1 FEDERAL TRADE COMMISSION
2 and
3 DEPARTMENT OF JUSTICE
4
5
6
7 HEARINGS ON
8 HEALTH CARE and COMPETITION, LAW, AND POLICY
9
10
11
12 REMEDIES: CIVIL/CRIMINAL
13
14
15 Wednesday, October 1, 2003
16 9:15 a.m.
17
18
19
20
21 FTC Conference Center
22 601 New Jersey Avenue, N.W.
23 Washington D.C.
24
25

1 MODERATORS:

2

3 Leslie Overton, Department of Justice

4 Cecile Kohrs, Federal Trade Commission

5

6 PANELISTS:

7

8 Jack Bierig, Sidley & Austin

9 James A. Donahue, III, Pennsylvania Office of the

10 Attorney General

11 Kevin Grady, Alston & Bird

12 Gail Kursh, Department of Justice

13 Kevin J. O'Connor, Godfrey & Kahn

14 Melvin H. Orlans, Federal Trade Commission

15 Toby Singer, Jones Day

16 Gregory Vistnes, Charles River Associates

1 FEDERAL TRADE COMMISSION

2

3 I N D E X

4

5 Remarks by Ms. Kursh - Page 3

6

7 Remarks by Mr. Orlans - Page 13

8

9 Remarks by Mr. O'Connor - Page 23

10

11 Remarks by Mr. Donahue - Page 34

12

13 Remarks by Mr. Singer - Page 45

14

15 Remarks by Mr. Grady - Page 53

16

17 Remarks by Mr. Bierig - Page 62

18

19 Remarks by Mr. Vistnes - Page 78

20

21 Roundtable discussion - Page 88

22

23

24

25

1 overreaching. Our ultimate and only goal is to protect
2 competitive markets for the benefit of consumers.
3 In the course of reaching that goal, we know that
4 remedies can have unintended effects in the marketplace. So
5 it's our job to try to predict such effects or consequences
6 to the extent we can, and avoid them if that's possible.
7 A second guiding principle, and this is
8 particularly important in civil conduct cases or civil non-
9 merger cases: There must be a close, logical nexus between
10 the remedy and the alleged violation. The Division will
11 carefully tailor the remedy to the theory of the violation.
12 And we think this is the best way to ensure that the remedy
13 will cure the competitive harm.
14 The third guiding principle is the well-known adage
15 that the remedy should promote competition and not
16 competitors. Although this may seem pretty obvious to all of
17 us, it is particularly important in crafting appropriate
18 relief. The Division’s goal is to promote and protect
19 competition, not to pick winners and losers in the
20 marketplace.
21 And finally, but very importantly, the remedy must

1 We also have to give careful attention to
2 identifying those persons who must be bound by the decree to
3 make the remedy effective, and also to insure that they are
4 giving effective notice of the decree's provisions.
5 Now, not only must the decree be enforceable, it

1 relief without any sort of divestiture, and most of those
2 were in the defense and telecommunications industries where
3 there's a long tradition of regulatory or quasi-regulatory
4 oversight.
5 The only case of stand-alone conduct relief from
6 the Division in the healthcare industry was the Morton
7 Plant/Mease hospital merger in 1994. And for those of you
8 who followed the Morton Plant/Mease judgment, you know that
9 it ultimately presented many problems down the road.
10 In June 2000, the Division filed a civil contempt
11 action against the hospitals, which among other things
12 permitted managed care companies to terminate their contracts
12 with4.8 0 TD0 0

1 The appropriate goals of a civil non-merger remedy
2 are to end the unlawful violation or the unlawful conduct,
3 the violation, prevent its recurrence, and eliminate the
4 anti-competitive consequences that came from the specific
5 violation.
6 Now, in some cases simply enjoining the specific
7 illegal acts that were challenged in the complaint may be
8 sufficient to accomplish these legitimate goals. And if
9 that's the case, that's where the remedy should end.
10 However, in the vast majority of civil non-merger
11 cases, including those in healthcare, more is generally
12 needed. In circumstances where there is a likelihood of a
13 continued or recurring violation, what we call fencing-in
14 provisions may also be appropriate.
15 Fencing-in provisions may prohibit lawful or
16 unlawful conduct, including conduct either not alleged in the
17 complaint or conduct that's completely different from that
18 alleged in the complaint.
19 Although the Division will avoid unnecessarily
20 restraining legitimate behavior, such constraints on
21 legitimate conduct are often needed to prevent recurrence of
22 the violation.
23 It may also be necessary to impose affirmative
24 obligations on the defendants to either prevent recurrence of
25 the violation or to eliminate its anti-competitive

1 consequences.

2 For example, in many of the provider most-favored-

3 nation cases and the physician price-fixing cases the decrees

4 permitted the purchasers of services to terminate or modify

5 their contracts with the providers which were tainted by the

6 violation.

7 In other healthcare decrees, both the Division and

8 the FTC required the defendants to obtain prior Agency

9 approval or, at a minimum, to notify the Agencies in writing

10 before engaging in certain conduct or transactions.

11 Now, although, as I said earlier, large-scale

12 divestiture or dissolution are relatively rare in civil non-

13 merger cases, there may be limited circumstances where no

14 combination of injunctive or affirmative conduct relief will

15 achieve the appropriate goals of an antitrust remedy, and

16 some form of structural relief is also needed.

17 For example, in the Division's older St. Joseph and

18 Danbury physician cases, we recognized that the physician

19 organizations had to reduce their size, and they were

20 required to reduce their size and modify their structure, if

21 they wanted to jointly negotiate with health plans.

22 Also, in our recent Asheville physician price-

23 fixing case, we required Mountain Healthcare, which is a

24 physician or was a physician network joint venture comprised

25 of almost all the private physicians in the Asheville area,

1 to dissolve.
2 Under the circumstances of that case, the Division
3 believed that dissolution of Mountain Healthcare was needed
4 to reestablish competition among physicians in the
5 marketplace.
6 Now, it's important to keep in mind that
7 permissible civil remedies do not have unlimited reach. And
8 the Division is very cognizant of that. Federal civil
9 antitrust remedies are limited to preventing and restraining
10 violations. They are not an opportunity to fix all
11 competitive problems in the marketplace, nor, as I mentioned
12 at the outset, are they an opportunity to punish the
13 defendants.
14 Finally, and very importantly, the remedy must
15 always be related to the violation charge and the competitive
16 consequences of that violation.
17 Now, my overview of Division remedies would not be
18 complete, of course, without at least a brief discussion of
19 criminal penalties. The Division brought a number of
20 criminal cases in the past ten years in the healthcare field
21 involving optometric services, dental services, and generic
22 drugs. All of these cases were per se price-fixing cases.
23 Although the vast majority of cases in healthcare,
24 as in other sectors of our economy, are civil, and with many
25 of them even under the rule of reason, the Division is

1 prepared to bring criminal prosecutions in healthcare where
2 there is a blatant violation of the antitrust laws and clear
3 harm to consumers.
4 Now, a criminal conviction brings up to three years
5 in prison and a $350,000 -- did I say that? -- $350,000 fine
6 for an individual, and a $10 million fine or twice the gain
7 or loss for a corporation. These are serious penalties, and
8 should cause any person in the healthcare industry to think
9 long and hard before engaging in per se price-fixing, bid-
10 rigging, or market allocation schemes.
11 So just in wrapping up, let me emphasize again that
12 the Division remains committed to appropriate, effective, and
13 principled relief in all of its antitrust cases. We try to
14 focus specifically on the facts of the cast at hand and craft
15 a remedy that is tailored to the competitive harm.
16 We also try to achieve the appropriate remedy in
17 the least burdensome way possible, doing as little damage as
18 possible to legitimate pro-competitive behavior.
19 MS. OVERTON: Next we'll have Mel.
20 MR. ORLANS: Good morning. What I'd like to
21 discuss today is the Federal Trade Commission's use of and
22 experience with monetary equitable relief as an enforcement
23 tool.
24 Before I do that, let me echo my colleague Gail's
25 comments that my remarks are my own and do not necessarily

1 reflect those of the Commission or of any individual
2 Commissioner.
3 Now, in antitrust cases, the Commission typically
4 seeks monetary relief when it feels monetary relief is
5 appropriate. It seeks monetary relief in the form of
6 disgorgement. And disgorgement, of course, is an effort to
7 eliminate the ill-gotten gain. That is, disgorgement has a
8 deterrent effect because it takes the profit out of the
9 wrongdoing.
10 These types of cases can involve -- and typically
11 do involve -- overlap with private class actions and also
12 with cases brought by the states.
13 By way of background, let me briefly describe for
14 you the legal authority that the Commission uses in these
15 sorts of cases. Basically, the Commission seeks injunctive
16 relief under Section 13(b) of the Federal Trade Commission
17 Act.
18 And in an injunction case, the court has -- the
19 district court has inherent equitable authority to utilize
20 all of the equitable relief and remedies available to it.
21 And that, of course, includes the authority to issue monetary
22 equitable relief. And again, in antitrust cases, that's
23 typically taken the form of disgorgement.
24 Let me emphasize at the outset that the Commission
25 seeks monetary relief, that is, disgorgement, quite sparingly

1 in antitrust cases. Recently, in July of this year, the
2 Commission set out a policy statement in which it outlined
3 the circumstances under which it would consider monetary
4 equitable relief in antitrust cases. And the Commission set
5 out essentially three criteria that it would consider in the
6 exercise of its prosecutorial discretion.
7 The first of those is whether the violation was a
8 clear violation. And the Commission defines a clear
9 violation as one that a reasonable person would recognize
10 would likely be a law violation in light of existing
11 precedent.
12 The second -- and let me emphasize in that regard
13 that a clear violation does not mean a per se violation, that
14 we have sought monetary relief, disgorgement, in cases
15 involving rule of reason. And I'll discuss some of those
16 more specifically in a moment.
17 Secondly, there has to be a reasonable basis for
18 the calculation of the amount of the monetary award.
19 Thirdly, the Commission's involvement has to yield
20 some value added. And by this criterion, what we mean is, is
21 there really a need for the Commission's action? We want to
21 insurment, in cases

1 reason for the Commission not to bring a case seeking
2 disgorgement.
3 The disgorgement approach is not a punitive
4 approach. The maximum amount of disgorgement is the amount
of the ill-gotten gain. So again, and this is my per4.8.C9cpc/F1 1
11111alle8 gottaisgogenSoic0drug-0.0001 Tc(d5)87 s

1 egregious and a clear violation of law.

2 Secondly, at the time that the Commission

3 considered what action to take, there were no private actions

4 that were pending. Moreover, because of the use of royalty

5 payments based on the excess profits that the companies had

6 achieved, it was clear that there was an easy method

7 available to us for calculating the amount of the remedy.

8 Now, we believed that without Commission action,

9 full disgorgement would have been unlikely. And the reason

for that is that the direct purchasers under Illinois Brick,

1 direct purchasers.

2 The real injury in Mylan was suffered by consumers

3 and by third party payors, that is, by the indirect

4 purchasers. The Commission and the states filed simultaneous

5 actions against Mylan and others, and shortly thereafter

6 class actions were brought on behalf of both direct and

7 indirect purchasers.

8 And all of those actions, of course, were

9 eventually settled. The Commission case and the state cases

10 settled first. The indirect purchaser cases settled at the

11 same time. And the direct purchaser class actions were the

12 last to settle.

13 The Commission and the states received over $100

14 million in disgorgement in the Mylan case, and that money was

15 allocated to compensate both the indirect purchasers, that

16 is, to address the consumer injury, and it also was used by

16 the states to address the direct injury that /F1 1 Ty

16

et inj1ury consumele.

10

11

millime. And i amountis, b co

13 es thamountll of e u inlasenrich

1 quite late and I think fairly cheaply, and that was because
2 as the Commission had originally envisioned, many of the drug
3 wholesalers opted out of that class action.
4 The second case I'd like to discuss is the First
5 Data Bank or Hearst Trust case, and that case was one in
6 which the Commission alleged a consummated merger to
7 monopoly.
8 The product market in First Data Bank was
9 electronic databases for prescription drugs. And after the
10 merger had been consummated, there were huge price increases
11 to the customers of those products.
12 The case also involved alleged Hart-Scott-Rodino
13 violations, and that consisted of the failure to provide
14 certain 4(c) documents to the Commission during the course of
15 the Commission's merger review.
16 Now, again, as in Mylan, the Commission sought
17 disgorgement or decided to seek disgorgement for a number of
18 independent reasons. For one thing, there were no private
19 class actions that were then pending. In addition to that,
20 we felt that absent a disgorgement action, the defendants
21 would be likely to retain their ill-gotten gains.
22 And that was because had the Commission brought an
23 action seeking only divestiture, we felt it was unlikely that
24 that would have attracted any follow-on class actions. So
25 again, we felt that there was a real need for the Commission

1 to bring a case seeking monetary relief.
2 Also, this was a case where the HSR violation was
3 particularly important. The failure to provide the 4(c)
4 documents had essentially hidden from the Commission the full
5 impact of the merger. And, of course, the HSR violation was
6 something that could be addressed only by the Commission or
7 by the Department of Justice and not by a private class
8 action.
9 And finally, as in Mylan, we felt that this was a
10 clear violation. There was a knowing merger to monopoly, and
11 the impact of that merger had been hidden from the Commission
12 in the course of its review by virtue of the failure to
13 produce 4(c) documents.
14 The Commission, in an effort to avoid duplicative
15 recovery, agreed early on in the course of negotiations, and
16 well before the complaint was filed, that any disgorged funds
17 could also be used to satisfy any class actions should class
18 actions be brought. And in that fashion, we felt that the
19 defendants would not be subjected to multiple liability.
20 After the Commission filed its case in district
21 court, class actions were filed on behalf of both direct and
22 indirect purchasers. And those class actions settled almost
23 immediately. The total amount of those settlements was about
24 $26 million, including legal fees.
25 The Commission's settlement was somewhat delayed.

1 Although we had agreed in principle to a monetary award, the
2 Commission's final settlement was delayed by the need to both
3 negotiate a divestiture and then monitor that divestiture to
4 ensure it's success.
5 Ultimately, the Commission settled for prohibitory
6 injunctive relief to govern future conduct, divestiture to
7 recreate a competitor in the market, and $19 million in
8 disgorgement.
9 And as I said before, that $19 million overlapped
10 with the monies that were used to settle the private class
11 action, so the Commission didn't take money on top of the 26
12 million that was being paid in the private class actions. We
13 further agreed to allow the class counsel to administer the
14 redress fund.
15 The DOJ settlement for the Hart-Scott-Rodino
16 violation was ultimately $4 million. So the total amount
17 paid by the defendants, including the civil penalty, was
18 roughly equal to $30 million. And again, our assessment was
19 that that roughly approximated the injury that we calculated
20 had occurred.
21 So what conclusions do we reach based on these two
22 cases? Well, the total recovery in these cases in both
23 instances roughly approximated single damages, not treble
24 damages. And although many parties brought cases, it's clear
25 from the results of these cases that the total monetary

1 relief that was awarded was neither punitive nor unfair.
2 In fact, the monetary relief was exactly what was
3 necessary to remove the profit from the wrongful conduct.
4 Now, whether or not that would be sufficient to deter in the
5 future is at this point still an open question.
6 In closing, let me briefly address the use of set-
7 offs or credits to address and avoid the problem of
8 duplicative recovery. That approach, we feel, is workable
9 where the injury is on the same level of distribution.
10 So, for example, in First Data Bank, where recovery
11 sought by the Commission and that sought by the class actions
12 was in both instances for the direct purchasers, the use of
13 set-offs to avoid duplicative recovery would have been an
14 appropriate and useful technique.
15 On the other hand, the use of set-offs is
16 theoretically problematic in a case like Mylan, where there
17 is recovery with Commission-sought recovery on behalf of
18 indirect purchasers and there was also separate recovery by
19 direct purchasers.
20 Nonetheless, the total recovery in Mylan, as I said
21 before, roughly approximately single damages. So although
22 this raises a theoretical concern, as a practical problem
23 this has not proved to be a problem in the cases where the
4 Commission has sought (2)Tj/TT2 1 Tm

1 Commission seeks monetary relief sparingly in antitrust
2 cases, chooses its targets carefully and in accordance with
3 the policy statement that it recently issued. But used as
4 the Commission has used it, monetary equitable relief in the
5 form of disgorgement has proved to be an effective antitrust
6 tool.

1 into by the Wisconsin Attorney General in healthcare matters

1 decree separating the long distance from the local
2 telecommunications business was regarded as a success because
3 it changed the incentives of the constituent components of
4 AT&T such that they perceived each others' turf as ready
5 targets for increased rivalry through new entry.
6 The line of business restrictions, however, of
7 course, were not generally regarded as effective in enhancing
8 competition, and also were difficult and somewhat expensive
9 to implement.
10 This high level view of remedies from the
11 perspective of I/O economics generally is not very helpful,
12 however, when one is on the ground trying to formulate a
13 conduct remedy for a particular situation, especially when
14 the likely outcome of the liability phase of the case is not
15 clear to either side.
16 For example, there is general agreement that
17 divestiture is preferred in merger cases. The issue becomes
18 considerably murkier when one takes into account litigation
19 risk and unclear case law in merger cases. This, of course,
20 is the question the federal Agencies and state enforcers have
21 had to face with respect to hospital mergers, given the
22 unsuccessful track record of both federal and state
23 litigation challenging hospital mergers.
24 So moving to my second point, the practical reality
25 of healthcare remedies, the history of hospital merger

1 enforcement suggests that flexibility and humility are
2 important virtues when dealing with remedies in healthcare
3 markets. These markets are usually characterized by multiple
4 lapses in the limiting assumptions and boundary conditions
5 for perfectly competitive markets.
6 For example, consumers typically do not pay

1 But the exact nature and extent of these effects is
2 often difficult to predict in an environment where many of
3 the other conditions for perfect competition are not met.
4 Remedy selection is impacted by this reality as
5 well. A merger that reduces the number of sellers by one,
6 especially a two-to-one or a three-to-two merger, is likely
7 to have adverse welfare effects.
8 The most direct route in such a situation would be
9 to litigate and prevent the merger. But if divestiture is
10 unobtainable or does not appear to be obtainable or is
11 unlikely or problematic prior to the decision whether to make
12 a suit, it is possible that in certain cases consumer welfare
13 can be enhanced by ameliorating the effects of the reduction
14 in the number of sellers by fixing other aspects of the
15 market in ways that are likely to enhance consumer welfare.
16 For example, requiring merging hospitals to pass on
17 claimed efficiencies can enhance consumer welfare. Requiring
18 hospitals to open their medical staffs and restricting tying
19 of services may actually improve market performance beyond
20 that in the pre-merger world.
21 Each of these remedy provisions may have costs
22 associated with them that must be balanced, of course,
23 against the possible consumer welfare benefits.
24 As an antitrust enforcer for the state of
25 Wisconsin, I entered into several consent judgments that

1 incorporated certain conduct provisions in lieu of
2 divestiture because they appeared to benefit the consumers of
3 Wisconsin.
4 Because I have described these in detail in the
5 material that I've submitted, I'm not going to go into each
6 one of them in detail here. Suffice it to say we were
7 involved in a hospital merger in the Kenosha area that
8 tracked some of the provisions that were in the Pennsylvania
9 consent decrees that Jim Donahue, I believe, is going to talk
10 about in somewhat more detail.
11 And we also had another consent decree in a merger
12 of two multi-specialty physician clinics in northern
13 Wisconsin: Marshfield Clinic and the Wausau Medical Center.
14 There, we entered into a consent decree that basically
15 limited future acquisitions on the part of Marshfield in a
16 particular area of the state, but allowed both of the mergers
17 to go forward.
18 And then we also had substantial -- and this is in
19 the record -- a decree in a non-merger conduct case against
20 the Wisconsin Chiropractic Association for attempting to use
21 their trade association, allegedly, as a focal point for
22 price-fixing.
23 That's another case where we started the
24 investigation as a criminal investigation, but then
25 eventually treated it as a civil investigation and settled it

1 on those terms with significant conduct relief that's still
2 in place.
3 Now, in each of these cases, the end point of the
4 negotiations, as reflected by the consent judgments,
5 reflected the parties' respective evaluation of their
6 position in the litigation or prospective litigation. A
7 negotiated solution has the added benefit of not only
8 reducing the risk of a complete shutout on remedies, it also
9 means that there may be a broader range of remedies available
10 for the government enforcer to bring into play.
11 For example, in the Marshfield matter, the state
12 was able to obtain relief which allowed Marshfield to enter
13 the Wausau area, where it had had virtually no presence prior
14 to the merger, but to craft relief which prevented Marshfield
15 from using its dominance in areas surrounding Wausau to tip
16 the market for primary and specialty care in that sparsely-
17 populated north central area of Wisconsin.
18 This result appears to have enhanced competition in
19 the Wausau area. At the same time, it allowed already strong
20 healthcare entities in the Wausau area to adjust to
21 Marshfield's entry and threatened Marshfield's dominance in
22 the surrounding areas.
23 The consent judgment we entered into with the
24 Wisconsin Chiropractic Association contains similar
25 provisions that attempted to monitor and limit the ability of

1 the state Attorneys General.
2 This induced a multiple focus on their part, where
3 Attorneys General began enforcing the antitrust laws with
4 great vigor in some cases in healthcare markets at the same
5 time their states continued to regulate and intervene in
6 healthcare markets, often with the Attorneys General in
7 advisory roles.
8 The attorneys general were and are required to wear
9 multiple hats even today when dealing with the healthcare
10 industry, including representing their departments of health;
11 actively participating in certificate of public advantage and
12 CON processes; protecting the integrity of charitable trusts,
13 which run most healthcare institutions, especially hospitals;
14 prosecuting healthcare fraud and abuse; and defending state-
15 employed healthcare providers in malpractice claims.
16 In conclusion, regulation at the state level and
17 the role of the state AGs explains why they are focused on
18 remedies that go beyond the all-or-nothing divestiture remedy
19 that we often prefer in merger cases, or even in Section 2
20 non-merger cases such as Microsoft.
21 In the healthcare area, there often -- we need a
22 broader range of choices and we need a considerable
23 additional degree of humility when we're picking remedies.
24 Thank you.
25 MS. OVERTON: Next we'll have Jim Donahue.

1 MR. DONAHUE: Thank you, Leslie and Cecile. It's
2 an honor to be asked to talk today about our experiences with
3 hospital mergers.
4 We have done some of the sort of unusual conduct
5 remedies that have been talked about a little bit by Gail and
6 Kevin earlier today. And I want to spend a couple minutes
7 talking about why we got to the place we did and what our
8 experience was.
9 And first, as Gail pointed out, typically in
10 antitrust cases you're thinking about two things. You're
11 thinking about a structural remedy or you're think about
12 conduct remedy. And when you're thinking about a conduct
13 remedy, you're thinking about something that is very simple
14 and easy to enforce.
15 We've entered into a number of consent decrees with
16 very complicated provisions, especially dealing with costs
17 and efficiencies, that don't really fall into the regular
18 mode of typical antitrust enforcement. So the question, you
19 know, that people ask us is: Why would you do that in the
20 first place?
21 There are sort of four basic reasons for that.
22 Hospitals are nonprofit corporations, and they have a
23 charitable mission. They oftentimes have a variety of
24 different charitable endowments that have been given to them.
25 And so they're viewed a little bit differently by us and by

1 the case law than for-profit corporations. And that's
2 something we have to take into account.
3 Also, the Attorney Generals have -- you know, they
4 are called the Attorneys General because they are the general
5 enforcers of all the laws in their states. And in addition
6 to the antitrust laws, all of the state Attorney Generals
7 enforce their charitable trust laws.
8 So they have an obligation to see that the
9 charitable mission of these institutions continues, as well
-2hosp2 1001DbornsTT2ompet(-2groupTf4laws. And, you know, we'in el8
.laws. And, you know, we'in e2hey

1 how do you -- what should you do about what has to be the
2 exit of some hospital capacity in this marketplace?
3 That's sort of the setup as to why we did what we
4 did in Williamsport and what the key factors were. Now, as I
5 said, we have the consent decree in the materials. But
6 there's sort of four key provisions, greatly oversimplifying
7 a fairly complicated consent decree.
8 One is no discrimination against non-employee
9 doctors or non-owned health providers in terms of services.
10 No additional employment of physicians; they also owned a lot
11 of primary care doctors. And to the extent that there's a
12 hospital market and a physician market that competes which
13 each other, and which to some extent occurs more and more, we
14 didn't want them getting additional market power in this
15 other market.
16 These two hospitals were very close to each other
17 physically, and that enabled them to eliminate duplicative
18 services and other things. So they believed they could save
19 $40 million over five years. And we required them to pass
20 that back, 80 percent of it back, $31.5 million. And there
21 was an obligation to negotiate in good faith.
22 I want to talk briefly about a couple of the key
23 provisions. On this pass-back provision, we had this
24 language about using the case mix adjusted net and patient
25 revenue per admission for all inpatients treated during the

1 fiscal year. And what we did was we had a base year where we
2 got that number, and then in each subsequent year we looked
3 at that number and compared them.
4 In reality, actually even before we did any sort of
5 adjustments for inflation, the net inpatient revenue went
6 down in Williamsport. In 1999 and 2000, their net inpatient
7 revenue was less than what it was in 1994 when the consent
8 decree started.
9 Now, as I'll get to in a second, the complaint we
10 got from the private health plans in particular was, where's

1 many rural communities, and there's been, you know, a couple
2 of requests from them to add more doctors, which we have
3 turned down so far.
4 In terms of savings, they saved a ton of money.
5 Almost 120 million instead of $40 million.
6 But there have been severe problems with
7 contracting with health plans. Every health plan has had a
8 problem contracting with them. Every health plan has -- you
9 know, there were days where I would get dueling letters from
10 the Williamsport hospital system to the health plan saying,
11 you know, you guys are being unreasonable, followed the next
12 day by a letter from the health plan saying, no, you're being
13 unreasonable. You're an extremely high cost hospital.
14 You're more expensive than every hospital in, you know, even
15 the major cities.
16 Harrisburg/Polyclinic was the next one that we did.
17 We did it a couple of years later. Here, you essentially had
18 two hospitals about two miles apart in the city of
19 Harrisburg. There you had a bigger market, or at least we
20 alleged a bigger market, a three-county market. And you can
21 see also from the revenues these are bigger institutions.
22 And the key factor in that case was that these
23 hospitals were really two miles apart and they did a lot of
24 the same things, and they could do things differently if they
25 eliminated a lot of the duplication, especially of the back

1 office type stuff, like pharmacies and laundries and kitchens

1 a monopolist but a very aggressive and very large -- and the
2 largest system in western Pennsylvania.
3 And there are reasons why they wanted to merge.
4 And there were also reasons why some type of consent decree
5 was worked out.
6 But we learned from our experience in the other
7 cases. We didn't want to have another situation where we had
8 sort of some language about negotiating in good faith. That
9 language is in there, but there's another step, and that
10 other step is that if the good faith negotiations break down,
11 they're forced into binding arbitration.
12 Like everything else, that's another pretty
13 complicated provision, where we have a whole bunch of things
14 the arbitration panel should consider in reaching a decision.
15 It's sort of a semi-last-best-offer type arbitration
16 provision.
17 What have been the results there? There have been
18 no reported problems with access, which was a big concern in
19 the community. And the health plans seem to be ecstatic with
20 this arbitration provision. And we put a lot of effort into
21 making it equally terrorizing for both the health plan and
22 the hospital so that they -- nobody really wants to go to the
23 arbitration provision; they hopefully will work things out,
24 which is the whole point of this.
25 There are some open questions, you know. If you

1 take the Williamsport situation -- which we're going to have
2 again, you know, I think, if you -- you know, unfortunately
3 the news is terrible in terms of employment in a lot of
4 places in Pennsylvania. Factories are closing down, and
5 those jobs are going overseas in, you know, a lot of
6 communities that have -- that really have a very strong
7 industrial base.
8 You know, is it better to organize the exit of the
9 hospital assets through a consent decree, or do you let these
10 people fight it out and let the health plans and consumers
11 get the benefit of that competition as one of the
12 institutions is failing?
13 You know, that's a tough question for us. It may
14 be an easier question for -- you know, on a theoretical
15 standpoint. But it's a very tough question for us when we've
16 got the dual role of protecting the charitable assets and
17 enforcing the antitrust laws.
18 Do we do things like what we've done in the past,
19 which is try to recreate the earmarks of a ,competitive
20 market? You know, in a competitive market, costs would equal
21 price. So if you had cost savings, that would show up in the
22 form of reduced prices.
23 So do we do the savings pass-back things, or do we
24 use these provisions where we do the binding arbitration,
25 where we peg that or try to peg that to other efficient

1 markets?

2 And lastly, you know, if we're going to do a pass-

3 back savings type of thing, how much savings should we pass

4 back to outweigh the competitive effects of the merger? Do

5 we estimate what the merger is going to cost people in terms

6 of higher prices, and then try to get more than that passed

7 back? Assuming you can do that. As Kevin said, pricing in

8 healthcare is obscure at best, and it's not -- it's

1 buying each other, and there you can have limited
2 divestitures.
3 But typically in the case that comes up nowadays,
4 like Harrisburg, like Williamsport, where you have two not-
5 for-profit hospitals, it's really all or nothing. Either you
6 enjoin the merger or nothing.
7 And from my observation, I think that there are
8 some real down sides in some of these cases to going for the
9 all-or-nothing approach, although it's clearly a lot cleaner,
10 more simple, and perhaps more free-market-oriented approach.
11 The benefit to the parties in these cases from
12 working out some kind of a conduct-related settlement like
13 the Harrisburg case is, first of all, they get to do the
14 deal. And as Jim pointed out, that's often a benefit to the
15 community as well because if there are significant
16 efficiencies and other good reasons for allowing the merger
17 to go through, that happens.
18 And at the same time, there is some regulation of
19 potential anti-competitive effects. And from my observation,
20 it's really only those cases where there are significant
21 efficiencies that these kinds of orders are entered and a
22 merger is allowed to proceed.
23 The cost to the government of taking a different
24 approach, I think you can see from what's happened in a lot
25 of the cases that the federal government has brought. The

1 best example of that probably is the Grand Rapids case, where
2 the parties offered to enter into some kind of a settlement.
3 The FTC said, no, we think we need to enjoin this merger,
4 lost in court, and the merger went ahead without any relief
5 whatsoever.
6 Contrast that to the success in Harrisburg, where
7 the merger was allowed to go forward. The hospitals
8 combined, achieved not only the efficiencies they'd projected
9 but went even further and, as census dropped even more than
10 had been predicted at the time of the consent decree, ended
11 up building an entire new patient tower, merging a lot more
12 than they had thought originally, and coming up with a
13 healthcare system in Harrisburg that probably would not have
14 been possible if the two hospitals had remained separate.
15 And at the same time, the Attorney General was
16 paying attention to what was going on in the Harrisburg
17 market, and I think would say that the anti-competitive
18 effects just didn't occur.

2the consent decree, ended

1 every business transaction that the hospitals want to enter
2 into, every physician grievance, turns into a compliance
3 issue with the Attorney General because the physicians will
4 automatically call up Jim or his staff and want to complain
5 about what the hospital is up to. I mean, typically that can
6 be worked out, but it adds to the cost of doing business.
7 I think probably the most interesting thing that's
8 gone on in these cases recently is the insertion of the
9 arbitration clause, which Jim says has been a wild success in
10 Pittsburgh. That's a very scary thing, and I know of at
11 least one set of hospitals that called off their deal -- I'm
12 sure that was not the only reason, but one of the big reasons
13 for deciding not to go forward was the insistence of the
14 Attorney General that an arbitration clause be inserted into
15 the contract. So it's certainly a significant piece of
16 relief.
17 And then, of course, there's some cost to the
18 government in monitoring these cases. It's a fairly
19 resource-intensive kind of thing to pay attention to every
20 year: Have the efficiencies been achieved? What does the
21 expert report say? Deal with the complaints that they're
22 getting. Deal with the "where is mine" from the health
23 plans, which I can attest to hearing myself.
24 But I've come -- you know, coming from sort of the
25 purist approach when I started in my career, I've come around

1 to the notion that there really are some benefits to these
2 conduct settlements in the hospital area, and especially from
3 the enforcement perspective when the alternative is to have
4 nothing. This way, there is some notion that the
5 efficiencies are really going to be passed on to the
6 community.
7 Moving on to a completely different topic, and
8 that's the physician collective negotiation cases, I sat down
9 to think about what the remedies have been in these cases and
10 realized that it's now been 20 years since the government --
11 or more than 20 years since the government brought its first
12 collective negotiation case.
13 And I'm not talking about Maricopa, price-fixing,
14 or anything like that. I'm talking about a case that's now
15 in the obscure annals of history called Preferred Physicians,
16 Inc. out of Tulsa, Oklahoma, which was brought by the FTC in
17 1982, and settled at that time.
18 That was a case where a group of physicians formed
19 what they called a PPO, decided they were going to
20 collectively negotiate with the health plans in the area, and
21 refused to deal individually with the health plans in the
22 area. They took a fee schedule that they called the Red Book
23 and decided that this is the fee schedule they were going to
24 use, and they weren't going to discount more than 10 percent
25 off of that fee schedule.

1 Now, does this sound familiar? Does this sound
2 like every other physician case that's been brought for the
3 last 20 years? Well, what's going on? Why can't either the
4 government figure out that this is not a problem or
5 physicians figure out that they're going to get nailed for
6 doing this same kind of thing over and over?
7 Well, I think we could probably spend the next four
8 hours trying to figure out the physician psychology and
9 everything else that might explain it. I'm sure Jack has
10 some thoughts on that as well. But focusing on the remedies
11 that have come across in these consent orders maybe will help
12 get to a point where at least these cases perhaps get less
13 frequent.
14 The core remedies have been the typical cease and
15 desist, don't do it any more remedies, with a little bit of
16 fencing in -- no information exchanges, reporting and record-
17 keeping, the kind of standard antitrust remedies. And the
18 early cases, with a few exceptions, pretty much stuck to that
19 framework. And that, of course, didn't have much impact.
20 So more recently, there have been other remedies
21 that are introduced into these orders that at least in some
22 cases may have an effect on the particular market in which
23 the physicians have been accused of wrongdoing, even if not
24 more broadly on physician behavior in general.
25 In particular, the more recent orders require the

1 physicians to -- the physician groups to terminate the
2 allegedly illegal contracts when asked to do so by the
3 payors. There have also been orders aimed at the agents who
4 are -- the consultants who are appearing in the field to
5 pretend to be messengers that have been in a few recent
6 cases.
7 And in the particularly egregious cases like the
8 Mountain Healthcare case that Gail mentioned and some the FTC
9 has brought, the Agencies have required dissolution, and in
10 at least one case, restitution.
11 These kinds of remedies are not without problems.
12 From the standpoint of at least some of the health plans that
13 I've talked to, for example, the terminate-the-contract kind
14 of approach ends up putting the burden on the victim of the
15 conduct to do something about it.
16 And the health plans are sort of in a dilemma
17 because in markets where there has been enforcement action,
18 it's typically where there's a large percentage of the
19 providers who are doing things to raise prices. And those
20 are the very providers that they depend on to form their
21 network.
22 So they sometimes are reluctant to terminate the
23 contracts, and sometimes the termination of the contracts
24 doesn't have the desired effect, especially if other health
25 plans in the market aren't doing the same thing.

1 Another problem is in some of these cases where the
2 consultants are going around telling the physicians that they
3 know how to be messengers when they really don't, some of
4 these orders are permitting them to continue to act as
5 messengers.
6 Perhaps they have to give notice or somehow that's
7 being monitored, but these agents are still going to be
8 allowed to be making their money telling physicians that they
9 are acting as messengers when in fact they're really engaging
10 in joint negotiations.
11 A couple of suggestions. The first would be
12 perhaps for the government to consider whether they want to
13 insert provisions automatically terminating the contracts
14 that were entered into by these illegal organizations.
15 What that does is it puts everybody on an equal
16 footing. It doesn't get the physicians -- the physicians
17 have agreed to that, presumably, if it's a consent order, so
18 it doesn't alter the dynamics with the health plans, and
19 perhaps will lead to the health plans being better able to
20 fix the problem.
21 On the messengers point, maybe it's time to tell
22 some of these consultants they can't do this. They can't
23 represent physician groups. They've got to figure out some
24 other way to create some value added into the marketplace.
25 I don't know if these things are going to work

1 better, but these are suggestions to perhaps give these
2 orders a little bit more teeth and perhaps have some more
3 force.
4 When I was talking to various people about what
5 their suggestions might be for maybe having -- not having
6 another 20 years of the same kind of case, it was urged upon
7 me that the government should consider some criminal remedies
8 in these situations.
9 I'm reluctant personally to recommend that because
10 it's not clear to me that this is criminal conduct. But I
11 think that other people have different views, and perhaps in
12 the appropriate case the government will consider bringing a
13 criminal case. I think maybe other people on the panel will
14 discuss that, too.
15 Thank you.
16 MS. OVERTON: Next we'll have Kevin Grady.
17 MR. GRADY: Thanks, Leslie. It's a real pleasure
18 to be here. For a minute, I was thinking that the panel was
19 going to outnumber the audience, but as I look around I do
20 think that the audience is just a little bit ahead of the
21 panel in terms of numbers. And so it's a real pleasure to at
22 least be talking to more people than are here on the panel.
23 It's an honor to be here on this last day. I mean,
24 the old adage about saving the best for last, I'm sure that
25 will go to the last speaker on this panel. But first of all,

1 without being too much of a sycophant, let me congratulate
2 the FTC and DOJ for conducting these hearings.
3 I have reviewed many of the materials from the past
4 sessions. As you know, the Healthcare and the FTC Committees
5 of the ABA Section of Antitrust Law have been publishing
6 summaries of these, and I realize that these materials are
7 also on the homepages and the websites of both Agencies.
8 But amazingly, the section has gotten a lot of
9 favorable comments from the people out in the field about
10 these summaries. I think Toby's the scribe for the
11 committees today.
12 As I've said in the past, both publicly and
13 privately to some of the people here, I think the key issue
14 in terms of what's going to happen after these hearings
15 conclude is what the FTC and DOJ are actually going to do
16 with the information that they've gathered here. And I
17 certainly think that one of the key issues is the whole
18 problem of remedies, on which this current session is
19 focused.
20 For those of us who've been active in the antitrust
21 healthcare arena for many years, we can remember the surprise
22 by many in the industry merely over the fact that the
23 antitrust laws even applied to the healthcare industry.
24 We can remember even more the tremendous surprise
25 when the Assistant AG in charge of the Antitrust Division,

1 Rick Rule at that time, spoke -- and I believe it was to the
2 meeting of the American Medical Association in Dallas some
3 time around 1988 -- and he announced, and it made the front
4 page of the New York Times, that violations of the antitrust
5 laws were criminal and that the Division would not hesitate
6 to prosecute physicians and others for violating the
7 antitrust laws in appropriate circumstances.
8 And we all remember even more the attention focused
9 on the criminal grand juries who were empaneled in the late
10 '80s and early '90s -- I think there were three -- and the
11 subsequent indictment and trial by the Division in
12 prosecuting the dentists in Tucson, Arizona in United States
13 versus Allston.
14 Now, perhaps as a result of the mixed results from
15 the prosecution of those dentists, the Division made the
16 strategy decision that except for some optometrists in Lake
17 Country, Texas, I think it was, criminal prosecutions in the
18 healthcare industry were more pain than gain, and that
19 prosecutorial resources could be better spent elsewhere.
20 As a result of the lack of any criminal bite to
21 violations of the federal antitrust laws in the healthcare
22 industry, and as a result of the perceived failure of the
23 Agencies to successfully prosecute hospital mergers in the
24 '90s, I believe that there's been a definite decline in
25 concern for the antitrust laws, certainly compared to the

1 concern by providers in the healthcare industry, to
2 violations of fraud and abuse or the anti-kickback statutes.
3 Indeed, I was struck in looking at the June 26
4 afternoon session of these hearings when there was a
5 discussion about the business review and staff advisory
6 letters -- and I see Jeff Brennan out in the audience, and I
7 know he participated in that -- and comparing those advisory
8 letters issued by the OIG concerning the federal anti-
9 kickback statute and fraud and abuse.
10 Now, Claudia Dulmage and Jeff pointed out the
11 obvious fact that for all intents and purposes, the business
12 review letters or staff advisory letters and requests with
13 respect to antitrust peaked in 1996 and 1997. They've
14 gradually fallen off to a mere trickle.
15 And we can all debate the reasons for the decline.
16 But there's a stark -- no pun intended, or maybe there is a
17 pun intended -- there's a stark comparison with the number of
18 advisory opinions issued by the OIG.
19 Vicki Robinson pointed out that there have been
20 approximately 363 advisory opinion requests since February of
21 '97, approximately 50 to 60 a year. OIG has issued
22 approximately 101 advisory opinions over that same time
23 period.
24 Now, one conclusion that you can draw is that the
25 advisory opinions reflect the greater concern over potential

1 violations of the federal anti-kickback and fraud and abuse
2 statutes than concern over potential violations of the
3 federal antitrust laws, both of which carry criminal
4 penalties.
5 Now, all of us are aware that the various U.S.
6 Attorney's offices throughout the country have not hesitated
7 to investigate anti-kickback and fraud and abuse violations.
8 Indeed, I believe healthcare providers and their consultants
9 are much more concerned about potential criminal liability
10 under fraud and abuse and anti-kickback than they are about
11 potential antitrust violations.
12 I think the reason, purely and simply, is that
13 providers and consultants in the healthcare industry do not
14 fear the antitrust laws as much as they fear violating fraud
15 and abuse and anti-kickback.
16 When you look at the FTC's recent volume of consent
17 orders challenging the various physician IPAs and even some
18 PHOs for price-fixing and group boycotts, it's obvious these
19 are all civil matters. Everyone knows the FTC doesn't have
20 criminal jurisdiction.
21 But the frenetic pace of the FTC in the last year
22 or so compared to the absence of similar activity by the
23 antitrust Division appears to send a clear message that
24 price-fixing is not considered criminal conduct in the
25 healthcare industry.

1 What's even more striking is that in some of the
2 actions brought by the FTC such as the recent consent order
3 against the anesthesia groups in San Diego, California for
4 allegedly attempting to "hold up" the hospital for payments
5 of $1,000-a-day stipends for covering OB and uninsured ER
6 patients.
7 The FTC's press release that announced the consent
8 order, described the physicians' activities as "a naked
9 agreement to fix prices without even a pretense of financial
10 or clinical integration between the parties."
11 When the Agencies announce that they've challenged
12 or uncovered naked agreements to fix prices, but then resolve
13 the claims with a civil consent order that basically says “Go
14 and sin no more,” that creates the impression within the
15 healthcare industry that antitrust violations are a mere
16 irritant.
17 Obviously, they can be expensive to defend. But in
18 the grand scheme of things, antitrust violations are less
19 worrisome for providers and consultants that concern over
20 errant billing practices.
21 Now, I don't have any magic answer as to how to
22 provide a greater realization as to the seriousness of
23 antitrust violations. I certainly am not advocating that the
24 DOJ and FTC suddenly view all physicians or hospital
25 administrators as criminals.

1 However, I do think the Agencies need to explore
2 the various potential remedies in order to send more clearly
3 the signal that violating the antitrust laws is not simply a
4 matter of being told to "go stand in the corner." If
5 providers and consultants have violated the law, they should
6 pay for it.
7 Certainly I believe the consultants, who have
8 suggested business arrangements and have encouraged providers
9 to believe that they can concertedly refuse to deal and to
10 fix prices, should face more serious repercussions than
11 simply being told that they can't represent provider groups
12 for two or three years.
13 I view the FTC's action a few years ago against the
14 College of Physicians and Surgeons in Puerto Rico as a
15 potential option at least for the FTC to consider. There,
16 the Commission challenged an eight-day boycott of the
17 Commonwealth's insurance program, and the consent order
18 included a $300,000 fine.
19 The amount of money involved at least emphasized
20 that what the physicians did in that case was not just an
21 antitrust violation, but also had financial consequences.
22 Now, certainly I believe the reluctance of the
23 federal Agencies to seek more of a penalty from providers and
24 others who violated the federal antitrust law sends a mixed
25 message to the healthcare industry. Candidly, the lack of

1 significant consequences often makes it more difficult to
2 counsel clients on antitrust matters because they're less
3 willing to recognize the potential serious nature of the
4 issues.
5 Obviously, the sheer volume of enforcement actions
6 brought by the FTC within the past year has at least placed
7 the issue of antitrust compliance on the radar screen of many
8 providers more visibly than in past years.
9 However, I believe that both the FTC and DOJ need
10 to think seriously about the consequences of proceeding
11 solely through civil proceedings that don't involve any
12 serious potential economic consequences except the defense
13 costs of responding to the investigations.
14 If the allegations in some of the recent complaints
15 filed by the FTC are true, the providers' collective actions
16 in those cases raised healthcare prices significantly above
17 the prices elsewhere in the various states.
18 After all these years, I am not a naive idealist,
19 nor am I a closet prosecutor. But I do believe that if the
20 Agencies are serious about their statements that the
21 antitrust laws apply to the healthcare industry in the same
22 way as they apply to any other industry such as retail
23 automotive replacement glass stores in North Texas and
24 Lubbock, Texas, who have recently been prosecuted criminally
25 for price-fixing, the Agencies need to consider more

1 significant remedies in an effort to get their message
2 across.
3 As one person said to me recently, Kevin, when will
4 the FTC stop bringing these complaints and getting these
5 consent orders? Now, I obviously did not have an answer, but
6 I did have an observation.
7 There will likely be little need to file numerous
8 complaints and get consent orders that appear to be almost
9 cookie cutters if the Agencies start bringing cases with more
10 bite, at least more economic consequences. Bringing fewer
11 cases with serious consequences will convey a stronger
12 message than bringing many cases with little or no real
13 consequences.
14 Thank you for your attention. I look forward to
15 the panel discussion.
16 MS. OVERTON: Next we're going to have Jack Bierig.
17 MR. BIERIG: Thank you. It's an honor to be here
18 this morning.
19 I've been asked to address two remedial issues
20 relating to application of the federal antitrust laws in
21 healthcare. One is the propriety of criminal enforcement,
22 and the second is the propriety of structural relief, and I
23 want to add in non-merger cases. These are important topics,
24 and I am honored to have the opportunity to discuss each of
25 them.

1 At the outset, I should say that my views have
2 developed over more than a quarter century of representing
3 providers, generally physicians and associations, in
4 antitrust proceedings. I served as counsel to the American
5 Medical Association in the first foray of the Federal Trade
6 Commission into healthcare back in 1975 when the Commission
7 challenged the AMA's ethical rules on physician advertising
8 and certain contract practices.
9 Subsequently, I've been involved in the defense of
10 various FTC proceedings such as South Bank IPA, in which
11 structural relief was an issue. I've also been involved in
12 numerous DOJ investigations, including criminal
13 investigations of allergists in Massachusetts and
14 obstetricians in Georgia. And I met on several occasions
15 with representatives of both Agencies as they were
16 formulating both the 1994 joint statements on enforcement of
17 the antitrust laws in healthcare and as they considered
18 subsequent revisions.
19 There's no question that my thoughts have been
20 shaped by my experience in representing physicians and other
21 providers. But I'm not here today on behalf of any client,
22 and I will try to speak as impartially as I can.
23 And in that connection, I would note that I teach
24 Health Law and Policy at the University of Chicago Law School
25 and at the Harris School of Public Policy at the University,

1 and in that capacity I've given a good deal of consideration
2 to the matters which we will be discussing this morning.
3 First, criminal enforcement. Let me begin by
4 saying that I do not believe that criminal antitrust
5 enforcement in healthcare is never appropriate. In my
6 judgment, however, criminal enforcement of the Sherman Act
7 should be limited to situations in which each of two elements
8 are present.
9 First, the challenged conduct should involve a
10 clear and well-established violation of the antitrust laws.
11 And second, there should be unambiguous proof that those who
12 engaged in the conduct did so knowing that conduct to be
13 unlawful. Unless both elements are present, criminal
14 sanctions should not be sought.
15 And I want to emphasize that I'm not putting
16 forward a special rule for healthcare. This rule should, in
17 my view, govern all sectors of our economy. It is necessary,
18 this rule, to harmonize two fundamental but competing
19 policies: first, effective enforcement of the antitrust
20 laws, which we've heard a lot about today; and second,
21 something that we have heard nothing about today, the basic
22 premise of our Anglo-American system of jurisprudence that
23 except for certain conduct which poses risk to human health
24 or safety, criminal punishment should be limited to conscious
25 and calculated wrongdoing.

1 In advocating a very circumscribed role for
2 criminal prosecution, I'd be the first to acknowledge that
3 criminal proceedings are a very effective means of antitrust
4 enforcement, as Kevin has just reminded us. I can tell you
5 that there is nothing like a criminal conviction or even a
6 prosecution to get the attention of those to whom the
7 antitrust Division is trying to deliver a message.
8 And criminal proceedings are effective, I've found,
9 in another sense as well. Several years ago, I served as
10 counsel for a number of obstetricians in Savannah who were
11 the targets of a criminal antitrust investigation. Well into
12 the investigation, the Antitrust Division offered to drop its
13 request for criminal sanctions if the obstetricians signed a
14 civil consent decree. That decree is reported as United
15 States versus Bergsteiner, who happened to have the
16 distinction of being the first name in alphabetical order of
17 the 22 obstetricians.
18 I advised my clients at the time that I thought the
19 proffered decree was over-broad, prohibited lawful conduct,
20 and imposed unduly burdensome procedural requirements.
21 But once the prospect of criminality was lifted,
22 these physicians fell over themselves to sign lest the
23 Division change its mind and return to the criminal approach.
24 I would liken the obstetricians in that case to lemmings
25 flocking to the sea, but the comparison would probably be

1 unfair to lemmings.
2 So if criminal enforcement is so effective, why
3 should its use be very carefully circumscribed? In my view,
4 there are two basic reasons, both of which ultimately derive
5 from two facts.
6 First -- I don't know if I did a slide on this --
7 yes -- the Sherman Act, unlike most traditional criminal
8 statutes, does not precisely identify the conduct which it
9 prohibits. Rather, its broad proscription against contracts,
10 covenations, and conspiracies in restraint of trade covers a
11 panoply of conduct whose competitive consequences are often
12 very difficult to predict.
13 And second -- well, consequently, wellmeaning
14 individuals may engage in conduct that violates the Act
15 without having any understanding that their conduct will
16 later be deemed unlawful.
17 And second, the Sherman Act, unlike most modern
18 statutes that impose criminal liability without intent, does
19 not regulate conduct that threatens the health or the safety
20 of the population.
21 From these two facts emerge two powerful arguments
22 against any but the most limited criminal enforcement of the
23 antitrust laws. I'll call the first one the fairness
24 rationale and the second the efficiency rationale. And both
25 of them were recognized by the Supreme Court in its seminal

1 decision in United States versus United States Gypsum Company
2 from 1978.
3 At bottom, the fairness argument is that outside
4 the context of regulation of health and safety, it is unfair
5 and inconsistent with the generally accepted functions of
6 criminal law to punish someone for engaging in conduct which
7 he or she did not know to be wrong. As William Blackstone
8 said in the 18th century, criminal law depends on what he
9 called "vicious intent."
10 On this issue, the Supreme Court has been quite
11 clear. I think this is a very important lesson for people
12 who advocate criminal law as an enforcement mechanism. The
13 criminal laws should not be used simply to regulate business
14 practices regardless of the intent with which they were
15 undertaken. Instead, the criminal laws should be reserved
16 only to punish conscious and calculated wrongdoing.
17 And the fairness rationale is particularly strong
18 in the physician context, where the potential defendants are
19 not sophisticated business persons with an army of lawyers at
20 their disposal. I can say unequivocally that in all of the
21 criminal antitrust matters with which I have been involved,
22 none of the physicians had a clue at the time that they were
23 engaged in the conduct for which they were investigated, that
24 that conduct was unlawful.
25 I wrote an amicus brief in the Ninth Circuit on

1 behalf of the American Dental Association and the American
2 Medical Association in United States versus Alston. In the
3 course of preparing that brief, I got to speak with the
4 legendary A. Lanoy Alston, D.D.S., one of the evil
5 triumvirate of Tucson dental practice. I can fairly say that
6 Dr. Alston had no idea that it was unlawful to seek the same
7 copayment amounts for dentists in Tucson that their
8 colleagues in Phoenix were receiving.
9 Similarly, I represented an allergist who was one
10 of the targets of the investigation in United States versus
11 Massachusetts Allergy Society. I got to know this physician
12 quite well, and I can say that he was an extremely decent
13 individual who never would have knowingly acted unlawfully.
14 He happened to be a member of an IPA that was
15 insufficiently integrated economically to satisfy the
16 antitrust requirements that the Agencies had set forth that
17 would have allowed an IPA to set and negotiate fees. But the
18 fact was, neither he nor most of the other people who were
19 associated with the IPAs recognized that there was anything
20 wrong with having that IPA suggest fees to various payors and
21 to try to negotiate those fees.
22 And as for the Savannah obstetricians, it just
23 didn't dawn on them that having a meeting to discuss a
24 proposed two-year contract proffered by a managed care
25 company with no agreement on their part regarding specific

1 fees to offer to that company might be deemed to contravene
2 the Sherman Act.
3 Counsel for the Department of Justice and counsel
4 for the Federal Trade Commission have repeatedly told me over
5 the years that everyone knows from the time you're in
6 elementary school that price-fixing is unlawful. And of
7 course, that's true. Everyone does know that price-fixing is
8 unlawful.
9 The problem is that even sophisticated antitrust
10 counsel, to say nothing of physicians and healthcare
11 providers, can quite agree on precisely what price-fixing is.
12 It comes as quite a surprise to physicians that agreeing on
13 fees to recommend to a payor, discussing the economic
14 implications of a proposed contract among themselves, or
15 negotiating with an insurance company or managed care plan
16 might constitute price-fixing, given that the ultimate
17 decision regarding payment is made by the payor, not by the
18 physicians.
19 One clear indication of a lack of criminal intent
20 is that almost all antitrust violations by healthcare
21 providers occur in the open. These are not covert operations
22 performed in secrecy or in code. Rather, the conduct in
23 cases like Alston is always carried out in the public eye.
24 And I would submit to you that very few criminals commit
25 their crimes overtly, with no attempt to cover up in some

1 way.

2 That the actions of healthcare providers which
3 raise antitrust concerns are not clandestine bespeaks, in my
4 view, a lack of criminal intent. And in this connection, to
5 take a point that I think Toby raised, I would point out that
6 it is a somewhat peculiar feature of Section 1 that antitrust
7 violations are predicated on agreement rather than on market
8 power.

9 Most individual physicians and small physician
10 groups feel themselves powerless against payors which control
11 any substantial percentage of their patients. They simply do
12 not see it as inherently evil or wrong to band together to
13 try to achieve countervailing bargaining power that will put
14 them in a position to negotiate on an equal footing.

15 And as a matter of economics, it's not entirely
16 clear that it is wrong, if you look to market power rather
17 than agreement. Indeed, congressional enactments such as the
18 federal labor laws and the Capper-Volsted Act attest that for
19 small sellers to band together is not inherently evil.

20 To prosecute people for engaging in conduct that
21 they do not see as wrongdoing is unfair. It's contrary to
22 our Anglo-American system of justice, and it also breeds
23 hostility to and distrust of the legal system on the part of
24 those regulated. For these reasons, it should be avoided.

25 Let me turn from fairness to efficiency. It is

1 presentation, but also the possibility of loss of the
2 physician's most precious possession, which is the license to
3 practice medicine.
4 There are numerous examples of pro-competitive
5 conduct that may well be deterred if criminal sanctions are
6 invoked too liberally. Some of these were catalogued in
7 Alston and Felth, which is the one relatively recent criminal
8 antitrust prosecution that has been litigated up to the Court
9 of Appeals.
10 As the Ninth Circuit noted, it is lawful for
11 individual healthcare providers to come together to level the
12 bargaining imbalance created by managed care plans and
13 provide meaningful input into the setting of fee schedules.
14 The Ninth Circuit also noted that it's lawful for
15 healthcare providers to pool cost data in justifying a
16 request for an increased fee schedule. And it is lawful for
17 providers to collectively negotiate other aspects of their
18 relationships with managed care plans.
19 The problem is that these activities are not all
20 that far from what the plans might characterize as implicit
21 threats of pass withdrawals from the plans, which would of
22 course implicate the antitrust laws.
23 If we don't want to intimidate healthcare providers
24 from engaging in lawful activities, activities which
25 generally promote competition and do something else that we

1 haven't heard about today at all, which is promote patient
2 care, the antitrust Division needs to be extremely judicious
3 about any criminal enforcement activities that it might
4 undertake.
5 And finally, I would like to return to the argument
6 that Kevin made that criminal enforcement is needed as a
7 deterrent because civil remedies are inadequate. You know,
8 it's worth remembering that in addition to government
9 actions, private treble damage actions are available.
10 As you know, defendants who lose such actions, of
11 course, are subject to treble damages and to pay the
12 plaintiff's attorney's fees even if only injunctive relief is
13 granted. There have been many such private antitrust cases,
14 the most recent of which that I've seen is the International
15 Healthcare Management versus Hawaii Coalition for Health.
16 And I've found that managed care plans and others
17 who feel that providers are acting anti-competitively are not
18 shy about threatening to bring private actions. So I believe
19 that the threat of private treble damage actions is deterrent
20 enough for those who would ignore antitrust requirements.
21 In sum, on the criminal point, I submit that the
Attorney General's National r385aorea(6ne2 1 Tf n1icr.itrus.)Tj/F1 1
14 eenynarrs feteTf n1Cubs laustw ona penn an -- wheen s.

1 where the law is clear and the facts reveal a flagrant
2 offense and plain intent to restrain trade."
3 That was said in 1955. I think the antitrust
4 people got it right half a century ago, and I don't think
5 they should deviate now from that wise conclusion.
6 Turning to structural relief, there are a number of
7 forms of structural relief in non-merger cases. We've heard
8 some of them today. I'm going to briefly talk about this. I
9 want to confine my remarks to dissolution and to breakup of
10 large IPAs, which is something that has been considered.
11 But I'd like to begin by doing something that I
12 very rarely do, which is to praise the Federal Trade
13 Commission. And I want to cite the words of the Commission
14 in Indiana Federation of Dentists. "Only in circumstances
15 where there is no significant function remaining for an
16 organization other than to repeat antitrust violations or in
17 which a conduct order would not reasonably be expected to
18 prevent repeating such violations or to restore competition
19 would a dissolution order be appropriate."
20 In that case, the Commission rejected the
21 recommendation of the ALJ to dissolve the Indiana Federation
22 of Dentists because the Commission concluded that the
23 Federation did serve some legitimate purposes and because the
24 antitrust violation at issue could effectively be addressed
25 by a conduct order.

1 I think that the approach taken to dissolution by
2 the Commission 20 years ago was correct. Dissolution should
3 be ordered only if either of two conditions is present: One,
4 it's absolutely clear that a conduct order is inadequate to
5 halt the antitrust violation, or two, the respondent has no
6 substantial legitimate function or is a sham designed to
7 perpetrate unlawful conduct. Where neither is present,
8 dissolution should not be ordered.
9 Now, there will not be many cases in which either
10 of these conditions is satisfied. In most cases, a well-
11 drafted conduct order should, for the reasons that Gail
12 stated at the outset, suffice to enjoin the violation and to
13 prevent its repetition. And not many organizations are
14 created as a sham or with no substantial lawful purpose.
15 So cases in which dissolution is ordered will be
16 very few. But that is as it should be because dissolution is
17 basically corporate capital punishment.
18 And finally, I'd like to discuss the breakup of
19 IPAs and similar organizations. And I think it's very
20 important for the Commission and the Division to note that
21 there are at least two, and maybe more, very important
22 distinctions between breakup of these organizations and
23 dissolution.
First, unlike dissolution, which is fairly simple,

1 So based on these considerations and my effort to
2 interpolate Indiana Federation of Dentists to the breakup
3 context, I would submit that breakup should be considered
4 only if each of three conditions is present.
5 First, it has to be clear that a conduct order will
6 not suffice to remedy the violation.
7 Second, the breakup has to be able to be
8 effectuated without substantial administrative costs.
9 And third, the breakup will not result in a loss of
10 significant efficiencies or in a diminution of the quality of
11 care received by patients. Unless each of these conditions
12 exists, breakup of an IPA would in my view be inappropriate.
13 I appreciate the opportunity to be part of the
14 panel, and I would be pleased to answer any questions or
15 discuss these matters further in the discussion. Thank you.
16 MS. KOHRS: Thank you, Jack. I think we will save
17 the best for last indeed, and we'll take a short break of
18 about ten minutes before we come back to hear the economist
19 on the panel.
20 (A brief recess was taken.)
21 MS. KOHRS: Here we go. After that big build-up,
22 Greg.
23 MR. VISTNES: Well, thank you for the opportunity
24 to come speak here.
25 When I was asked to come speak on the panel, I

1 started thinking, well, what can an economist say that will
2 hopefully hold folks' interest? And especially what can an
3 economist say when they'll be at the end of a speaking panel
4 with a bunch of lawyers?
5 It would be okay if I was first; I could say
6 anything and beat people to the punch. But as it was, I was
7 trying to think what can an economist say that will be a
8 little bit different than what the attorneys will be saying?
9 And after a little bit of thought, I thought, well,
10 I can talk about some empirical issues. What have we seen
11 empirically with regard to the success of different types of
12 conduct relief, structural relief? What can we say? What
13 have we learned from the past?
14 And that sounded really good when I was on the
15 phone. Then I hung up the phone and started thinking, what
16 the heck am I going to say? Because the fact of the matter
17 is there really isn't much in the way of empirical
18 literature.
19 There's a little bit of anecdotal knowledge, as
20 we've heard some of the speakers talk about today, about what
21 has worked, what hasn't worked, some of the pluses and
22 minuses. But very little in the way of a broad-based
23 coverage of what's worked.
24 Now, the good part of that is I very quickly
25 realized that I was going to have absolutely no trouble

1 keeping to the ten-minute limitation on speaking. And I
2 actually thought about maybe I should just finish my talk
3 right now and sit down.
4 But again, in line with being the last of the
5 speakers, not just of this panel but I take it of the entire
6 sessions, I thought that would be ending a little bit with
7 too much of a whimper instead of a bang. So I struggled to
8 think what I could say.
9 And I think there are still some things that
10 hopefully as an economist that we can bring to the picture as
11 to the issue on relief. And I'm going to be talking
12 primarily with respect to relief as directed to the physician
13 joint ventures, the physician groups that get put together as
14 opposed to some of the hospital mergers or some of the other
15 conduct-type cases.
16 And what I want to talk about with respect to
17 empirics is, first of all, what evidence do we have with
18 respect to some of the determinants of appropriate relief?
19 That is, even if we can't hit the grand slam of saying, here
20 is the answer with respect to empirical evidence on relief,
21 can we figure out what are the right building blocks to
22 figure out what the right answers are, and what can we say
23 the evidence is in regard to that?
24 And secondly, in order to figure out what are these
25 right building blocks that we should be trying to get the

1 empirical answers to, it gets a little bit to the fundamental
2 or more what are the determinants of the appropriate relief.
3 So it's bringing it a little bit back more to the conceptual,
4 a little bit back more to the theoretical, end of it.
5 What I came to the realization as I started working
6 on this is that there are some very fundamental questions, I
7 think, that should be asked, ultimately that need to be
8 answered, things that at least for me, as I went down this
9 path, probably with the perspective of being somewhat
10 aggressive in the sense -- and I think I share this with a
11 lot of the folks at the Agencies, certainly not everyone --
12 but it made me fundamentally question some of the
13 preconceptions I had on some of the appropriate relief for
14 physician joint ventures.
15 And so I think it's worth putting some of these
16 questions on the table as areas where further work is really
17 warranted in deciding what kind of relief is appropriate for
18 these physician joint ventures.
19 So I'll start with what seems to be the most basic
20 building block of the questions: Why do we even allow these
21 physician joint ventures? Why not just bust them up, break
22 them down to the ground, and dissolve them completely
23 whenever we see them doing bad?
24 Well, the answer is pretty clear, is they're joint
25 ventures. And we allow these joint ventures just as we allow

1 a joint venture in any industry because we think not that
2 there is necessarily good associated with them, necessarily
3 good that will overcome any anti-competitive harm associated
4 with the joint venture, but we believe there's a real
5 possibility of some good. And so we have to engage in a rule
6 of reason. We have to at least allow for the possibility of
7 these joint ventures having some net positive benefits.
8 And this is pretty well established in the way the
9 Agencies act, certainly the whole rule of reason approach
10 under which most of the physician joint ventures, at least
11 those embodying risk-sharing or some other attribute deemed
12 to promote efficiencies, are viewed.
13 The healthcare policy statements pretty explicitly
14 recognize that these joint ventures must have some real
15 potential value to them. Heck, the fact that the joint
16 ventures go so far as not just to say that yes, we will treat
17 them under a rule of reason policy, but there is this
18 implicit recognition that these benefits must be potentially
19 pretty darn significant because we give them a safety zone.
20 We say, if you're going to be non-exclusive, you
21 can have 30 percent of the providers getting together setting
22 price, and you've got a safety zone. That to me is a pretty
23 significant statement. There aren't too many industries
24 where we'll let 30 percent of the folks just get together
25 with a safety zone and jointly set prices.

1 So this is, to me, at least, highlighting -- let me
2 back up a minute. With respect to the question of why don't
3 we always impost structural relief on these guys, we've heard
4 some discussion today about how structural relief in general
5 is perhaps the better approach; at least, some people think
6 that because it gets away the risk of anti-competitive harm.
7 We don't need to worry about ongoing regulation.
8 We don't need to worry about evasion of this regulation.
9 Let's just impose the structural relief and be done with it
10 and move on.
11 Well, certainly we're right that structural relief
12 is more likely to fix the competitive problem. But at the
13 same time, structural relief is much more likely to eliminate
14 any of these efficiencies which we've just accepted must be
15 potentially there.
16 And so we come to the fundamental question in
17 deciding: Do we want conduct relief versus structural
18 relief? How big do we think these efficiencies are? What is
19 the real risk of throwing the baby out with the bath water
20 when we impose structural relief?
21 Now, I think the Agencies have a pretty good sense
22 as to what is the likely competitive harm associated with a
23 lot of these physician joint ventures. I'm not so sure that
24 the Agencies have as good a sense -- certainly I don't have a
25 good sense, so I'll limit it to myself -- I don't have a good

1 sense what the real efficiencies are.
2 I know that for many years I had a strong
3 preconception that the efficiencies associated with physician
4 joint ventures really weren't so great. But at the same
5 time, I've also got to admit that I, and I suspect many at
6 the Agencies also, are potentially subject to a real bias
7 concern.
8 The only physician joint ventures I ever saw at the
9 Agencies were the ones who were doing bad. I never saw much
10 in the way of the good ones, assuming that they're out there
11 somewhere.
12 If there are these really good physician joint
13 ventures out there somewhere, we should know more about them.
14 We should learn about them. We should get a better sense as
15 to what are the efficiencies, the benefits associated with
16 them, so we can do this cost/benefit analysis of what are the
17 risks of breaking them up.
18 I think we also need to know a little bit more
19 about sort of what is the growing path of this baby we're
20 afraid is going to be thrown out with the bath water. Is it
21 at least possible that a physician joint venture needs a
22 certain amount of time before it can really realize
23 efficiencies?
24 How quickly can they realize these efficiencies,
25 the ones promised with whether it's going to be risk-sharing,

1 whether it's going to be from some sort of a practice setting
2 pattern? Does it take one year or five years? And again,
3 how big are those benefits going to be?
4 I think it's also important to ask the question of
5 what are we really asking when we're asking about what is
6 appropriate relief in the context of I'll call it a bad
7 physician joint venture.
8 Are we considering structural relief because we've
9 seen these guys have done bad in the past? Or are we in fact
10 really talking a more fundamental policy issue, that
11 fundamental policy issue being, do the Agencies just not
12 really like these guys at all?
13 Do the Agencies just not really like big physician
14 joint ventures at all, and it doesn't matter that they've
15 been caught in the bad act of setting prices or of not
16 realizing real efficiencies?
17 But even in an ex ante sense, if the Agencies saw a
18 physician joint venture with 70, 80, 90 percent physician
19 market share, are they really going to be concluding this
20 physician joint venture shouldn't be allowed to survive; it
21 needs some sort of additional structural relief?
22 One way of thinking of this question is when the
23 Agencies look at a high share physician joint venture and
24 they make a conclusion that they want or they're considering
25 structural relief, are they in effect saying, we don't find

1 that this particular physician joint venture is living up to
2 our expectations, to the potential promise of efficiencies
3 that could be realized, or are they instead saying, well, we
4 didn't think you ever really were going to be achieving much
5 efficiencies, or at least that was our ex ante view, and you
6 kind of confirmed it here.

7 Because the conclusion, how you look at this, again
8 goes back to the ramifications of what sort of relief you
9 want. If it's the former case, where you're looking at a
10 particular high market share physician joint venture and
11 saying, you in particular didn't live up to our expectations,
12 then that's still very much embracing the possibility that
13 physician joint ventures in general can realize significant
14 efficiencies.

15 If that's what you believe, then you still need to
16 ask, well, if we break you up now, we're throwing that baby
17 out with the bath water. Maybe conduct relief is more
18 appropriate.

19 Because if we really believe there is a potential
20 for those efficiencies to be realized -- and that's again
21 going back to the general policy issue, do we believe there
22 are significant efficiencies that can be realized -- then we
23 need to be considering more carefully this issue of maybe we
24 don't impose structural relief. Maybe we impose the conduct
25 relief so they can still realize the promise of efficiencies

1 that motivates us to allow physician joint ventures at all.
2 Alternatively, though, if we really don't believe
3 that these physician joint ventures are really going to do
4 much at all, then it's more in tune with let's impose
5 structural relief.
6 I think the other way, at least for me, of trying
7 to figure out what are the Agencies' views with respect to
8 efficiencies with physician joint ventures is I at least have
9 a sense that to some extent, the Agencies' perspective with
10 regard to high physician joint ventures is -- high market
11 share physician joint ventures, sorry -- is that there's a
12 little bit of a live-and-let-live policy.
13 Go ahead, fine. You can have a high market share
14 if you want to, and we're not going to come after you. But
15 the minute we hear complaints, then we're going to come after
16 you, and once we hear complaints, chances are pretty good
17 that we're not going to be swayed by these efficiencies, or
18 at least in few cases the efficiencies are likely to sway us.

1 Agencies or what do other folks feel about the physician
2 joint venture efficiencies? Are they big or are they small?
3 I don't think we really know that. I think that more
4 information on this point is necessary because again, I think
5 the Agencies may well -- or again, at least while I was at
6 the Agencies, I think I suffered from a biased perspective of
7 only seeing the bad guys, not knowing what the good ones
8 could do.
9 So I think a retrospective or some sort of more
10 general survey about what are the good physicians joint
11 ventures doing? How big are their efficiencies? How did
12 they realize them? What was the growth path to achieve them?
13 What are the characteristics? I think all that would be very
14 valuable learning for the Agencies in trying to decide how to
15 move forward.
16 And then finally, a little bit more in line with
17 what we were talking about earlier, some of the speakers, is
18 what have been the successful and the unsuccessful elements
19 of the structural relief or the conduct relief?
20 Have employers really cared? Have payors cared
21 when structural relief has been imposed? If the payor
22 doesn't much care, that again is more suggestive of
23 efficiencies that aren't big. But I think this is all an
24 area where certainly more information is necessary.
25 Thank you.

1 MS. OVERTON: We're going to begin our round table
2 discussion by allowing each panelist a chance to respond to
3 anything that they've heard this morning or to add something
4 that they didn't get a chance to say.
5 And we can begin with Gail, and just come from
6 Gail's end down to Greg.
7 MS. KURSH: I'll make a couple of comments.
8 MS. OVERTON: Please speak into the microphones.
9 Thank you.
10 MS. KURSH: Oh, I'm sorry. I'll make a couple of
11 comments. I'll start with Jack because I just can't resist.
12 It all came back, Jack, in a flash, our many discussions over
13 the years.
14 The intent standard that you set out for what you
15 believe is the criminal intent standard, it's funny because
16 last night I did go back and read Gypsum again. I didn't
17 know what you were going to say, but I had forgotten myself.
18 I said, what did Gypsum say again about a criminal intent?
19 And I don't recall reading that it said there must
20 be unambiguous proof that the defendants knew they were
21 engaging in unlawful behavior. I mean, as I recall Gypsum,
22 it was that they knew that they were engaging in conduct that
23 was unlawful as opposed to specifically proving that they had
24 that knowledge that that was unlawful, which I think is maybe
25 perhaps what Gypsum argued but not what the Supreme Court

1 adopted.

2 Did I misread it, or is your standard stronger than

3 what the Supreme Court came out with?

4 MR. BIERIG: You absolutely read Gypsum correctly.

5 The question in Gypsum was whether some intent should be

6 imported into the Sherman Act because there's no specific

7 reference to intent, and the Supreme Court said you have to

8 have some element of criminal intent.

9 The standard that I'm proposing did not -- the

10 standard that I put up there, as opposed to the quotes, did

11 not purport to quote Gypsum. It quoted me. They --

12 MS. KURSH: Or Gypsum, I think, made that argument.

13 MR. BIERIG: No, no.

14 MS. KURSH: Not the Court.

15 MR. BIERIG: I indicated that in my view, there

16 should be unambiguously unlawful conduct, and there should be

17 clear evidence that the individual knew that the conduct

18 which he or she undertook was unlawful at the time that they

19 did it. That is not what Gypsum says. I'm advocating that

20 as a matter of prosecutorial decision-making by the Division.

21 MS. KURSH: And you're saying actual knowledge as

22 opposed to should have known?

23 MR. BIERIG: Well, no. I mean, you know, should

24 have known would also work. But we have to be very careful

25 about should have known because, remember, these physicians

1 and others don't have the sophistication that the people
2 around this table have.
3 And as I tried to -- I explained some of the
4 reasons why physicians don't regard, you know, sort of coming
5 together to negotiate collectively with payors as being
6 unlawful. It comes as quite a surprise to them to find out
7 that that is really unlawful.
8 And indeed, you have cases, you know, such as Judge
9 Kozinski's opinion in Alston in which he lays out several
10 things that the Federal Trade Commission and the Antitrust
11 Division have viewed as unlawful, and he concluded that those
12 were quite lawful.
13 So the should have known is a pretty slippery thing
14 to get to. But I do think at bottom -- I'll go back to the
15 18th century since -- you know, when you read Blackstone, the
16 basic premise of our system of criminal justice is that
17 criminality should be reserved for people who had a conscious
18 intent, or what he called a vicious intent, to do wrong.
19 And we have deviated from that in the 20th Century
20 in the areas of environmental protection and food safety and
21 other things. But those have to be understood to be very
22 limited deviations for purposes of a higher good, which is
23 maintaining the absolute purity of the food supply or
24 maintaining an environment free of -- or, you know,
25 relatively free of contaminants.

1 benefits you get from these kinds of decrees warrant the
2 very, very extensive costs and entanglement in the market?
3 And then I think we also just have a great deal of
4 difficulty deciding that we're indeed getting what a
5 competitive market would get when we inject ourselves. I
6 mean, can -- it may be difficult to control price, but it's
7 even more difficult to control quality and innovation.
8 So, you know, you may be able to control the prices
9 that hospitals charge, but how do you account for changes in
10 quality? And if they reduce quality but keep prices within
11 some regulated standard, you in fact may be increasing the
12 price because it's adjusted for the quality.
13 And then on the other hand, you know, you may be
14 limiting the hospital's ability to respond competitively or
15 efficiently to change in market circumstances where let's say
16 prices have to increase in response to increases in costs.
17 And there's all these dynamics that come into play that I
18 think make a regulatory decree very, very tricky.
19 And then just finally, I've just always been
20 concerned about how do we show that cost savings have indeed
21 been passed on to consumers, and also how are we -- how can
22 we be certain that the cost savings that we are requiring be
23 passed off, that there might not have been even greater cost
24 savings had we let the market remain competitive.
25 And I guess my sense is that if we thought a

1 hospital was truly failing -- someone raised this as a
2 possibility -- then perhaps the failing firm defense applies
3 in that case. But I think we've seen very few hospitals that
4 have actually failed and exited the market despite their
5 claims that they were failing.
6 So yes, we may have to litigate, and as history has
7 proven, lose some of these cases. But perhaps that's better
8 than accepting a decree that -- where we're not really
9 confident we're making the situation any better.
10 So I guess I just have some concerns about the
11 regulatory decrees even though I understand why there's the
12 temptation to adopt them in certain local markets.
13 MS. OVERTON: Mel?
14 MR. ORLANS: Well, actually, Gail hit on the point
15 I wanted to make. I have the same concerns from the
16 perspective of somebody who's litigated hospital mergers
17 about accepting anything less than structural relief in a
18 hospital merger context.
19 It strikes me that the main rationale that I heard
20 sort of underlying everything seemed to be that we can't win
21 with structural relief, that the government has a history and
22 the states have a history of lack of success in recent
23 hospital merger cases, and therefore that the conduct
24 remedy -- that a regulatory decree is sort of the best that

1 And I guess -- I think that's a pretty slim reed on
2 which to justify these sorts of devices. I think that they
3 are very difficult to monitor and enforce.
4 Moreover, it strikes me that if the concern is, as
5 it seems to be, that the government in recent years has had
6 difficulty litigating -- successfully litigating hospital
7 mergers, that there are other approaches that can be taken
8 that still will end up in structural relief.
9 Right now the Commission is looking at consummated
10 hospital mergers, and in those situations presumably where we
11 can show, for example, price effects, the government will be
12 in a much better position to go after the hospitals and
13 hopefully demonstrate to a court that there have been price
13 effec[illegible] [illegible]d therefor f4.-yofil[illegible]e b3gyty wmay caitprice
13
6

13 And I

10
10
10
11
6

f9cdD0 t2

1 approach by the parties, and the Commission rejected that and
2 therefore got nothing.
3 In fact, what happened in that case was that the
4 judge did accept the parties' offer and incorporated it in
5 his decree, even though the Commission didn't ask for it. He
6 incorporated the parties' market regulatory order in his own
7 decree.
8 At the Agency, our view was that we weren't
9 involved in enforcing that. And in fact, I remember getting
10 one call from someone who was interested in that and thought
11 they had a complaint and wondered if the Commission would be
12 interested in that.
13 And I said as far as I was concerned, it was
14 judge's decree and they should find a way to bring the matter
15 up to the judge, that, you know, we weren't interested in
16 doing that. I don't think anything further came of it.
17 But as a practical matter, the judge did actually
18 incorporate the parties' proposal into his consent decree.
19 MS. OVERTON: Kevin?
20 MR. GRADY: A couple of comments. Number one, I
21 think that we ought not lose the focus in terms of what these
22 hearings are all about, at least what I think the hearings
23 are all about, and that is what the Agencies are going to do
24 going forward.
25 And I'm not minimizing the difficulty of that

1 decision. And I know that -- or at least I have every
2 confidence that you'll make thoughtful determinations,
3 regardless of what administration is in power.
4 But a couple of comments. Number one, Toby touched
5 on, you know, how many years ago, you know, the Tulsa
6 physicians were accused of doing illegal price-fixing. And
7 you have to say, at least I think, after 20 years of these
8 consent orders and seeing the same types of activities, and
9 the Agencies coming down saying these are price-fixing, these

1 But candidly, you know, what was it, Gail, you guys
2 were involved with the Pershing Yoakley, you know,
3 accountings down in Tampa, and, you know, the group of
4 accountants from Knoxville, Tennessee going around claiming
5 they knew how to, you know, advise physicians to get big
6 increases in their reimbursements or something like that.
7 And, you know, they were precluded from
8 representing that group for a number of years afterwards.
9 But they weren't banned from doing it. There was no criminal
10 action taken against them. And you have to ask yourself
11 after a while the confusing signals that are being sent when
12 the Agencies say something time after time after time is
13 illegal, and how many shots across the bow do you have to
14 take before people supposedly get the message?
15 And if the antitrust laws indeed have a criminal
16 component, when do you actually impose it? And I realize
17 that, you know, you guys were not all that successful in the
18 Alston case. And I will also recognize the difficulty of
19 saying that a doctor with a, you know, white coat and a
20 stethoscope ought to be put in jail for violating the
21 antitrust laws.
22 But on the other hand, the U.S. Attorneys around
23 the country are not having problems saying that with respect
24 to fraud and abuse and Stark. And with all deference, Jack,
25 you talk about the Sherman Act being somewhat amorphous in

1 terms of what's illegal. I don't see anybody saying fraud
2 and abuse is, you know, a clarion of clarity in terms of
3 what's a violation.
4 The other thing that I'd like to point out is that
5 to the extent that the Agencies have as a remedy
6 disgorgement, one of the things that I haven't seen -- and
7 there have been one or two examples, Jack -- but I haven't
8 see a wellspring of class action litigation following on the
9 heels of these consent orders that have been entered into.
10 I don't think that there is a huge number of
11 potential class actions out there, at least from the
12 standpoint of direct purchasers, because the payors aren't
13 going to have the chutzpah to go in and challenge the doctors
14 that they need to have in their networks later. That's just
15 not going to happen.
16 And so who else is going to be there to try to
17 somehow say that these people who engaged in illegal conduct
18 should pay more than a price of, as I said in my remarks,
19 standing in the corner? And that's something I think that
20 needs to be seriously considered.
21 One of the things that we have to deal with -- I'm
22 dealing with it right now -- I mean, with people who have
23 been the subjects of some of these consent orders, they come
24 to us now and ask, okay, so now what do we do?
25 And you look at some of the actions that they were

1 about this and not bring a case in a situation where, like in
2 Williamsport where the Justice Department didn't bring the
3 case, where there is no real structural remedy that's going
4 to work -- you know, we'll go in and try to do this in a way
5 that at least preserves some of the benefits of the merger,
6 but yet has the potential for at least the term of the
7 consent decree to not have the real negative effects
8 happening.

And I think while there have been mixed results, I

1 that the criminal culpability will be there with some of
2 these consultants that are going around trying -- you know,
3 telling the doctors, I'm a messenger, but in fact are doing
4 something beyond that?
5 MR. BIERIG: Well, first of all, I think as a
6 matter of fact the criminal intent is much more likely to be
7 present on the part of the consultants.
8 But to sort of follow up on Gail's question about
9 the should have known, you certainly would expect consultants
10 who hold themselves out as experts in antitrust law and
11 reimbursement issues to be in a position to -- you know, they
12 should have known what the law is, as opposed to some
13 practicing physician. So I agree with you.
14 However, by the way, I don't think that the fact
15 that the doctors are interested in lining their pockets is
16 not equal to they have criminal intent. Everyone is
17 interested in lining their pockets. That's, you know, called
18 the American way. Okay?
19 So there's nothing wrong with wanting to line your
20 pockets. It's only if you do so in a way that you know
21 violates the antitrust laws.
22 MS. SINGER: I'll let that comment pass. I have
23 one other thought on something that Greg said. One of Greg's
24 recommendations was maybe the FTC should think about a
25 retrospective in these physician cases similar to the

1 hospital merger retrospective.
2 And I just would like to caution that there are
3 really serious difficulties in trying to study these markets
4 and figure out what's happened. And I think that the -- what
5 the hospital merger retrospective process has shown is that
6 it's not really easy to go into a market and say, ah hah,
7 prices have kind of gone up. This must have been an anti-
8 competitive merger. There's a lot of things that go into
9 that.
10 And I think that a lot of us would welcome a real,
11 legitimate study of some of these markets and where there
12 have been consent orders, especially where you can contrast
13 different kinds of remedial provisions. But before that kind
14 of thing can work, somebody has to really figure out just how
15 you measure prices in these kinds of markets and how you
16 figure out what the competitive result would have been had it
17 not been for the anti-competitive conduct.
18 MS. OVERTON: Kevin?
19 MR. O'CONNOR: I'm struggling to bring together all
20 the points that have been made here. And the thing that I
21 keep coming back to is we're still struggling with the
22 interplay between using a competitive regime versus a
23 regulatory regime to deal with this industry.
24 And I go back to my original point, which was that
25 until 20 years ago, this industry was basically regulated top

1 to bottom at the state level. And we have tried the
2 deregulation route, and we tried to substitute competition
3 for direct regulation, and in some cases it's worked and in a
4 lot of cases it hasn't worked.
5 It hasn't worked very well. And we keep seeing the
6 reverberations of that in the antitrust enforcement world.
7 Four points in that regard, quick points.
8 First, you see it when the state AGs try to
9 reinject a form of indirect regulation because the antitrust
10 enforcement remedies do not provide relief. They do not give
11 you -- give the state AG the ability to protect its citizens.
12 I mean, in the Kenosha Hospital case, which my
13 office investigated with the FTC, we were left with the
14 decision at the second request stage whether we were going to
15 continue it after the FTC dropped it.
16 Well, they were litigating the Butterworth decision
17 at the time, and we were forced to make that difficult call
18 whether we were going to go forward with a situation where
19 the two hospitals in Kenosha were merging, a Catholic
20 hospital and a nonsectarian hospital, and there was
21 significant community opposition, and it did appear that
22 there was going to be some significant anti-competitive
23 effects from the merger.
24 Would we have won the case had we litigated it?
25 Very difficult to tell. It would have been a very difficult

1 case. Did we feel we had to go forward and protect the
2 citizens of Kenosha even though, in a broader sense, it was
3 small potatoes?
4 Yes, we felt we had to do that, and so we
5 effectively issued a second request and went forward and I
6 think achieved some welfare gains for the people in that
7 community.
8 But again, was it ideal? No. I mean, in a normal
9 merger case would we look at that kind of remedy? Probably
10 not. But this is a different kind of industry in many
11 respects.
12 On the criminal point -- this is my second point --
13 I hear Jack sort of suggesting that, well, you know, the docs
14 don't quite get it. They need -- they think that because
15 there's market power on the other side of the bargaining
16 table, maybe they -- you know, they should be entitled to get
17 together, that sort of thing.
18 I have to tell you, from having done this criminal
19 enforcement on the -- criminal antitrust enforcement from the
20 state perspective in other industries, I don't buy that at
21 all.
22 I think at this point -- I mean, I was out giving
23 speeches when Rick Ruhl was giving speeches in the '80s to
24 healthcare groups in Wisconsin, telling them, there's a new
25 ball game in town. It's called antitrust. You know, if you

1 get together with your competing doctors, you know, there's a
2 potential that -- of criminal enforcement and other bad
3 things happening to you.
4 And I can't believe that the medical community does
5 not understand that at this point, at least at some level. I
6 mean, in the securities industry, you have a willfulness
7 standard. It's not even an intent requirement. I mean, if
8 you sell an unregistered security, it's a five-year felony in
9 Wisconsin. And I've prosecuted people for that.
10 I mean, so I don't think this is -- criminal
11 enforcement in this industry is at all unwarranted, where you
12 have, you know, direct collusive price-fixing, bid-rigging,
13 market allocation. I mean, those kinds of violations are
14 pretty clear-cut.
15 And I think if the medical professionals are not
16 getting the message, then their lawyers ought to be going to
17 more CLE courses or something on this sort of thing.
18 Third, my third point -- and again, it's a
19 reflection of this divide between competition and regulation
20 as a mechanism for dealing with the market imperfections here
21 and the significant market imperfections here.
22 And you see that -- I mean, I heard that
23 reverberating in Gail's comment when she mentioned that it
24 was difficult to determine if conduct relief in the state
25 remedies was really working or not. I agree, it is difficult

1 to determine whether it's working or not.
2 But I don't think it's effective to say or an
3 appropriate response to that to say, wouldn't it be better to
4 let competition, competitive markets, determine how resources
5 are allocated and so forth?
6 I got news for you: These markets aren't
7 competitive. I mean, let's understand this. I mean, you
8 have a situation in many cases where there's one or two
9 health plans buying most of the services.
10 And why do you think that over 85 percent of the
11 purchasers of hospital services in Lycoming County that Jim
12 Donahue mentioned supported the merger to monopoly in that
13 area? It's because they probably figured they were on the
14 boards of the hospital, they were essentially both the
15 purchaser and the de facto seller of the services in some
16 form, and that they could get their hands around this and
17 could control the bad stuff that might happen in a normal
18 market where you didn't have that situation.
19 And again, another market imperfection, another
20 quirk in these markets, that suggests that letting
21 competitive markets organize these resources is not
22 necessarily going work all the time because the markets don't
23 operate in that way.
24 Finally, to Mel's point about the perception that
25 the reason the states and others, you know, adopt these

1 regulatory decrees is because of the perception that they
2 can't win the case and that this is the next best alternative
3 or the only alternative to get any kind of relief, I think
4 there's some truth to that, that it's difficult to win these
5 cases, especially when you have federal judges, like in the
6 Butterworth case, basically making judgments about how
7 employers on a board of a hospital can effectively control
8 the anti-competitive effects that might result from a merger.
9 I mean, you have the judges at least implicitly and
10 sometimes explicitly directing -- injecting those kinds of
11 considerations into the case law, which makes it very
12 difficult to win the cases. Again, they're reflecting this
13 difficulty coming to grips with whether competition can
14 really organize these markets or not.
15 Anyway, thank you very much.
16 MR. DONAHUE: Let me see. On the one hand, I agree
17 with everything that Gail and Mel said. The criticisms of
18 the regulatory consent decrees are all, you know, in theory
19 correct.
20 And in fact, when I was preparing this, I was
21 thinking, you know, doing these slides, I was thinking, you
22 know, the one flaw in my argument about the -- or flaw in the
23 reasoning about the firms going out of business is that
24 necessity is the mother of invention.
25 So if a hospital is in the Williamsport situation

1 and facing its ultimate demise, maybe it does find a way,
2 pressed by really severe economic circumstances, to come up
3 with some way to reinvent itself, maybe as an outpatient
4 surgical center or using some new technology or that type of
5 thing.
6 And so I think all of those are, you know,
7 legitimate criticisms of what we've done in the past. On the
8 other hand, you know, the purist approach doesn't always work
9 from where I sit. You know, we have an obligation to
10 zealously represent our clients, which are the communities in
11 the state and the state government.
12 And an all-or-nothing approach, where we say, okay,
13 you know, we either make this case and block this merger or
14 we let it go maybe isn't the best possible -- you know, or
15 the best result.
16 We've looked at these cases and have tried to come
17 up with something that we continually review. You know, as
18 Toby has said, we had worked out something, you know, in
19 Harrisburg in a subsequent case that we were working with
20 Toby, a sort of unusual case where all of our correspondence
21 between us was published in the paper.
22 But, you know, we took some of the faults in our
23 earlier case, or what was the perceived faults, and adjusted
24 that. Whether we would do this again, you know, I don't
25 know.

1 The other thing that I think is important to note
2 is that this is something we are only going to do in the
3 nonprofit to nonprofit merger context. It's not something
4 we're going to do in the commercial context, where there's
5 any sort of -- where there are commercial players involved in
6 the healthcare industry, of which there are a lot.
7 And I think that makes a big difference both
8 because of the -- you know, the case law that talks about the
9 boards of the two institutions being dominated by the
10 business community, but also, as a practical matter, the case
11 law might be right on that. There may be situations where
12 you do have active boards that are going to do what's in the
13 best interest of the community and not necessarily try to
14 gouge everybody.
15 You know, these are extremely difficult cases for
16 us from, you know, a factual standpoint and from a policy
17 standpoint. And I think we've made -- what we're doing in
18 these regulatory consent decrees is clearly a compromise.
19 It's not a purist approach. It's not saying, you know,
20 either you make an antitrust case or you don't.
21 And we recognize that. And I think we're going to
22 continually evaluate both the results of what we've done in
23 the past and what we come across in the future.
24 MS. OVERTON: Jack?
25 MR. BIERIG: First I'd like to say I'm glad that my

1 remarks got everyone's attention, at least, judging from the
2 comments.
3 I'd like to make three points. The first is that a
4 couple people have said, well, come on. All these guys
5 really should know that price-fixing is unlawful, that what
6 they're doing is unlawful.
7 You know, no one is going to sit here -- certainly
8 I'm not going to sit here and defend sort of minimum price-
9 fixing in the classic sense by physicians any more than in
10 any other industry. Someone talked about price-fixing, big-
11 rigging, market allocations. These kinds of very blatant
12 traditional violations of the antitrust laws no one's going
13 to defend.
14 But as I tried to say in my presentation, a number
15 of things that are characterized as price-fixing are not
16 inherently evil. You look at the facts of Maricopa, where
17 these physicians got together to offer what they regarded as
18 a competitive alternative to what we today call managed care
19 plans, and they set up a fee schedule that they were going to

1 competitive.
2 You know, similarly, negotiating with managed care
3 plans who are, you know, generally quite powerful because
4 they control the patients that these physicians are going to
5 be seeing, negotiating with them and saying, here is what we
6 would like you to pay us and here is why and here's the fee
7 that we think is reasonable, that is really not price-fixing
8 in the classic sense of the minimum price-fixing, where all
9 the lore about per se arose.
10 So I really do think that it is a mistake to think
11 that physicians should know that banding together to try to
12 negotiate collectively with powerful managed care plans or to
13 set prices for a venture that they would like to, you know,
14 offer as a competitive alternative is understood by them to
15 be classic price-fixing and therefore unlawful and subject to
16 criminal violation. I think we have to distinguish among
17 different kinds of price-fixing.
18 Second, I want to address Kevin's point about, you
19 know, he thinks we need criminal enforcement because
20 physicians don't take the antitrust laws seriously. And from
21 that -- he deduces that from the fact that we have so many
22 more inquiries about the fraud and abuse laws than we have
23 about the antitrust laws in the form of, you know, business
24 advisory letters and things like that.
25 The fact of the matter is that there is far more

1 operate these hospitals "more efficiently."

1 learning. Let's do some self-education. Let's talk to some
2 people. Let's try to find out some joint ventures where
3 people think that they really have been doing good, where
4 they've been doing a good job, of practice protocols,
5 whatever some of these efficiencies that we think may
6 ultimately be justifying, especially some of the large
7 physician joint ventures, and try to get a better sense.
8 Do we think these efficiencies really are big or
9 not? And then I think once we have that feel, we can go back
10 and reevaluate where we stand on the balance between
11 structural relief and giving up the promise of efficiencies
12 in the future versus allowing for that continued promise
13 through the form of conduct relief.
14 MS. KOHRS: I'm just going to say with regard to
15 that, Greg, we actually had two days of hearings last week,
16 and September 25th was specifically on IPAs: Patterns and
17 benefits. And as reflective of these hearings, we were
18 trying to get people to come in and talk about some of these
19 issues. So that's a place where we're starting.
20 MR. VISTNES: I'd like to say I was prescient, but
21 obviously I just wasn't paying attention.
22 MS. OVERTON: Okay. Let's see. The first question
23 that I have touches on the deterrence issue that's come up.
24 And I'm just wondering, do dissolution and disgorgement, do
25 the panelists think that those might have more of a deterrent

1 I don't know whether, you know, Pershing Yoakley is
2 still out there advising people on how to, you know, set up
3 networks or not. Maybe they are, I mean, because the time
4 period has passed. But, you know, certainly that got a lot
5 of attention when it happened. I think it was probably the
6 first time that it did happen, I think, when you guys went
7 after them.
8 But anything that you can do that puts some dollars
9 on it and that puts some meat to the remedy I think is going
10 to be important. And with all due deference to Jeff Brennan
11 and the incredible job that -- I can't imagine that Jeff even
12 sleeps at night with all these consent orders coming down --
13 but, I mean, the fact is that you reach a point where it is
14 like Groundhog Day. It's the same thing time after time
15 after time.
16 And why is that? I think it's because the people
17 haven't gotten the message. And I think that the reason they
18 haven't gotten the message is I don't think they're frankly
19 scared enough.
20 MR. ORLANS: Let me just add to that from the
21 disgorgement/monetary relief perspective, I would agree with
22 Kevin. I think that the use of monetary relief in this area
23 does have a greater potential for deterrent than a simple
24 conduct prohibition going forward.
25 That said, there is the issue that I raised in my

1 initial talk about what the standards are that the Commission
2 would look to. And as Jack indicated, we are looking to more
3 than simply was there a violation. There needs to be a clear
4 violation such that essentially knowing or knowledge could be
5 imputed.
6 And so typically in our disgorgement cases, we've
7 required a situation where there's been ample legal precedent
8 such that we could reasonably believe that the participants
9 had some reason to believe that their conduct was likely to
10 be unlawful.
11 And in these physicians cases, that may or may not
12 be true, depending on how the organization has been set up.
13 I know that, you know, we have a couple of those cases in
14 trial now, and certainly they believe there are factual
15 issues that justify the legality of the way they set up those
16 particular organizations.

1 that's another reason to consider it seriously.
2 You know, the other point is that in terms of a lot
3 of the activities, you know, that are involved in deciding
4 whether or not cases should be brought and so forth, I think
5 it's really important -- and I'm not saying that you
6 criminalize everything, and I don't want to be, you know,
7 accused of saying that I believe that, you know, they should
8 abandon or the Agency should abandon civil approaches and go
9 only criminally.
10 I do think that it's important, though, that if the
11 Division were to focus in a case that in their minds there
12 was clear criminal intent, that you had a situation where you
13 had people who knew what they were doing was wrong, there
14 wasn't any doubt about it, and you brought that kind of a
15 case, that would get one heck of a lot of attention even if
16 you lost it. Okay? It would make people understand that
17 there are serious consequences.
18 The other thing, the third point I'd make here, is
19 that again to the extent that you believe the allegations in
20 the complaint that the FTC has filed recently in several of
21 these cases, there appears to be a very clear allegation that
22 you can show the difference in the prices being charged by
23 the physicians in certain communities versus communities in
24 the rest of the state where the allegations didn't take
25 place.

1 Again, I think for disgorgement purposes, you've
2 got -- again, if it's true, you've got a clear idea as to
3 exactly what the amount of the relief could be in those
4 situations. I'm not saying it's perfect. But I do think it
5 will get a heck of a lot more attention than that.
6 And I say that as a defense attorney. Okay? I
7 mean, I'm not saying this -- I don't have any dog in this
8 fight in terms of, you know, plaintiffs' class actions. I'm
9 not trying to bring that.
10 I think if you look at everybody up here, we're all
11 defense oriented except for the government people, and maybe
12 Greg, who's, you know, sitting there as the angel of the
13 economists.
14 But the fact is if we're really serious, Jack,
15 about telling -- or asking the Agencies or helping them
16 understand what needs to come out of these hearings, what
17 they ought to be doing in the future in terms of more
18 rational antitrust enforcement and how you get peoples'
19 attention, I don't think that you can ignore options such as
20 disgorgement and the appropriate criminal action.
21 And particularly I don't think that you should
22 ignore the fact that so far, I think that the dadgum
23 consultants have gotten off like bandits.
24 MS. KURSH: Could I just add one quick point? I
25 just want to -- just to sort of pick up, I think there's no

1 doubt that an appropriate criminal case and a disgorgement is
2 going to get peoples' attention a lot more than a civil
3 injunctive decree.
4 We've just also got to go back to the basic premise
5 is, at least from the Division in seeking equitable relief,
6 we have a limitation, and the purpose of our relief is to
7 stop the violation, prevent its recurrence, and eliminate
8 anti-competitive consequences.
9 Even though we may want to punish or we think a
10 little bit more would deter someone else there, we have to

1 against the consultant as well. So there's an effort on the
2 part of the FTC, at least, to look at that issue.
3 MR. GRADY: They've been mentioned in a couple of
4 consent orders. But the fact is, the relief that was imposed
5 on them, in my view, was a little more than a slap on the
6 wrist. Candidly, I mean, I don't think that that's going to
7 deter many other consultants from going out and doing what
8 they've been doing. It's a personal opinion.
9 MS. KOHRS: And that's why we invited you.
10 I wanted to ask another question. We're talking
11 about the difference between structural relief and conduct

1 I guess there could be a situation where the
2 concern you would have would be with a specific area of care
3 that could be set up as a separate unit and compete
4 independently. I just don't know that many hospitals that
5 are set up that way, that you can spin off like the
6 children's wing and let them continue to be a children's
7 hospital, and the other, too.
8 It may have come up or considered possible in some
9 hospital mergers where psych care was involved. That may be
10 a situation. But I just -- I myself haven't -- I don't
11 recall any situation where it was really considered.
12 MS. SINGER: If I could just make one comment on
13 that. In a way, Morton Plant was sort of a reverse
14 divestiture. It was a let's let some things merge and keep
15 other things separate. And that didn't work too well.
16 MR. DONAHUE: You know, we certainly have thought
17 about it. And I think the problem is -- or the problem so
18 far has been, where has been the competitive problem? If you
19 divide the industry, say, by cardiology, obstetrics, and that
20 sort of thing -- let's take cardiology as a example.
21 Maybe you've got two hospitals and they both have
22 cardiac cath labs. And you say, okay, let's divest one
23 cardiac cath lab and have it go somewhere. The problem is
24 you can't do that. I mean, under the health law and
25 regulations in Pennsylvania, any hospital that has a cardiac

1 cath lab has to be able to do open heart surgery.
2 So you've got a lot of technical problems that
3 exist so far. Now, that doesn't mean -- I mean, technology
4 is changing things all the time, and one reason for the big
5 drop in hospital days is technology moreso than managed care
6 and that sort of stuff.
7 So, you know, it may be possible. And certainly
8 things -- we have thought about that. We have thought about
9 it. Is there a way to divest the outpatient operation? Is
10 there a way to divest the -- although you usually don't get
11 it that way.
12 You usually get it as, you know, these guys have --
13 are dominant in cardiology. These guys are also dominant in
14 cardiology, and they're merging. On the orthopedic side and
15 on the gastro side and all those other sides, there's not
16 much of a competitive problem. But there is a competitive
17 problem in cardiology.
18 But that's hard to fix because, you know, there's
19 no model right now for -- in fact, the model is kind of the
20 reverse. It used to be there were heart institutes all over
21 the place that just focused on cardiology. And the model is
22 for the single specialty hospitals to kind of disappear.
23 So it's in theory something that we have kicked
24 around, and --
25 MS. KURSH: Actually, all the hospital mergers, or

1 for these physicians who engaged in price-fixing because they
2 were unintegrated. It's okay for them to integrate and start
3 doing things that are allowed under the guidelines.
4 But if they're going to do that, it can only be a
5 subset of this big group of physicians because if it's too
6 big then it's going to have a negative impact on the market.
7 Is that an accurate description of those?
8 MS. KURSH: Yes. I think it's a very important
9 issue, and in crafting appropriate relief in a physician
10 network situation, I think it's very important for the
11 Agencies to focus not on just were they were a legitimate
12 joint venture, but even if they legitimize by integrating in
13 some way of reducing some efficiencies, does that still
14 justify the size of the network?
15 And I think we need to look at that because if they
16 have been achieving -- exercising market power over the
17 years, which many of them have, and they've not been
18 integrated, and we challenge them as per se price-fixing and
19 all we do is say, well, now just, you know, integrate a
20 little and you can keep on getting those high prices even
21 though you've got 95 percent of the market, I'm not sure
22 we're really achieving effective relief.
23 And we need to at that point think about some form
24 of structural relief. And I do understand -- I think it was
25 Jack's point that it is very, very difficult, and we've heard

1 this many times, for physician organizations to restructure
2 and figure who's in and who's out.
3 And maybe in some ways the answer is dissolution
4 and reforming of a more appropriate joint venture. Because
5 just because you're a joint venture and legitimate under the
6 rule of reason doesn't mean that you still can't be -- I
7 mean, just because you fall under the rule of reason doesn't
8 mean you're legitimate under the rule of reason. You still
9 may have too much market power.
10 MS. OVERTON: I think that is -- I don't think we
11 have any time for any more comments here. And so I think I'd
12 just like to thank all of our panelists for their very
13 thoughtful presentations and for the lively discussion here.
14 MS. KOHRS: And in addition to thanking the
15 panelists who participated today, I want to say that this is
16 in fact, the last session. I want to thank all the
17 participants who have soldiered on with us through this whole
18 series of hearings.
19 And I want to say thanks to David Hyman, who is the
20 Special Counsel at the Federal Trade Commission who put these
21 together with the folks over at the Department of Justice.
22 I'd like to encourage people to submit written
23 comments. We are accepting those through November 28th. I'd
24 encourage people also to check our website, which is
25 www.ftc.gov. And DOJ has their website also, which also has

1 comprehensive information on these hearings.

2 And we will be writing the report, which is due in

3 2004. And did I leave anything else out? Thank you very

4 much for coming.

5 (Whereupon, at 12:30 p.m., the hearing was

6 concluded.)

7 * * * * *

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

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

2

3 DOCKET/FILE NUMBER: P022106

4 CASE TITLE: HEALTH CARE AND COMPETITION LAW AND POLICY

5 DATE: OCTOBER 1, 2003

6

7 I HEREBY CERTIFY that the transcript contained herein is

8 a full and accurate transcript of the tapes transcribed by me

9 on the above cause before the FEDERAL TRADE COMMISSION to the

10 best of my knowledge and belief.

11

12 DATED: OCTOBER 16, 2003

13

14 ____________________________

15 LISA SIRARD

16

17 **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**

18

19 I HEREBY CERTIFY that I proofread the transcript for

20 accuracy in spelling, hyphenation, punctuation and format.

21

22 ____________________________

23 SARA J. VANCE

24

25