically significant that it's meaningfully  
6 higher or lower. What is statistically significant is  
7 the valuations at which the money is going in.

8           Small companies and entrepreneurs who are  
9 starting innovative companies are suffering because of  
10 the risks that the investors see coming before the  
11 company. As I said, while GPO contracting isn't the only  
12 barrier that can foil a young company's success, it does  
13 have an impact in a long list of items that can trip them  
14 up.

15           I think it's also important to notice that  
16 while valuations of established companies, i.e., public  
17 companies in the public market, are now fairly  
18 attractively priced, there's a big difference between the  
19 two. Again, there's a lot of confidence, I think, in  
20 shareholders of these larger companies that they are  
21 going to be able to maintain their market power.

22           So, again, there are good and legitimate ways  
23 for them to do that. I just do not think and the venture  
24 capital team does not think that the added advantage of a  
25 GPO who is being paid by them is the most efficient way

1 to be sure that they're doing so fairly. There's  
2 absolutely no way to be sure that the savings are true  
3 savings.

4 Thank you very much.

5 (Applause)

6 MR. ELIASBERG: Thank you, Ms. Weatherman.

7 Mr. Heiman, you get to bat clean up.

8 **STATEMENT BY GARY HEIMAN**

9 MR HEIMAN: Well, since I know that I'm the  
10 only one that separates all of you from the end of this  
11 or the panel discussion, I'll try to be very, very brief.

12 Well, first of all, I would like to thank the  
13 members of the Federal Trade Commission and the

Department of Justice fwoum.SBERG: TFTD(ehynabT13.3cepart TFTDi 9iE



1       founded in 1940. We employ approximately 1,200 people in  
2       the United States. We have 22 manufacturing facilities  
3       worldwide, and we sell in over 40 countries.

4               Let me just begin by saying that when we  
5       received our first significant GPO contract, we were a  
6       small company of \$60 million. We actually won the  
7       contract for our textile products from a \$5 billion  
8       Fortune 500 company because we were able to show that we  
9       offered value beyond price, benefits, and as well as  
10      superb pricing that they could not do. So, despite all  
11      the other things that they were offering, they were  
12      excluded from the textile contract and we were awarded  
13      it.

14              Let me talk about what Standard Textile is all  
15      about and what our mission is all about. We are  
16      committed to contributing to patient care excellence and  
17      staff protection in cost effective and sound  
18      environmental ways. We are also committed to developing  
19      innovative technologies and systems which better serve  
20      our customers and lower their total cost. The meaning of  
21      this is essentially finding ways to reduce the cost of  
22      health care.

23              We have a strong commitment and a strong  
24      budgeting which goes into research and development, to  
25      taking commodity products, generic products, and



1                   I do want to mention that we have what I would  
2                   call strong competition in every product category that we

1 their GPOs and say, hey, Standard Textile has 35  
2 consultants that will work with us to lower our total  
3 cost and not just the cost of the acquisition cost or the  
4 unit cost of the products which we are acquiring.

5 Likewise, we have another system which actually  
6 goes into hospital laundries, which are generally run as  
7 something that has to be in the hospital because they  
8 have to have some way to process and to launder their  
9 products. But nobody there has -- they have a mind set  
10 of providing the best possible medical care for their  
11 patients. They don't understand that a laundry is a  
12 production facility. The way that we think about it,  
13 it's a manufacturing facility. So, we bring in our  
14 engineers.

15 We do for them forecasting, planning,  
16 engineering, and we have been able to take tremendous  
17 costs out of their laundering operations and literally  
18 brought down hospital costs by hundreds of thousands of  
19 dollars per year between their laundry costs and  
20 everything else which goes within their process. So, we  
21 truly bring value beyond price, and I think the GPOs have  
22 recognized that.

23 I'll go through this very, very quickly because  
24 I'm going to get into more detail in one second. The  
25 benefits of GPO contracts, as we see them and have seen

1       them, is that they reduce cost and increase efficiencies.  
2       They level the playing field for all vendors. They  
3       increase purchasing options for hospitals, and they lower  
4       the total cost to our customers.

5               By reducing costs and increasing efficiencies,  
6       the GPOs allow us to decrease costs across the entire  
7       supply chain, and that means from our acquisition of raw  
8       materials, fiber, chemicals, energy costs, water, and  
9       transportation services. Across the entire spectrum they  
10      have allowed us to decrease our costs in those areas.

11             They've also allowed us to decrease our  
12      marketing expenses and reducing our sales force by about  
13      15 to 20 percent, as well as bringing our bidding  
14      department down to about three people because we're  
15      dealing not with thousands, hundreds and even thousands  
16      of hospitals, but we're dealing with large groups that  
17      are negotiating for the benefit of their members.

18             Speaking about leveling the playing field for  
19      all vendors, GPOs help us and have helped us compete with  
20      large companies. We developed a new and innovative  
21      fabric which we then turned into surgical gown and  
22      draping in surgical packs.

23             At the time that we did this, one of the GPOs  
24      had a sole source agreement with one of the large Fortune  
25      500 companies, bringing value to their hospitals,





1 value-added service has had a major impact on cutting  
2 their costs.

3 So, in conclusion, let me just say the  
4 following things. Number one is that in our experience,  
5 GPOs have lowered costs for the vendors and  
6 manufacturers. But, in doing that, they have  
7 significantly lowered the costs for our customers and for  
8 their members.

9 They've leveled the playing field for small and  
10 medium-sized vendors like ourselves and have given us the  
11 opportunity to compete against the Goliaths. We did that  
12 when we were a \$60 million company and as a medium-sized  
13 company today, we still do it today.

14 They have greatly improved supply chain  
15 efficiency. When I say they've improved supply chain  
16 efficiency, they've done it from the manufacturer or the  
17 vendor all the way through the hospital. I think it's  
18 very, very important to point out that hospitals today  
19 don't have to carry inventory on their shelves because  
20 vendors help them do their forecasting, their planning.

21 They get consolidated shipments. Sitting on  
22 all that capital, which was a common practice before, the  
23 GPOs together with suppliers have virtually eliminated  
24 all of that.

25 So, with that, I promised I would be brief.





1       sole source contracts don't foreclose choices because  
2       there are opt out provisions. On the other hand, these  
3       contracts allegedly generate large supply side  
4       efficiencies, which they generate by providing certainty  
5       to suppliers.

1                   MR. STRONG: I'd like to point out, too, that I  
2 think the argument has been made in the past that sole  
3 source contracts somehow only benefit big companies. I  
4 don't think that's the case at all. I think we have  
5 examples of a number of suppliers that are small  
6 manufacturers, that we have maybe one or two million  
7 dollar contracts with that would argue that a sole source  
8 contract is very beneficial. There's a couple of reasons  
9 for it.

10                   Probably, the single biggest reason is that if  
11 a market share leading company, a large manufacturer, has  
12 a dual source contract with us, it's oftentimes very hard  
13 to get the health care providers, the hospital, to take a  
14 look at anything else. If you have a sole source  
15 contract with a small innovative manufacturer, there's  
16 much more incentive for the hospital to take a look at  
17 that.

18                   There's probably better value. At the end of  
19 the day, the small supplier is going to be rewarded by  
20 actually seeing the volume move from the market share  
21 leader to their sales ledger. So, I think that sole  
22 source contracts can have significant benefits for small  
23 manufacturers.

24                   MR. EVERARD: I'm going to weigh in on that as  
25 well. I think again the key here is that it's not so

1 much whether or not there's a sole source contract; it's  
2 how big is the contract, how big is the GPO, how much  
3 volume are we talking about. If you're talking about a  
4 tremendous amount of volume, you do have the potential to  
5 foreclose competition.

6 But I believe in sole source contracts, and I  
7 think John's GPO is of the size that for him to do a sole  
8 source contract, regardless of the size of the company,  
9 it's going to provide a good result. On the other hand,  
10 if Novation and Premier decide to do sole source  
11 contracts, the outcome may be different.

12 So, I think it's a matter of looking at how big  
13 the power of the GPO is in terms of deciding whether or  
14 not a sole source contract is of benefit.

15 MR. BLOCH: I guess I would weigh in there in  
16 response to that. Simply because a GPO is large doesn't  
17 mean that there's going to be an anticompetitive effect.  
18 The word that's used is the potential. But you just  
19 can't take it at a surface analysis. You've got to get  
20 underneath that contract to find out whether or not  
21 people are free to buy on contract or off contract, how  
22 long the contract is, whether it can be broken, whether  
23 people can join other organizations and buy through those  
24 organizations.

25 I think there's empirical data out there that

1 suggests from SMG that most hospitals belong to somewhere  
2 between two and four GPOs. So, they have a lot of  
3 options. As long as those options are there and  
4 hospitals aren't forced to buy through a particular  
5 contract, whether they're with a small GPO or a large  
6 GPO, it doesn't mean there's going to be any  
7 anticompetitive consequences to it.

8 MR. BYE: As a purely factual question, do GPOs  
9 or suppliers ever break these contracts using opt out  
10 clauses?

11 MR. EVERARD: Well, don't have representatives  
12 -- well, John maybe can speak to that.

13 MR. STRONG: We have from time to time broken  
14 contracts. Our intent in going into a contract is not to  
15 rip it up, but I think that when we went back and took a  
16 look at our code of conduct last year, we tried to cover  
17 not only terminating the contract but also allowing for  
18 new and innovative products so that we could continue to  
19 work with the manufacturer who held the contract as well  
20 as somebody who offered a new and innovative contract.

21 I think the thing that gets ignored in the  
22 conversation is the fact that at the end of the day, the  
23 market, which is really made up of caregivers and  
24 hospitals, are the ones that ought to be deciding whether  
25 something is new and innovative. I think they're the

1 ones that ultimately make the decision as to whether a  
2 product fails or succeeds.

3 MR. BLOCH: I also think that these contracts,  
4 whether they end up sole source or otherwise, you can't  
5 overlook the fact that there's a competitive process  
6 involved here, usually at the front end. So, for  
7 example, if companies like Novation and Premier put out  
8 requests for bid and they get a lot of bids, the result,  
9 the sole source result is the result of a competitive  
10 process. It creates an incentive for the vendors to  
11 submit their best offers, their best prices, their best  
12 terms and conditions, because there's a lot at stake.

13 So, if you look at the economics literature, if  
14 you look at antitrust cases, you will see that that is a  
15 form of competition that is important, that is valued.  
16 As long as those decisions are being made by people who  
17 have a significant interest in the outcome of how those  
18 contracts are awarded, I think that's your principal  
19 safeguard from an economic point of view.

20 MR. HILAL: If I may, I can see how Mr. Bloch,  
21 as representative of Novation, would see it that way.  
22 Frankly, in a lot of bids, we don't even get the RFP to  
23 bid on. Our issue is still whether or not there are  
24 punitive measures when someone deviates from the existing  
25 contract.

1           The hospitals may be free to cross the road,  
2           but if someone is ready to run them over financially, I  
3           would submit to you that they're not as free as one would  
4           like to think.

5           MR. ELIASBERG: If I could ask a follow-up to  
6           that to any of the panelists who care to respond, when  
7           you read some of the materials on the web concerning  
8           hospital group participating organizations, there's a  
9           suggestion that there are what sometimes are described as  
10          penalty clauses, that is to say, provisions that if a  
11          hospital would terminate with the particular GPO or start  
12          using a product other than what the particular GPO has on  
13          its supply list, that the hospital not only will no  
14          longer receive discounts but has to pay back a discount,  
15          sometimes over a few years.

16          I guess the question I have, simply, is an  
17          empirical one, and I open it up to anyone on the panel,  
18          and I guess, Merrile, I'm going to pick on you first, if  
19          anyone knows of just empirically, is there data out there  
20          on how frequently that occurs or how often that's there?  
21          If not, people can just give their sense of if that's an  
22          accurate assessment or not.

23          MS. SING: That's not something that we covered  
24          in our most recent report.

25          MR. HILAL: Our understanding is that the

1 rebates can be recalled, simply stated. In other words,  
2 if certain requirements are not met, not only are the  
3 rebates subject to interruption, but the previous rebates  
4 made under certain conditions can actually become due.

5 Mr. Elhauge in his report touched on that. So,  
6 for those of you who got that report, you may want to  
7 visit that aspect of it and find out how chained some  
8 hospitals are or a lot of hospitals are in this aspect.

9 Thank you.

10 MR. EVERARD: I'd like to respond to that as  
11 well. I think again the real question we're facing right  
12 here is if the GPOs want to have it both ways. On one  
13 hand, they want to tell their members that they've got  
14 these great contracts, they're getting the best prices.  
15 You simply can't get great contracts with the best prices  
16 and not give anything in return. It doesn't work that  
17 way in the real world.

18 If we're to believe that a GPO can offer the  
19 best prices, then we believe that you can get -- and yet,  
20 not have a requirement for compliance and participation,  
21 then we believe that you can get something for nothing.  
22 I think most of us are old enough to realize that in this  
23 world, you can't get something for nothing.

24 If a manufacturer is going to go to the trouble  
25 of getting a contract, there's certain things that they





1       they vary across GPOs.  If members are free to  
2       participate in those or not participate, then the fact  
3       that they choose to do so makes it clear that they think  
4       there's some value or benefit to them.  So, if they make  
5       that commitment knowing what the fine print says going  
6       in, it doesn't mean that there's something wrong with it.

7                I think one pervasive assumption that underlies  
8       a lot of the really critical comments that I've heard  
9       here this afternoon is the fact that the hospitals which  
10      own the organizations that are involved here, who sit  
11      across the table from the manufacturers and from the  
12      consultants and from the brokers, somehow don't know or  
13      understand what's in their economic interest.

14              The critics seem to think that they don't  
15      understand how to run their hospitals.  They don't  
16      understand how to provide care in an effective and  
17      efficient way.  I think there's a lot of sour grapes in  
18      this.  I think a lot of these people do understand that.

19              That's why they belong to a lot of these  
20      organizations.  That's why they have an ownership  
21      interest.  That's why they form coops.  That's why they  
22      direct them about what the programs they want.  If they  
23      didn't, they would either not belong or go elsewhere.

24              MR. HILAL:  It's really interesting that at  
25      this point in time we're pondering whether hospitals know

1        what's best for them or not. We have every respect for  
2        the customer. We believe the customers are entitled to  
3        know what they're paying for.

4                There was a time when buying an airline ticket  
5        was very confusing, and the customer had a chance to find  
6        out more and more about the pricing. Mr. Bloch's client,  
7        Novation, has agreements in place that actually are very,  
8        very difficult. We know it firsthand.

9                It is something to present a hospital with a  
10       situation that would save them, let's say, \$200,000 on a  
11       \$500,000 purchase and have higher ups in the hospital  
12       say, boy, this looks really interesting. That would help  
13       a lot. We have to check with our J&J sales rep and find  
14       out if we can do this. When you ask them what does that  
15       mean, the answer is, well, we need to know if we comply.

16               Time after time with documented example after  
17       example, the Ethicon person or the J&J person, what have  
18       you, will come in and will always start with, you won't  
19       comply. That savings of \$200,000 will cost you another  
20       \$300,000 in suture price increases. Then we go through  
21       the numbers. More often than not, we find the so-called  
22       mathematical errors.

23               But it's a back and forth situation where the  
24       customer doesn't really know. It's a shell game. Then,  
25       when we're done with the pricing of the individual

1 products and their bundling, then we get into the so-  
2 called rebates. There's another shell game.

3 Now, specifically, the largest GPOs have a  
4 tendency to play this to the fullest with the largest  
5 most dominant of suppliers. The customer deserves to  
6 know something as simple as what am I paying for this  
7 product. It doesn't have to be a four-level equation to  
8 figure that out.

9 MR. STRONG: I think that what's being  
10 described here can't all be laid at the feet of the  
11 largest or the smallest group purchasing organizations  
12 entirely. I think some of this needs to be owned by  
13 medical device manufacturers, both large and small, the  
14 tactics of their sales force, the tactics that they  
15 employ to try to retain business when business tries to  
16 move from one competitor to another.

17 I think that it's an overgeneralization to say  
18 that complicated contracts are purely the business of the  
19 group purchasing organizations. I don't think that's the  
20 case at all. We try to simplify contracts, but it's a  
21 very complicated marketplace, and it's very difficult to  
22 do that in some cases.

23 The suggestion has also been made that group  
24 purchasing organizations are somehow controlled by  
25 manufacturers. I have 12 board members who would take

1 great umbrage at that comment. I think that if you look  
2 at the facts with the large group purchasing  
3 organizations, those are also controlled by the hospitals  
4 who own them.

5 There is an independent board who runs them. I  
6 think the hospital executives who run those boards and  
7 are on those boards and serve as their chairman would  
8 probably take umbrage with that comment and that  
9 implication as well. These are independent boards that  
10 see value in aggregating purchases.

11 MR. BYE: That partially preempts my next  
12 question, which was I was interested to hear the views on  
13 incentives of the GPO vis-a-vis the hospitals. Some of  
14 the panelists have suggested that GPOs might have a  
15 different incentive to those of the hospital. That would  
16 seem to me to be only possible if the members didn't have  
full ownership of that entity.

1 determine whether or not they want to see a contract  
2 structured the way it is or not. So, I think they have a  
3 pretty clear idea going in what the contract is going to  
4 look like, what the value proposition is.

5 I can tell you that most group purchasing  
6 organizations do very extensive analysis of what the  
7 value proposition of a contract is going into the  
8 contract decision-making process, there may be some shell  
9 games that are played by sales representatives in the  
10 field. We have a pretty good idea going into the  
11 implementation of a contract exactly what kind of value  
12 is going to be delivered, as was evidenced by the slide I  
13 showed you on suture and endosurgical products.

14 MR. BYE: Even if a GPO is entirely owned by  
15 its members, are there circumstances in which it could  
16 have incentives to behave in a way that was contrary to  
17 their members' interests?

18 MR. STRONG: I think the end game is always low  
19 price and good value. The suggestion has been made that  
20 somehow group purchasing organizations are selling out  
21 for bigger administrative fees. Group purchasing  
22 organizations have to compete with one another for  
23 business.

24 As several people have noted here, there's  
25 change going on in the industry and health care providers







1           considerably limited.

2                        Venture capital did a phenomenal job for the  
3 past 30 years absorbing the majority of risk for the  
4 large corporations in medical devices. They bet on  
5 companies when they're very risky, very young. When they  
6 develop, and usually development means development of  
7 technology, development of product market testing it,  
8 proving its safety, its efficacy, getting some clinical  
9 input, clinical papers, etc., when most of the risk is  
10 absorbed, that's when corporations step forward and claim  
11 that innovation. They include it in their channels of  
12 distribution and go forward.

13                      But in the process, venture capital had the  
14 ability to at least get a return on its investment. The  
15 reason they were able to do that is because there was  
16 always the option of going out and getting 20 people,  
17 establishing a sales force and saying, look, if you're  
18 not going to be able to recognize this technology and its  
19 value, then I've got other options.

1 with them, why would they have to buy it? That's one.

2 Secondly, if venture capital has no way out, no  
3 way of liquidity other than to sell to them, why would  
4 they pay them the full price? They wouldn't. That's  
5 what's being reflected on the pricing. That's what's  
6 being reflected on the returns for these things.

7 MR. BLOCH: Let me make just one observation  
8 here, and I don't know if Merrile can add to this.

9 To the extent that these general comments  
10 relate to GPOs, the GAO report that was released in July  
11 had a very interesting statistic. In fact, to me, it was  
12 probably the most interesting conclusion in the entire  
13 report.

14 It was on page 10 and it said that nearly one-  
15 third of all newly negotiated contracts awarded by the  
16 seven GPOs, these that represent so-called 80 percent of  
17 the market, in 2002 were awarded to manufacturers with  
18 which the GPO had not previously contracted.

19 So, clearly, and there are literally hundreds  
20 of contracts with all of these GPOs because there are  
21 thousands of products, so clearly, a very, very  
22 significant percentage of manufacturers who haven't been  
23 involved with one GPO or another are getting contracts.

24 Now, I don't know how many of those reflect  
25 innovative products. You know, maybe Merrile can comment

1 on that if she knows. But it certainly suggests that  
2 there aren't significant barriers to entry here in terms  
3 of manufacturers being able to develop relationships with  
4 organizations like this that didn't exist before.

5 MR. EVERARD: Can I respond to that? Many of  
6 the contracts that came out were in a flurry of activity  
7 that took place in late 2002 after the first GPO  
8 hearings in the Senate Antitrust Subcommittee. What you  
9 saw happen in many cases, and this would have skewed the  
10 numbers, was that large GPOs opened their contracting to  
11 very large numbers of small suppliers.

12 For example, in the glove contracts for Premier  
13 and Novation, they opened up their contract to as many as  
14 a dozen suppliers. What you may not know is that those  
15 contracts, and many others, were for only 18 months.  
16 Right now, as we're sitting here, Premier is deciding  
17 which of those suppliers on the glove area it's going to  
18 get rid of. It intends to pare it down significantly.

19 So, yes, that's a nice statistic, but we have  
20 to look behind the numbers to see what it really means.

21 MR. HILAL: If I may add one comment also, I  
22 truly believe that the number of contracts is the wrong  
23 metric to observe because it's very easy to give  
24 contracts out of politeness, out of political expediency.  
25 You can give a lot of contracts out.

1           The simple question is this, can the new  
2 entrants be given an even grounds opportunity to  
3 penetrate the market? How much has the market share been  
4 changed by such contracts? That's an important issue.  
5 If the products are bundled together the way they are  
6 with a Novation agreement, then is the penalty still  
7 there?

8           The fact that I may have a trocar agreement  
9 with Novation but the penalty, the financial penalty is  
10 still there, if the customer were to buy anything but  
11 Johnson & Johnson's trocars, what advantage does this  
12 contract give me? Next to nothing.

13           MR. STRONG: But at the end of the day, it's up  
14 to the customer who is a member of the group purchasing  
15 organization to really decide whether they want to do  
16 that and use the new technology or continue with the  
17 incumbent supplier.

18           So, it's the hospital that's still making the  
19 decision. It's not the group purchasing organization  
20 that is driving that phenomenon. It is the hospitals  
21 that own the group purchasing organizations that make the  
22 decision.

23           I think that it's commendable that certain  
24 group purchasing organizations have put out multi-source  
25 contracts. But at the end of the day, it's up to the



1       entrusted with making sure that these things don't  
2       happen, step in and say this bundling and this illegal  
3       kind of one thing with the other, if that is the case in  
4       these situations, are to be examined and ought to be

1 MR. BYE: Exactly.

2 Do any other panelists have suggestions as to  
3 data that might be worthwhile gathering?

4 MR. EVERARD: I want to go back to something  
5 that we talked about a few minutes earlier. The notion  
6 that one might be suggesting that the hospitals maybe  
7 don't know what they're doing when it comes to the supply  
8 chain, I don't think that's the issue. I think the real  
9 issue is the question that I keep coming back to, because  
10 I just can't understand it and maybe some of you can  
11 enlighten me.

12 On one hand, it's the hospitals that are  
13 telling the GPOs to come up with these complicated,  
14 convoluted contracts that will save them more money.  
15 Yet, the hospitals are hamstrung by their own desires  
16 that they want to go and use a better product but now  
17 they can't because it's going to cost them more money.

18 So, I just have to ask the question, why would  
19 a hospital CEO, a board member, or somebody actually  
20 agree to do it that way? What am I missing?

21 MR. BLOCH: I'll let John answer, too, but I'm  
22 not sure you're missing anything. I think the decision  
23 to have these programs and have these contracts are  
24 because that's what they want. If they didn't want it,  
25 they wouldn't ask for it.

1           So, it goes back to my point that once they  
2           have these programs, individual hospitals are free to  
3           decide whether they want to participate in them or not.  
4           They're not shoved down their throat. If they decide to  
5           participate in those programs, it's because they want the  
6           benefits of them and they're willing to accept the  
7           compliance and commitment levels. So, there's nothing  
8           wrong with that.

9           There are lots of people who participate in  
10          these GPOs that don't participate in the committed  
11          programs because they don't want that. They want the  
12          freedom to go off contract or go elsewhere. So, I'm not  
13          sure you're missing anything. I think that's the  
14          explanation.

15          MR. STRONG: I think I agree with Bob. Some  
16          people see value in bundled programs and see economic  
17          return in that. They're comfortable with the products  
18          that are contained in the bundle, and others aren't.  
19          They don't participate in those cases.

20          MR. HILAL: This begs the difference, then.  
21          What was the advantage, if I may ask, of breaking the  
22          bundle between endomechanical, which is bundled itself,  
23          but endomechanical separate from sutures for what your  
24          organization --

25          MR. STRONG: We thought that there might be an



1 opportunity to lower cost by looking at the two  
2 marketplaces independently. We, in fact, did that. We  
3 asked for sole and dual source pricing from both  
4 suppliers. At the end of the day, we chose United States  
5 Surgical, both on the basis of their cost, as I  
6 illustrated in the chart, as well as the clinical  
7 acceptability of their product.

8 So, we did look at both. We tried to include  
9 other manufacturers as well. But I have to tell you, at  
10 the end of the day, one of the decision-making points in  
11 U.S. Surgical getting the award for both suture and endo  
12 was a complete product line. Our owners saw value in  
13 having products that they perceived to work well  
14 clinically and work well together. That's why the award  
15 was made that way.

16 MR. HILAL: The silver lining here is there's  
17 agreement between Consorta and Applied that unbundling in  
18 a lot of situation ends up resulting in lower prices,  
19 more options for the buyer, especially in a monopoly  
20 situation.

21 If, for some reason, U.S. Surgical did not have  
22 a suture, would that have affected the pricing on  
23 endomechanical, on ligation, on clipper pliers, on  
24 sutures, I'm sorry, on trocars? That is the question I  
25 had of us. That is a key element of what we're asking

1 for here.

2 MR. STRONG: Well, I think that's very  
3 speculative and it's tough to say. I mean, the market  
4 determined what the cost was going to be when we went to  
5 market a year or 18 months ago. The market is already  
6 changing. I think you're seeing different competitive  
7 tactics now in the marketplace than you would have seen  
8 two years ago with regard to the pricing of those  
9 products, with the bundling or unbundling of those  
10 products. As a result, I don't think you can speculate  
11 what would happen if you had or hadn't put certain  
12 products under contract. The market is very fluid and it  
13 will react to those types of changes.

14 MR. ELIASBERG: I'm going to jump in here now  
15 to turn to another topic, which I can't resist asking a  
16 question about. We heard a little allusion to Statement  
17 7. Just so that everybody is clear, Statement 7, which  
18 covers group purchasing by health care entities, has a  
19 safety zone in it that has a two-prong test, the safety  
20 zone being that it's something that automatically will  
21 not be challenged by the Agencies, and not necessarily  
22 something falling outside of it will.

23 The first test is that the group purchasing  
24 arrangement not account for more than 35 percent of the  
25 total volume of the product being sold in the relevant

1 market. The other test is a 20 percent test, basically  
2 that the items being bought do not account for more than  
3 20 percent of what the actual final product being sold by  
4 the purchaser is charged, or costs, I should say.

5 Mr. Everard has indeed pressed a great deal on  
6 Statement 7. I would be particularly interested in  
7 hearing any views or thoughts about just how appropriate  
8 Statement 7, as it is currently drafted, is with respect  
9 to the hospital group purchasing organization situation?

10 I'll take any volunteers here.

11 MR. BLOCH: I guess I'll jump in here. Ed,  
12 you've outlined the two provisions that fall within the  
13 safe harbor, but let me clarify a couple of points.  
14 First of all, the first requirement that the purchases  
15 under the arrangement are less than 35 percent of total  
16 sales of the product in the relevant market, that's  
17 directed at whether the participants in the arrangement  
18 have monopsony powers. So, that's a significant issue  
19 directed at a number of the topics that have been  
20 discussed here.

21 Second, the second requirement, whether the  
22 product being purchased is less than 20 percent of all  
23 the revenues derived from all the products and services  
24 sold by each participant, really goes to the requirement  
25 of whether the arrangement could result in standardizing

1 prices of a common significant input among the  
2 participants in a way that would enable them to fix the  
3 price of their products as they compete with each other.

4 The question, I guess, is, is there a problem  
5 with the Statement that needs changing? My answer to  
6 that is no, for several reasons. First, I don't think  
7 there's any evidence to suggest or really demonstrate  
8 that there's anything wrong with the Policy Statement as  
9 it presently exists. The underlying rationale for this  
10 Statement is still valid with respect to the subject  
11 matters that it addresses.

12 Secondly, there is no evidence that I've seen  
13 in the years that it's been out there to suggest that the  
14 legal principles underlying the Policy Statement are  
15 wrong or have changed.

16 Third, there is no evidence that I can see to  
17 suggest that the Policy Statement is a barrier or an  
18 impediment to the enforcement agencies being able to  
19 address any legitimate antitrust issue that may be raised  
20 concerning GPOs, or the enforcement agencies are somehow  
21 incapable of pursuing legitimate issues concerning GPOs  
22 if there's evidence to support them.

23 Fourth, to the extent that the issues raised  
24 concern exclusive dealing or monopolization or monopsony,  
25 which has been discussed here quite a bit today, there's

1 no evidence to support the view, that I see, that the law  
2 is inadequate as it exists now to address them or that  
3 the courts have not been able to deal fairly with these  
4 issues, or that the enforcement agencies cannot deal with  
5 this subject or these issues, which they have done in the  
6 past in other contexts, if evidence or a legitimate  
7 problem presents itself.

8 You don't have to have a policy statement for  
9 every problem that exists when there's adequate law,  
10 there are adequate venues to investigate or prosecute  
11 such cases. In fact, the antitrust law has been in  
12 existence since 1890. There hasn't been a rule for every  
13 single practice or piece of conduct which has ever  
14 occurred. If that were the case, the Agencies would  
15 never have been able to enforce anything.

16 There are laws of general application.

17 There are laws dealing with exclusive dealings.  
18 There are laws in cases dealing with monopolization. It  
19 doesn't have to be located in a policy statement  
20 somewhere when these cases have been brought for decades.

21 In short, I don't see any evidence to suggest  
22 that there's been a failure of the law or of enforcement  
23 or of the courts to deal with these issues when they're  
24 presented. Changing the Policy Statement, for example,  
25 the safe harbor, just take that as an illustration, by



1                   So, in short, I think the rule as it exists  
2 today is perfectly adequate for the reasons that I  
3 mentioned. I think the law is perfectly adequate to deal  
4 with these problems. I think the Agencies are perfectly  
5 capable of dealing with issues that are presented to them  
6 if they feel they're justified.

7                   MR. EVERARD: Could I just ask a question of  
8 Mr. Bloch? You said that none of those cases had been  
9 successful. Then, your client agreeing to a settlement  
10 out of court would not be a success for the company that  
11 brought the suit?

12                   MR. BLOCH: Well, first of all, I'm not going  
13 to discuss litigation.

14                   MR. BYE: This is not the forum to discuss  
15 particular cases, I'm sorry.

16                   MR. EVERARD: He made a blanket statement, so I  
17 felt like it's important to respond.

18                   MR. BLOCH: I made a statement that said that  
19 the cases that have been brought, the litigated cases  
20 that have been brought and been decided by the courts,  
21 there has never been a case that has ultimately been  
22 successful against a GPO.

23                   MR. HILAL: I will stay away from the  
24 litigation issues. I am not a lawyer, Mr. Bloch is, and  
25 so I'll stay far away from that issue.

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1           might be pharmaceuticals and I really can't speak to  
2           that. But in terms of all other products, our costs, I  
3           know, at our hospital and within our system have come  
4           down dramatically.

5                         MR. ELIASBERG: Thank you. It appears that we  
6           have run out of time. That being so, I want to thank all  
7           the panelists for their excellent presentations. I'd  
8           appreciate it if you would join me in giving a hand to  
9           this panel.

10                        Thank you.

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

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MATTER NUMBER: P022106

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CASE TITLE: HEALTH CARE AND COMPETITION LAW

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DATE: SEPTEMBER 25, 2003

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

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DATED: OCTOBER 17, 2003

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KAREN GUY

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

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

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