This agenda is the complete history of the health care hearings, which were held February, 2003 - October, 2003. It is in one document to allow researchers to access the entire agenda and search for the issues discussed on various days, to see who participated on different days, and so on. Once you learn the date of the testimony you are interested in, please go to the transcript for that day to find testimony, or the agenda/materials for that day to find hand-outs and PowerPoint presentations.

Agenda for Joint FTC/DOJ Hearings on Health Care and Competition Law and Policy:

Wednesday, February 26, 2003, Afternoon Session

Keynote Address:
Overview of the health care industry, market developments, and regulatory framework. How well does the health care marketplace perform with regard to cost, quality, and availability of the services that are provided? How is quality defined and measured? What is the optimal level of enforcement of competition law and policy in health care markets to ensure the continued delivery of high quality products and services?

Introductory Remarks:
Timothy J. Muris, *Chairman, Federal Trade Commission*
R. Hewitt Pate, *Acting Assistant Attorney General, U.S. Department of Justice*

Keynote Address:
Thomas A. Scully, *Administrator, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services*

Framing Presentations:
Paul B. Ginsburg, *Center for Studying Health System Change*
Mark V. Pauly, *Wharton School of Business, University of Pennsylvania*
Martin S. Gaynor, *Carnegie Mellon University*

Thursday, February 27, 2003, Morning Session

Title: Perspectives on Competition Policy and the Health Care Marketplace
Health care is a complex field, subject to extensive regulation at the state and federal levels. Although there is no "learned professions" exception to the antitrust laws, the application of competition law and policy to health care is often controversial. What specific market imperfections exist in health care and how severe are these imperfections? What pro-competitive and anti-competitive responses (both public and private) have emerged in response to these imperfections? What specific challenges and complications arise in applying competition law and policy to health care? What impact has competition law and policy had on health care markets?

Opening Remarks:
William E. Kovacic, *Federal Trade Commission*

Framing Presentations:
James F. Blumstein, *Vanderbilt University*

Peter J. Hammer, *University of Michigan*

Panel:

Helen Darling, *Washington Business Group on Health*
Jacqueline M. Darrah, *American Medical Association*
Charles N. Kahn, III, *Federation of American Hospitals*
Stephanie W. Kanwit, *American Association of Health Plans*
Arnold Milstein, M.D., *Pacific Business Group on Health*

Thursday, February 27, 2003, Afternoon Session

Framing Presentations:

Thursday, March 27, 2003 Morning Session

Title: Single Specialty Hospitals
In recent years, single-specialty hospitals have emerged in various locations in the United States. Instead of offering a full-range of inpatient services, these hospitals focus on providing services relating to a single medical specialty or cluster of specialties (typically cardiology/cardiac surgery or orthopedic surgery). What factors have driven this unbundling of inpatient hospital services? What have been the effects of this unbundling? Has quality of care been enhanced as "focused factories" have emerged? Have costs and access increased or decreased? How has competition been affected for services provided by both the general inpatient hospital and the single-specialty hospital, and for services provided only by the general inpatient hospital? Is this development any different than the emergence of specialized hospitals for children, rehabilitation, and psychiatry? What actions have general inpatient hospitals taken in response to the emergence of competition from single-specialty hospitals? Do any of these actions involve anti-competitive conduct?

Framing Presentations:

Cara S. Lesser, *Center for Studying Health System Change*

Panelists:

H.E. Frech, III, *University of California, Santa Barbara*
Dennis I. Kelly, *MedCath Corporation*
George F. Lynn, *representing American Hospital Association*
Edward Alexander, *Surgical Alliance Corporation*
David Morehead, M.D., *Ohio Health*
John G. Rex-Waller, *National Surgical Hospitals*
Dan Mulholland, *Horty, Springer & Mattern, P.C.*

Thursday, March 27, 2003, Afternoon Session

Title: Contracting Practices
In recent years, some providers have developed complex networks for the delivery of health care services. These networks frequently involve multiple geographic and product markets. In several instances, there have been complaints that such provider networks are requiring that payors that wish to contract with a "desirable" hospital in one product or geographic market, must also contract with all other hospitals offered by the network, and include all network hospitals in their "most favored" tier for purposes of co-payments and other financial incentives. Payors allege that these contracts restrict their ability to steer patients to lower-cost providers in particular geographic markets. How prevalent is such conduct? What does economic theory indicate about the circumstances under which such conduct is likely to emerge? When are such arrangements likely to be pro-competitive and when are they likely to be anti-competitive? Does traditional antitrust analysis, including but not limited to tying doctrine, adequately address the forms of anti-competitive conduct likely to emerge? Does the existence of such conduct have any implications for merger review?

Panelists:

Thomas R.McCarthy, National Economic Research Associates, Inc.
Margaret E. Guerin-Calvert, *Competition Policy Associates, Inc.*
Bradley C. Strunk, *Center for Studying Health System Change*
Arthur N. Lerner, *Crowell & Moring, LLP*
Vincent Scicchitano, *Vytra Health Plans*
Harold N. Iselin, *Couch White, LLP*

Debra Holt, *Federal Trade Commission*

Friday, March 28, 2003, Morning Session

Title: Issues in Litigating Hospital Mergers
Prior to 1994, the Federal Trade Commission and the Department of Justice had considerable success in challenging hospital mergers. During the intervening eight years the Commission and the Department lost seven successive cases challenging hospital mergers. What explains this string of losses? Do these cases suggest that courts have become more skeptical of competition law and policy as applied to health care? What, if any, are the broader prospective implications of these losses? What strategies should enforcement authorities employ to ensure their efforts are targeted appropriately in the future?

Robert E. Hurley, *Virginia Commonwealth University on behalf of the Center for Studying Health System Change*
Jim Burgess, *Boston University School of Public Health*

Thursday, April 10, 2003, Morning Session

Title: Hospitals - Non-profit Status
Nonprofit hospitals comprise approximately 60% of community hospitals in the United States. Nonprofit insurers comprise/administer a substantial proportion of total premium dollars spent on health care in the United States. Conversely, physicians, nursing homes, and many other health care providers are organized as for-profit operations. How does entity status affect performance? Are there systematic differences between the performance of nonprofit and for-profit entities? How do consumers perceive the performance of nonprofit and for-profit entities, with regard to cost, quality, and access? Do consumers know when they are receiving care from a nonprofit entity? How should competition law and policy address nonprofit status?

Panelists:
William J. Lynk, *Lexecon Inc.*
Cory S. Capps, *Kellogg School of Management, Northwestern University,*
Gary J. Young, *Boston University School of Public Health*
Peter D. Jacobson, *University of Michigan School of Public Health*
Frank Sloan, *Duke University*
Eugene Anthony Fay, *Province Healthcare Co.*
Dawn M. Touzin, *Community Catalyst*

Thursday, April 10, 2003, Afternoon Session

Title: Hospital Joint Ventures and Joint Operating Agreements
Hospital joint ventures and joint operating agreements ("JOAs") raise a number of distinct issues for competition law and policy. Because these arrangements fall short of full merger, such collaborations may, even when entered into between rivals, present fewer competitive concerns than a merger would. On the other hand, lack of complete integration may limit the prospect for substantial, pro-competitive efficiencies to be realized. Joint ventures are discussed in the 1996 Statements of Antitrust Enforcement Policy in Health Care jointly issued by the Federal Trade Commission and the Department of Justice ("Statements"), but JOAs are not. What are the advantages and disadvantages of joint ventures and JOAs? Under what circumstances are joint ventures, JOAs, and other forms of cooperation likely to be pro-competitive and under what circumstances are they likely to be anti-competitive? Can some types of joint ventures help limit costly "medical arms races?" If so, would the reduction in this form of rivalry represent merely a savings to the parties, or would it constitute a net benefit to consumers? What other types of efficiencies may result from joint ventures, and what does the available historical evidence indicate about these claims? Do administrative efficiencies, in the absence of clinical integration or efficiencies, constitute a "unity of interest" so as to merit single entity treatment under *Copperweld Corp. v. Independence Tube Corp*., 467 U.S. 762 (1984)?

Panelists:
John (Jeff) Miles, *Ober/Kaler*
Robert Taylor, *Robert Taylor Associates*
Margaret E. Guerin-Calvert, *Competition Policy Associates, Inc.*

William G. Kopit, *Epstein Becker & Green, P.C.*
Robert Hubbard, *New York State Attorney General Office*

David Balto, *White & Case LLP*
James Langenfeld, *LECG, L.C.C.*
David A. Argue,

Lawrence Wu, *National Economics Research Associates, Inc.*
Steven Pizer, *Boston University School of Public Health*
Fred Dodson, *PacifiCare of California*

Thursday, April 24, 2003, Morning Session

Title: Health Insurance Monopoly Issues - Entry and Efficiencies
In most geographic markets in the United States, insurance plans frequently enter and exit. This session

interesting or unusual geographic market issues for different supplier groups are implicated by insurer monopsony theory?

Panelists:

Roger D. Blair, *University of Florida, Gainesville*
Stephen Foreman, *representing American Medical Association*
H.E. Frech III, *University of California, Santa Barbara*
Thomas R. McCarthy, *National Economic Research Associates, Inc.*
John (Jeff) Miles, *Ober/Kaler*

Friday, April 25, 2003, Morning Session

Title: Health Insurance Monopsony - Competitive Effects

Mergers between health insurers may raise a concern that monopsony power could be exercised against providers. Many providers accuse insurance companies of forcing them to accept unreasonably low rates and unattractive contract terms. When a merger increases the share of a physician's patients covered by a given insurance plan, the cost to the physician of withdrawing from that plan in response to a lowering of rates increases. What is the relationship between market shares and this cost? How do the agencies distinguish between a shift in relative bargaining power and an unlawful exercise of monopsony power? Is it sufficient to show that provider prices will likely be reduced from premerger levels to demonstrate the exercise of monopsony power, or must we affirmatively show that price levels will fall below competitive levels? Must the acquisition and exercise of monopsony power be accompanied by a reduction in the output of provider services? Is it plausible that a payor without downstream market power could exercise monopsony power unilaterally? What are the conditions that must exist for such a payor to exercise monopsony power? Are those conditions likely to be satisfied in health care markets?

Panelists:

Sharon Allen, *Arkansas Blue Cross and Blue Shield*
Stephen Foreman, *representing American Medical Association*
H.E. Frech III, *University of California, Santa Barbara*
Dennis A. Hall, *Baptist Health System, Inc.*
Stephanie W. Kanwit, *American Association of Health Plans*
Thomas R. McCarthy, *National Economic Research Associates, Inc.*
John (Jeff) Miles

health plans be permitted to acquire monopsony power in response to the possession of significant market power by providers? Should both physicians and hospitals be permitted to acquire countervailing market power, or is this an option that should only be available to certain providers? Leaving aside the economic justifications for acquiring countervailing market power, does existing legal precedent leave open the possibility of doctrinal developments that would permit providers to engage in what would otherwise be unlawful collective bargaining?

Panelists:

Donald Crane, *California Association of Physician Groups*
Stephen Foreman, *representing American Medical Association*
Martin S. Gaynor, *Carnegie Mellon University*
James Langenfeld, *LECG, L.C.C.*
Robert Leibenluft, *representing Antitrust Coalition for Consumer Choice in Health Care*
Monica Noether, *Charles River Associates*
Mark Tobey, *Office of the Attorney General, Texas*

Wednesday, May 7, 2003, Afternoon Session

Title: Most Favored Nation Clauses

A "most favored nation" ("MFN") clause is a contractual agreement between a supplier and a customer that requires the supplier to sell to the customer on pricing terms at least as favorable as the pricing terms on which that supplier sells to other customers. These clauses are not infrequently found in contracts health insurers enter into with hospitals or physicians. They allow the insurer to be confident that the reimbursement rates it pays providers are no greater than those that its competitors have negotiated. MFNs, however, may raise competitive concerns because they can discourage providers from lowering the reimbursement rates they offer to some insurers. Consequently, the agencies continue to receive and evaluate complaints about MFNs to determine whether they merit more complete investigation and enforcement action. This session will consider the following questions: What are the pro-competitive justifications for MFNs? What competitive concerns do they raise? What are the Agencies' prior enforcement activities with respect to MFNs, and what are the characteristics of the market and/or the contracts that lead to such action?

Panelists:

Jonathan B. Baker, *American University Washington College of Law*
William G. Kopit, *Epstein Becker and Green, P.C.*
Thomas Overstreet, *Charles River Associates*
Robert M. McNair, Jr., *Drinker Biddle & Reath LLP*
Steven E. Snow, *Partridge Snow & Hahn LLP*

Thursday, May 8, 2003, Morning Session

Title: Physician Hospital Organizations

A Physician Hospital Organization ("PHO") is a vertical arrangement that combines physician and hospital services within one organization. In theory, PHOs may create incentives to lower prices and enhance quality. In practice, many PHOs have declared bankruptcy or dissolved. The agencies have taken several enforcement actions against PHOs in response to specific anti-competitive conduct. What anti-competitive risks do PHOs create? For example, would doctors who are not members of the PHO be denied privileges at the hospital or given less favorable treatment? Under what circumstances might it be anti-competitive

for a physician hospital organization to offer an insurance product? What factors have led the agencies to

Thomas Piper, *American Health Planning Association*
Megan D. Price, *Professional Nurses Services, Inc.*
Robin Wilson, *University of South Carolina School of Law*

Afternoon Session Panelists:

Jeffrey C. Bauer, *Superior Consultant Company, Inc.*
Maxwell Gregg Bloche, M.D., *Georgetown University School of Law*
Steven Lomazow, M.D., *American Academy of Neurology*
Francis J. Mallon, *American Physical Therapy Association*
Jerome H. Modell, M.D., *representing American Society of Anesthesiologists*
Michael Morrisey, *University of Alabama, Birmingham, School of Public Health*
Russ Newman, *American Psychological Association*

Wednesday, June 11, 2003, Morning Session

Title: Noerr Pennington/State Action

How do Noerr Pennington and the state action doctrines affect competition law and policy? Are there specific anti-competitive practices that current enforcement efforts have not addressed because of the Noerr Pennington or state action doctrines, including but not limited to abuses of state licensure, certificate of need and other regulatory and petitioning processes? Does competition law and policy impede providers from jointly discussing their concerns with government payors? What are the appropriate boundaries for these doctrines given the competing interests at stake? Are antitrust enforcement efforts appropriately targeted in light of the impact of the Noerr Pennington and state action doctrines?

Panelists:

Meredyth Smith Andrus,

Karen Love, *Consumer Consortium on Assisted Living*
Barbara Manard, *American Association of Homes and Services for the Aging*
Barbara Paul, M.D., *Centers for Medicare and Medicaid Services*
Jan Thayer, *National Center for Assisted Living*
Keren Brown Wilson, *Jessie F. Richardson Foundation*

Thursday, June 12, 2003, Morning Session

Title: Financing Design/Consumer Information Issues
For the non-elderly, health care is financed through voluntary insurance contracts. Employment-based health insurance covers the majority of non-elderly insured Americans. How effectively do employers reflect the preferences of their employees in designing and implementing health insurance coverage? What distortions result from making employers the nexus of health insurance? Are there off-setting advantages associated with having employers involved in the health insurance market? What changes have there been in the structure of employment-based health insurance in recent years? What information is disclosed to employees in connection with obtaining health insurance? How does employment-based health insurance differ from insurance available in the individual market? Health insurance is aggressively regulated by the states, with more limited regulation by the federal government. What are the effects of this regulation on the cost and content of the health insurance products available in the marketplace? Does such regulation correct for specific failures in the market for health insurance coverage? Has the emergence of new forms of health insurance coverage (i.e., point-ofservice options, consumer-driven health insurance, and medical savings accounts) had an effect on the health insurance market and the regulatory environment?

Panelists:
Marcia L. Comstock, M.D., *Wye River Group on Healthcare*
Helen Darling, *Washington Business Group on Health*
Newt Gingrich, *The Gingrich Group*
Warren Greenberg, *George Washington University*
Greg Kelly, *Coalition Against Guaranteed Issue*
David Lansky, *Foundation for Accountability*
Michael Young, *Aon Consulting*

Thursday, June 12, 2003, Afternoon Session

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Jack Calfee, *American Enterprise Institute*
John Dicken, *General Accounting Office*
John Richardson, *The Health Strategies Consultancy*

Thursday, June 26, 2003, Afternoon Session

Title: Prospective Guidance
To provide prospective guidance to requesting parties and to the public, the FTC provides advisory opinions and the DOJ provides business review letters. Over the past decade, the FTC and DOJ have each generated approximately a half dozen such opinions and letters relating to health care per year. Does this modest volume reflect the true demand for prospective guidance, or are parties discouraged from obtaining advisory opinions and business review letters? Is prospective guidance helpful or unhelpful in the health care context? Is prospective guidance too costly or

Title: Physician Information Sharing

What kinds of information (both price and non-price) are physicians who provide services in separate practices sharing (1) among themselves; (2) with payors; and (3) with others such as employer organizations, public interest groups and the media? Under what circumstances, if any, does such information sharing pose an unacceptable risk of competitive harm? What forms of aggregation might permit the sharing of pricing data and other information among competing physicians, without facilitating tacit or explicit coordination? What, if any, are the potential procompetitive benefits and anticompetitive risks of physician surveys of price, payor reimbursement amounts, and non-price information? What, if any, are the likely effects on physician competition of

described in the Health Care Policy Statements? How timely and eff

Merrile Sing, *U.S. General Accounting Office*
John W. Strong, *Consorta, Inc*.
Elizabeth Weatherman, *Warburg Pincus*

Tuesday, September 30, 2003, Morning Session

Title: International Perspectives on Health Care and Competition Law and Policy
A number of countries other than the United States have grappled with the application of competition law and policy to health care. How do other countries apply competition law to their systems for the coverage and delivery of health care services? What, if any, is the applicability of those experiences to U.S. competition law and policy?

Introduction:
Commissioner Mozelle W. Thompson, *Federal Trade Commission*

Panelists:
Sitesh Bhojani, *Commissioner Australian Competition and Consumer Commission*
Bruce Cooper, *Australian Competition and Consumer Commission*
Michael Jacobs, *DePaul University School of Law*
Dr. Liu, Len-Yu, *Taiwan Fair Trade Commission*
Declan Purcell, *Irish Competition Authority*

Tuesday, September 30, 2003, Afternoon Session

Title: Medicare and Medicaid
Medicare and Medicaid are major purchasers of health care services. For certain populations and illnesses, they are the sole purchaser of services, and their actions have spill-over effects on the rest of the market. How should the government's roles as regulator and purchaser of health care services be reconciled? How can the government utilize its purchasing power to encourage the disclosure of information and make healthcare coverage and delivery markets more efficient? What, if any, are the limitations on the government's ability to employ its purchasing power in this fashion? What steps, if any, should the government take or avoid so that its purchasing power does not harm consumers and competition?

Panelists:
Joseph R. Antos, *American Enterprise Institute*
Joseph A. Cashia, *National Renal Alliance, LLC*
Dan L. Crippen, *Former Director, Congressional Budget Office*
Walton Francis
Jeff Lemieux, *Progressive Policy Institute*

Wednesday, October 1, 2003, Morning Session

Title: Remedies: Civil/Criminal
Health care antitrust violations, like other antitrust violations, can be addressed through both civil and criminal enforcement proceedings. With respect to civil enforcement, under what circumstances, if any, should the Agencies seek relief beyond merely prohibiting the unlawful conduct? What are the comparative advantages and drawbacks of structural remedies such as dissolution and divestiture versus conduct remedies such as membership bars, restitution and firewalls? Have the civil remedies employed in

past cases been effective? Have the Agencies sufficiently monitored and enforced compliance with final judgments once they have been entered?

With respect to criminal enforcement, prosecutions of health care professionals by the DOJ are relatively rare. What circumstances, if any, justify criminal enforcement in health care antitrust cases, and what are the impediments to such prosecutions? Given the rarity of criminal prosecutions, are civil remedies adequate? How, if at all, should the availability of private treble damages affect the relief sought by the Agencies? What changes in remedies might make the application of competition law to health care more effective?